3.002

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 16/19

Title:	**Caring for and safeguarding children and young people who attend adult services for admission, care or treatment**			
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Ownership:	Mr Aidan Dawson, Director of Specialist Hospitals and Women's Health			
Approval by:	Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting		**Approval date:**	20/06/2019 01/08/2019 07/08/2019
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Key words:	Children, young people, adult wards, safe care, safeguarding			

Links to other policies	•BHSCT Administration of intravenous fluids to children aged from 4 weeks until the 16th birthday: Reducing the risk of Hyponatraemia Policy (2016) SG 02/08 •BHSCT Adverse incident reporting and management policy (2018) TP 08/08 • BHSCT Being Open policy – Saying Sorry When Things Go Wrong (2018) SG 56/11 •BHSCT Medicines Code Policy (2017) SG 09/11 •BHSCT Claims Management & Engagement of Legal Services Policy (2017) TP 27/08 •BHSCT General Health and Safety Policy (2018) TP 50/08 •BHSCT Guidance on Actions to be Taken after a Patient's Death in Hospital (2018) SG 04/09 •BHSCT Policy and Procedure for the Management of Comments, Concerns, Complaints & Compliments (2017) TP 45/10 •BHSCT Policy on the Data Protection Act 1998 and Protection of Personal Information (2018) TP 26/08 •BHSCT Policy to be followed when obtaining consent for examination, treatment or care in adults and children (2015) SG 27/13 •BHSCT Policy for Chaperoning during Intimate Examination and Care (2012) SG 13/08 •Intimate Care guidelines (Revised Regional Core Policies & Procedures (2017) •BHSCT Procedure for Reporting and Managing Adverse Incidents (2018) TP 94/14 •BHSCT Procedure for Grading an Incident (2018) TP 95/14 •BHSCT Procedure for Investigating an Incident (2018) TP 93/14 •Recommendations from the Inquiry into Hyponatraemia-related deaths. •BHSCT The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) procedural arrangements (2018) TP 42/08 •BHSCT Serious Adverse Incident (SAI) Procedure (2016) TP 97/14 •BHSCT Policy for Sharing Learning (2016) TP 98/14 •BHSCT Visitors Policy (2019) TP 10/08 •BHSCT Whistleblowing Policy - Your right to raise a concern (2018) TP 22/08

Date	Version	Author	Comments
3rd May 2019	1.0	P McKinney	Version sent to Child Safeguarding Committee for comment (no amendment required)
20th June 2019	1.0	P McKinney	Standards & Guidelines Policy Committee (amendments to be made)
21st August 2019	1.0	P McKinney	Standards & Guidelines Policy Committee
3rd October 2019	1.1	P McKinney F Moody K McKeever	Operational amendments required – disseminated to relevant teams for comments.

19th November 2019	1.2	P McKinney F Moody K McKeever	Final amendments and returned to Standards and Guidelines.
30th January 2019	1.3		Final amendments and returned to Standards and Guidelines

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast Health and Social Care Trust (BHSCT) is committed to the provision of a high quality service to all children and young people who attend adult services for admission or have contact with adult services in an outpatient setting. This will involve the promotion and enhancing the welfare and health of the children and young people via access to age appropriate information, discussion and involvement in their care.

The Trust is committed to providing care for this group of children and young people within the framework of the Children (NI) Order 1995, the Human Rights Act 1998 ,Co-operating to Safeguarding Children 2017 and Safeguarding Board Northern Ireland (SBNI) Revised Regional Core Policies and Procedures (2017).

The Trust recognises that 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 whilst providing the safest care to meet both their physical and emotional needs. Parents and carers will be valued and their opinions taken into account, as they are experts on the child/young person.

The trust is committed to designing and delivering services which ensure that all children and young people are cared for in a developmentally appropriate setting. Further guidance and developments in relation to age appropriate care up to aged 16 and transition considerations will be part of ongoing commissioning discussions.

At present, all children requiring access to regional, tertiary specialist services, with the exception of Neurology, receive their care in the Royal Belfast Hospital for Sick Children (RBHSC) up to the 16th birthday.

The age limit for admission to RBHSC for secondary care services in Paediatric Medicine, Paediatric Neurology and Paediatric Surgery remains the 14th birthday. The trust will deliver further service re-design in a phased process to deliver the care of all children, where appropriate, in RBHSC up to the 16th birthday.

Paediatric respiratory and Diabetic services are delivered by the department of Paediatric Medicine in the secondary care sector.

The main gateway to admission to secondary care services in RBHSC is through the Children's Emergency Department. The age limit for Children's ED remains the 14th birthday.

Clinical teams should seek advice from their Paediatric colleagues, where required, regarding children aged up to the 16th birthday, attending RVH ED, or admitted to an in-patient ward. This conversation should occur between the Adult services Consultant and Consultant Paediatrician.

Children aged 16-17 years should be managed in age appropriate settings within the adult wards/facilities. All staff caring for children under 18 years should be competent to do so or access expert paediatric opinion as required.

In relation to Outpatient or similar settings the normal safeguarding considerations in relation to children/ young people should be in place and staff up to date on all required training.

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 attend adult services for admission or who attend adult services for treatment and care in an outpatient setting.

1.3 Objectives

- To provide a framework which guides staff in the decision-making process in relation to physiologically appropriate and age appropriate care of a child or young person who attend adult in patient services or have contact with adult services in an outpatient setting.
- To ensure the child or young person's needs are paramount and central to decisions, and that care is planned, integrated and co-ordinated around the individual needs and the needs of the family unit.
- 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.
- To ensure staff are aware of how to raise concerns of risk of harm toward children appropriately.

2.0 SCOPE OF THE POLICY

This policy applies to the safeguarding, multi-professional treatment and physiological care of children up to the age of 18 years who attend adult services for admission or have contact with adult services in an outpatient setting.

3.0 ROLES/RESPONSIBILITIES

3.1 All Staff

All staff must adhere to this policy and the Safeguarding Board Northern Ireland (SBNI) Revised Regional Core Policies and Procedures (2017).

Staff must ensure that children/young people are treated appropriately for their age and abilities using relevant guidance and seek advice from paediatric or other speciality colleagues, for example mental health when required.

If Intravenous fluids are required, these should only be prescribed and administered by staff who have up to date mandatory training in relation to intravenous fluids, pertinent to their role and responsibilities.

All staff should have a good understanding of the laws regarding competency and consent in young people under 18 years old (Seeking Consent, Working with Children DHSSP 2003, Gillick Competency)

Staff will have a responsibility to access the relevant child protection training pertinent to their role. The Safeguarding Children Nurse Specialist (SCNS) will advise on levels of training required. Contact should be made via main phone number **(Appendix 3)** and the relevant Safeguarding Nurse will be notified.

Staff must ensure that parents/carers have access to the consultant in charge of their child's/young person's care.

Staff are required to adhere to their Professional Codes of Conduct in relation to their Duty of Candour when delivering care to a child or young person.

Staff must ensure that the Hospital Social Worker (in the case of admissions) or the appropriate Social services gateway service (in the case of outpatient settings) is contacted/consulted where there are child protection concerns or if there is a history of social work involvement (see section 6.0 and 7.0). After 5pm in the evenings, weekend or public/bank holidays the Regional Emergency Social Work Service (RESWS) should be contacted/consulted. Contact numbers for these services can be obtained from the hospital switchboard.

3.2 Managers

Managers at all levels are responsible for ensuring that staff are aware of this policy, how to access it and provide and update on any amendments or changes to this policy or any related policies.

Managers are also responsible for keeping staff up to date about any changes to this policy.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

'A child` is a person under the age of 18 years as defined in the Children (NI) Order 1995.

A young person is defined as being aged 14-17. For the purpose of this policy we will be using the term child/young person side by side.

4.2 Effective safeguarding activity will:

- **Promote** the welfare for the child and young person;

- **Prevent** harm occurring through early identification of risk and appropriate, timely intervention; and
- **Protect** children and young people from harm when this is required.

(Co-operating to Safeguard Children and Young People in Northern Ireland 2017)

4.3 Key Policy Statement(s)

To provide staff and management with information and guidance in relation to providing both safe care and ensuring safeguarding of all children and young people who attend adult services for admission, care or treatment.

5.0 POLICY PRINCIPLES

Where children and young people are cared for in an adult environment, the following considerations should be made:

5.1 The views of children/young people and their carers should be sought and included in the planning and delivery of their care.

Every effort should be made to ensure the provision of appropriate facilities and/ accommodation for the child or young person.

5.2 The care provided for each child or young person should be sensitive to their individual needs and aspirations and take account of their race, ethnicity, gender, sexual orientation, ability or disability, anatomy and physiology. (See also 7.0 Consent).

Staff should be aware of indicators which may be suggestive that a child or young person is the subject of abuse, neglect, human trafficking or self-injurious behaviour and take appropriate action. This also includes concerns about the parents/guardian's behaviour or presentation. (See 6.0 what to do if you have child protection concerns about a child in your care)

If the child/young person is unaccompanied on admission, nursing/midwifery staff should consider the need to inform the parent/carer and hospital social services/Gateway if appropriate (see section 7.0 Consent).

5.3 All children and young people admitted will have a named consultant in charge of their care. The child/young person will be medically reviewed twice a day (morning and evening). In the event of an unplanned admission, the consultant will be informed as soon as possible that a child /young person has been admitted under their care and they will be kept informed of the patient's condition for the duration of their stay. Parents/carers will have access to this consultant. Any changes to clinical accountability/named consultant should be recorded in the notes and the child/ young person and their parents advised accordingly.

5.4 All children and young people admitted will have an identified nurse/midwife to act as an advocate for them on each shift, during their stay. Where possible this nurse should be a Registered Children`s nurse or have previous experience working with children. This nurse should, insofar as possible, be in attendance during interactions between a doctor and the child/young person.

Each child/young person will have an individualised nursing/midwifery assessment and care plan which will be fully discussed with the child/young person/parent/carer (with their consent if required). Clinical staff (Medical, Nursing and Allied Health Professionals) should respect parental knowledge and expertise in relation to their child's needs and incorporate the same into their care plans. Notes should record discussions between clinical staff and parents relating to patient care.

5.5 Staff will use the adult documentation including the nursing/midwifery assessment and plan of care document, medicine prescription kardex and risk assessments to document care, except where the child/young person's height/ weight/ anatomy would indicate that it is more appropriate to use the paediatric version.

The appropriate Paediatric Early Warning Scores chart should be used for children/young people.

The paediatric fluid prescription and balance chart **must be** used for children up to their 16th birthday. The only exceptions are

- Diabetic ketoacidosis (DKA) when specialised fluid prescription charts may be used.
- Acute burns when specialised fluid prescription charts may be used.
- Day case patients where the ward has a clear protocol for the management of these patients using operating and post-operative documentation. Any day case patient, who requires an inpatient stay, must be started on a fluid prescription and balance chart.

If in doubt, seek advice (see below), document the advice given and the name and grade of the professional giving advice in the child's nursing/medical notes, and clearly communicate the decision to the team caring for the child/ young person. The rationale for any change in treatment should be clearly recorded. Documentation must be available at the bedside when required by the multi-professional team.

5.6 Good monitoring systems should be in place to ensure all children under 18 years admitted to adult wards are identified, any issues highlighted and length of stay recorded. This should also be reported to Trust board on a quarterly basis. The Trust will explore electronic solutions to the maintenance of a live record of the status of all children/young people receiving in-patient care out-with RBHSC.

All children/ young people (under 18 years) being cared for on adult wards in BHSCT should be notified to relevant site Patient Flow on duty and reported at the 10am or 6pm Control room meeting, via RVH control room. Details should be supplied as per **Flowchart Appendix 1**. These details should then be supplied by Site Coordinator or deputy via email to the Safeguarding team and RBHSC Patient Flow and retained for monitoring purposes only. Care of the child/young person on the adult ward remains the responsibility of the staff and relevant speciality, where he/she is being cared for, including initiating Safeguarding processes as required and/or seeking paediatric advice through normal processes- **See Flowchart Appendix 1.**

If there are any issues with Consultant to Consultant referrals in this regard, these should be escalated to the relevant CD for Child Health.

5.7 Patient flow/Senior Nurse for RBHSC are contactable 24/7 to provide nursing advice or to signpost to other appropriate staff. They can be contacted via switchboard in RBHSC or Patient flow mobile.

5.7.1 Medical advice can be sought from the paediatrician on call, the paediatric consultant of the week (both available through admissions in RBHSC) or the named doctor for child protection in the Belfast Trust.

5.8 The British National Formulary for Children is available as follows: www.bnfc.org and http://belbnfweb01.belfasttrust.local:8080/bnf/.

If additional advice is required on any aspect of paediatric medicines administration the following should be contacted:

- The nominated clinical/ward-based pharmacist
- Northern Ireland Regional Medicines and Poisons Information Centre, the Royal Hospitals. Enquiry answering service is available Monday-Friday, between 9.00am and 5.00pm 90632032 or 9063 3847 by fax 9024 8030 or by e-mail: nirdic.nirdic@belfasttrust.hscni.net.
  Out-of-hours, the on-call pharmacist can be contacted for advice.

5.9 Staff must complete and update training in the recognition of the deteriorating child and be aware of how to escalate concerns in the case of a deteriorating child/young person.
This is for nursing staff and needs to be booked via the Clinical Education Centre. It is Face to Face learning and simulation- https://cec.hscni.net/programmes- "Deteriorating Child: Assessment, Intervention and Management"

Staff must familiarise themselves with the content of the resuscitation trolley and emergency drug box in their area. All adult resuscitation trollies have a variety of different sizes of equipment. Advice can be sought from the Resuscitation Services Team, Elliott Dynes, RVH contact 02890633312 resuscitation.services@belfasttrust.hscni.net

5.10 Staff must adhere to the Intimate Care guidelines (Revised Regional Core Policies & Procedures 2017).

5.11 Written information on how to raise concerns about care or submit a complaint should be given to children/young people and carers. This must be documented in the child/young person's notes and staff must adhere to relevant Trust policies (see policy links).

In the event of an untoward, adverse or serious adverse incident occurring in relation to a child/young person and staff must adhere to relevant Trust policies (see policy links).

5.12 When a child /young person wants a parent or carer to stay overnight, all efforts should be made to accommodate sleeping arrangements near to the child / young person.

Discussion should be undertaken with parents/guardians regarding appropriate television viewing, social media, electronic devices and mobile phone usage and curfews.

5.13 If the young person is 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. The hospital school co-ordinator should be consulted if the child/young person is anticipated to have prolonged admission. The hospital school co-ordinator can be contacted via the children's hospital. If it is required they should have access to play therapy.

5.14 Age appropriate care of children/young people may include assessment of sexual/reproductive and gynaecological health needs.

Social services will meet and complete a needs assessment for all children/young people who require access to maternity/sexual health/ gynaecological services during their admission. Further information is available from "Seeking Consent: Working with Children" (DHSSPS 2003). "Reference Guide to Consent for Examination, Treatment or Care" (DHSSPS 2003). Gillick Competency and Fraser guidelines- NSPCC and SBNI policies and procedures reference these. (The Fraser Guidelines specifically relate to contraception and sexual health and are pertinent to giving contraceptive advice and treatment to those under 16 without parental consent. The guidelines also apply to decisions about treatment for STI's and termination of pregnancy).

6.0 VISITING ARRANGEMENTS

6.1 All of the points referenced in the Trust's Visitor Policy equally apply to children/young people. Information will be provided to the children/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 if appropriate.

6.2 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.

6.3 There should be a visible, vigilant staff presence evident at visiting times, to reduce potential risk to and vulnerability of the child/young person.

7.0 CONSENT

7.1 Regardless of age, if required, emergency treatment to save life or prevent deterioration can go ahead without consent.

7.2 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.

7.3 Only a person who legally has parental responsibility may provide consent to a child's treatment. (Please refer to Section 8.0).
N.B- Exceptionality- where the Trust has an Interim or Full Care Order in place, social services will have responsibility for provision of consent.)

7.4 By virtue of section 4 of the Age of Majority Act (Northern Ireland) 1969, people aged 16 or 17 are entitled to consent to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed individual capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16-17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court.

7.5 Section 4 of the Age of Majority Act (Northern Ireland) 1969 applies only to the young person's own treatment. It does not apply to an intervention which is not potentially of direct health benefit to the young person, such as blood donation or non-therapeutic research on the causes of a disorder. However, a young person may be able to consent to such an intervention under the standard of Gillick competence, considered below.

7.6 Following the case of Gillick, the courts have held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention. This is sometimes described as being "Gillick competent" and may apply to consent to treatment, research or tissue donation.
As the understanding required for different interventions will vary considerably, a child under 16 may therefore have the capacity to consent to some interventions but not to others. As with adults, assumptions that a child with a learning disability may not be able to understand the issues should never be made automatically.

7.7 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. Staff may wish to consult with hospital social work/Gateway/RESWS for advice and guidance.

7.8 Further information is available from "Seeking Consent: Working with Children" (DHSSPS 2003). "Reference Guide to Consent for Examination, Treatment or Care" (DHSSPS 2003). Gillick Competency and Fraser guidelines- NSPCC and SBNI policies and procedures reference these. Consent in Adults, Adolescents and Children in Emergency Departments (Royal College of Emergency medicine (2018).

8.0 PARENTAL RESPONSIBILITY

8.1 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, or the Trust as a Corporate Parent. Not all parents will legally have parental responsibility.

8.2 The following applies to children whose birth is registered in Northern Ireland as to who has parental responsibility:

- 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 15th 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, Adoption and a Care Order.

9.0 STAFF TRAINING

9.1 All staff involved in the care of children/young people must have access to relevant training to enhance knowledge and enabling them to meet the needs of this age group. This includes mandatory Safeguarding Children Training Level 1-3, Identification of the deteriorating Child and management of paediatric intravenous fluids – including prescribing and/ or administration - depending on roles and responsibilities. This is available to book via the Clinical Education centre- https://cec.hscni.net/programmes/
-Intravenous Administration of Medicines (Children)

There is also a useful, free online resource approved by Royal College of Paediatrics and Child Health (RCPCH) and Department of Health – www.spottingthesickchild.com.

10.0 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- see Appendix 3

10.1 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.

10.2 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.

10.3 Seek medical attention if required.

10.4 Identify and discuss concern(s) with:

- Line manager.
- Hospital social worker (in the case of admissions) or the Gateway Team (in the case of outpatient settings) or RESWS (after 5pm/weekends/public or bank holidays)
- Named Safeguarding Children Nurse Specialist (SCNS) 9am-5pm Mon-Friday.

10.5 Document accurately all consultations with parents and or child and commence an "Understanding the Needs of Children in Northern Ireland" (UNOCINI) assessment if appropriate. Follow UNOCINI process (Appendix 2).

10.6 During normal working hours (9am to 5pm) ,where there is a child protection concern, ward staff should inform the hospital social worker and liaise with the a Safeguarding Children Nurse Specialist via written notification of any child protection concerns, using the form in appendix 2. This form may be e-mailed to the SCNS as per Trust e-mailing policy. Staff in centres that are outside the hospital setting can contact Gateway Services between the hours of 9-5 and the then the regional out of hours service outside of these times.

10.7 A UNOCINI should be submitted to Social Services Gateway Services regarding staff concerns.

10.8 Outside normal working hours (5pm to 9am) where there is a child protection concern ward staff should contact the Regional Emergency Social Work Service.

10.9 A nursing and medical care plan for the child should be jointly agreed between social services and ward staff to ensure the safety of the child.

10.10 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.

11.0 IMPLEMENTATION OF POLICY

11.1 Dissemination

Dissemination of this policy should be implemented to all BHSCT hospital staff, medical and hospital social work staff/field social workers via team meetings. Information pertaining to the policy will also be available via the Trust Hub Policies and Procedure page.

11.2 Resources

All staff involved in the care of children/young people must 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 HRPTS and UNOCINI training.

11.3 Exceptions

Belfast Health and Social Care Trust (BHSCT) aims to provide a high quality service to all children and young people requiring admission to hospital. On occasion, children and young people may be admitted to an adult ward for care and treatment. This policy applies to staff working in adult wards and departments who admit 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 and Adolescent Mental Health Services who are admitted to Acute Adult Mental Health'.

12.0 MONITORING

The policy will be reviewed after one year in the first instance.

13.0 EVIDENCE BASE / REFERENCES

1. British Medical Association (2010) Children and young people tool kit
2. British Medical Association (2001) Consent, rights and choices in health care for children and young people. London: BMJ Publishing Group
3. Children Order1995 (Northern Ireland) www.legislation.gov.uk/nisi/1995/755/contents/made
4. Department of Health. Co-operating to Safeguarding Children.2017:www.health-ni.gov.uk/publication/co-operating-safeguard-children-and-young-people-northern-ireland
5. Department of Health. Safeguarding Board for Northern Ireland Procedures Manual.2018:www.proceduresonline.com/sbni
6. Department of Health. Standards for Child Protection Services.2008.www.health-ni.gov.uk/publication/standards-chil-protection-services
7. Consent in Adults, Adolescents and Children in Emergency Departments Royal College of Emergency Medicine Best Practice Guideline (2018).
8. Gain Guidelines on Caring For People with a Learning Disability in General Hospital Settings June 2010 Ch 12: Improving the Experience of Children with a Learning Disability
9. Gilmore, S. and Herring, J. (2011) 'No' is the hardest word: consent and children's autonomy. Child and Family Law Quarterly, 23(1): 3-25
10. Human Rights Act (1998) available at www.hmso.gov.uk
11. BHSCT Intimate Care – Examination - Chaperoning Policy Ref SG 13/08 (under review)
12. O'Hara, J. (2018) The Inquiry in Hyponatraemia related deaths
13. NSPCC Consent process https://learning.nspcc.org.uk/research-resources/briefings/research-with-children-ethics-safety-avoiding-harm/
14. Protection of Children &Vulnerable Adults (NI) Order (2003):www.legislation.gov.uk/nisi/2003/417
15. Record Keeping – Guidance for Nurses and Midwives (NMC 2009) Reference Guide to consent for examination or treatment (DOH 2009)
16. Regional Nursing Assessment & Plan of Care document.
17. Safeguarding Board Act (Northern Ireland) 2011: www.legislation.gov.uk/nisi/2011/7/contents
18. Safeguarding Children and Young People - every nurse's responsibility (RCN Guidance for Nursing Staff 2014)
19. Seeking Consent: Working with Children (DHSSPS 2003)
20. Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008)
21. UNOCINI Guidance, Understanding the Needs of Children in Northern Ireland
22. United Nations Convention on the Rights of the Child (1989)
23. BHSCT Visitors Policy Ref TP 10/08 (2008)

14.0 CONSULTATION PROCESS

- AHP team

- Collective Leadership teams across all divisions (Including Chairs of Division for Children's services and Divisional Nurses & Divisional Midwife)
- Consultant Paediatrician (Clinical Lead)
- Consultant Paediatrician Safeguarding Lead
- Consultant Anaesthetist (Lead for deteriorating patient)
- Deputy Medical Director
- Deputy Director of Nursing
- Named Nurse for Safeguarding Children
- Nursing Development Lead
- Pharmacy team
- Resuscitation Services Team
- Safeguarding Children Nurse Specialists
- Safeguarding Children Committee members
- Senior Nurse Management Team
- Social Worker team Safeguarding Specialists

15.0 APPENDICES / ATTACHMENTS

- Appendix 1 – Referral Form.
- Appendix 2 - Safeguarding Children Nurses Specialists.
- Appendix 3 - Flowchart for Making Referral to Family & Child Care Social Services.

16.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it should be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☒

No impact ☐

17.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this link.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

18.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

19.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

Patricia Mcmurray

_____ **Date:** 30/01/2019

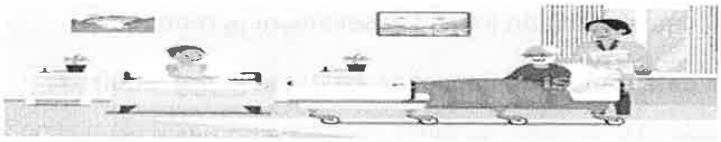
Authors

Damian.

_____ **Date:** 30/01/2019

Director

Appendix 1- Flowchart for Safeguarding of child/young person cared for in an Adult Setting



CHILD/ YOUNG PERSON – UNDER 18 ADMITTED TO ADULT WARD

NURSE/MIDWIFE IN CHARGE OF WARD NOTIFIES SITE PATIENT FLOW BY EMAIL OR PHONE IN NEXT 24 HOURS BY 10AM OR 6PM WITH THE FOLLOWING INFORMATION:**

Demographics - H&C, Initials, DoB, Sex, Ward of admission

Safeguarding Input Required? Y/N
- Referral made by:
- Referral made to:
Paediatric Input Required? Y/N
- Referral made by:
- Referral made to:

IF TO EITHER QUESTION – ADULT WARD/DEPARTMENT SHOULD INITIATE CONTACT AS PER POLICY.

Patient Flow on each site forward emails to RVH Control Room (mail to SiteCo-ordinators@belfasttrust.hscni.net) by 10am and/or 6pm daily.
Site Coordinator then collates information. Any concerns or escalations to be discussed on the 10am and 6pm calls.

Collated information emailed by Site Coordinator/deputy to Safeguarding Team (mail to SafeguardingCNS@belfasttrust.hscni.net) and RBHSC Patient Flow (mail to Patientflow.RBHSC@belfastttrust.hscni.net) and filed daily.

** **Contact Details**:
Patient Flow Team BCH-SM PatientFlowTeam.BCH@belfasttrust.hscni.net
Patient Flow Team RVH-SM patientflowteam.rvh@belfasttrust.hscni.net
Patient Flow Team MIH-SM patientflowteam.mih@belfasttrust.hscni.net
MPH Patient Flow – Mobile - 07788210400
Maternity Services – Mobile - 07860179478

Appendix 2

Unocini
Understanding the Needs of Children in Northern Ireland
A1 REFERRAL V2_1

Section 1: Child or Young Person's Details		
Surname: **Forename:**	**ID No.**	
Known As:	**HCN:**	
Address: **Postcode:** **Telephone No:** **Mobile No:**	**Previous Address:** **Previous Postcode:** **Locality:**	
Date of Birth:	**Gender**	
GP Name: **GP Address:** **GP Postcode:**	**GP Tel No:** **GP Email Address:**	
School Name: **School Address:**	**School Tel No:** **School Postcode:**	
Does the Child have a Disability? Yes ☐ No ☐	**If Yes, What Disability:** (& source of diagnosis)	**Other Special Needs:**
Nationality:	**Ethnic Origin:**	
Religion:	**Country of Origin:**	
Language Spoken:	**Communication Support:** Yes ☐ No ☐	
Interpreter ☐ **Signer** ☐ **Document Translator** ☐		

Section 2a: Referrer's Details	
Name of Referrer:	**Designation:**

Address:	**Date of Referral:** Click here to enter a date.
Postcode:	**Contact Details:**

Section 2b: Reason for Referral

Section 2c: Immediate Actions

Are Immediate /Actions necessary to safeguard the child(ren) or young person(s)?	Yes ☐ No ☐

Section 3a: Primary Carers & Other Household Members (Incl. non-family members)

	Member 1	Member 2	Member 3	Member 4
Last Name:				
Alternative Last Name:				
First Name:				
Telephone No:				
Mobile No:				
Date of Birth:				
Relationship to Child/ YP:				
Language Spoken:				
Nationality:				
Communication Support:	☐ Interpreter ☐ Signer	☐ Interpreter ☐ Signer	☐ Interpreter ☐ Signer	☐ Interpreter ☐ Signer

	☐ Doc. Trans Details	☐ Doc. Trans Details	☐ Doc. Trans Details	☐ Doc. Trans Details
Section 3b: Significant Others (Incl. family members who are not members of the child(ren) or young person(s) household)				
	Other 1	**Other 2**	**Other 3**	**Other 4**
Last Name:				
Alternative Last Name:				
First Name:				
Address: **Postcode:**				
Mobile No:				
Date of Birth:				
Relationship to Child/ YP:				
Language Spoken:				
Nationality:				
Communication Support:	☐ Interpreter ☐ Signer ☐ Doc. Trans Details	☐ Interpreter ☐ Signer ☐ Doc. Trans Details	☐ Interpreter ☐ Signer ☐ Doc. Trans Details	☐ Interpreter ☐ Signer ☐ Doc. Trans Details

Section 4a: Summary of Referrer's Previous Involvement

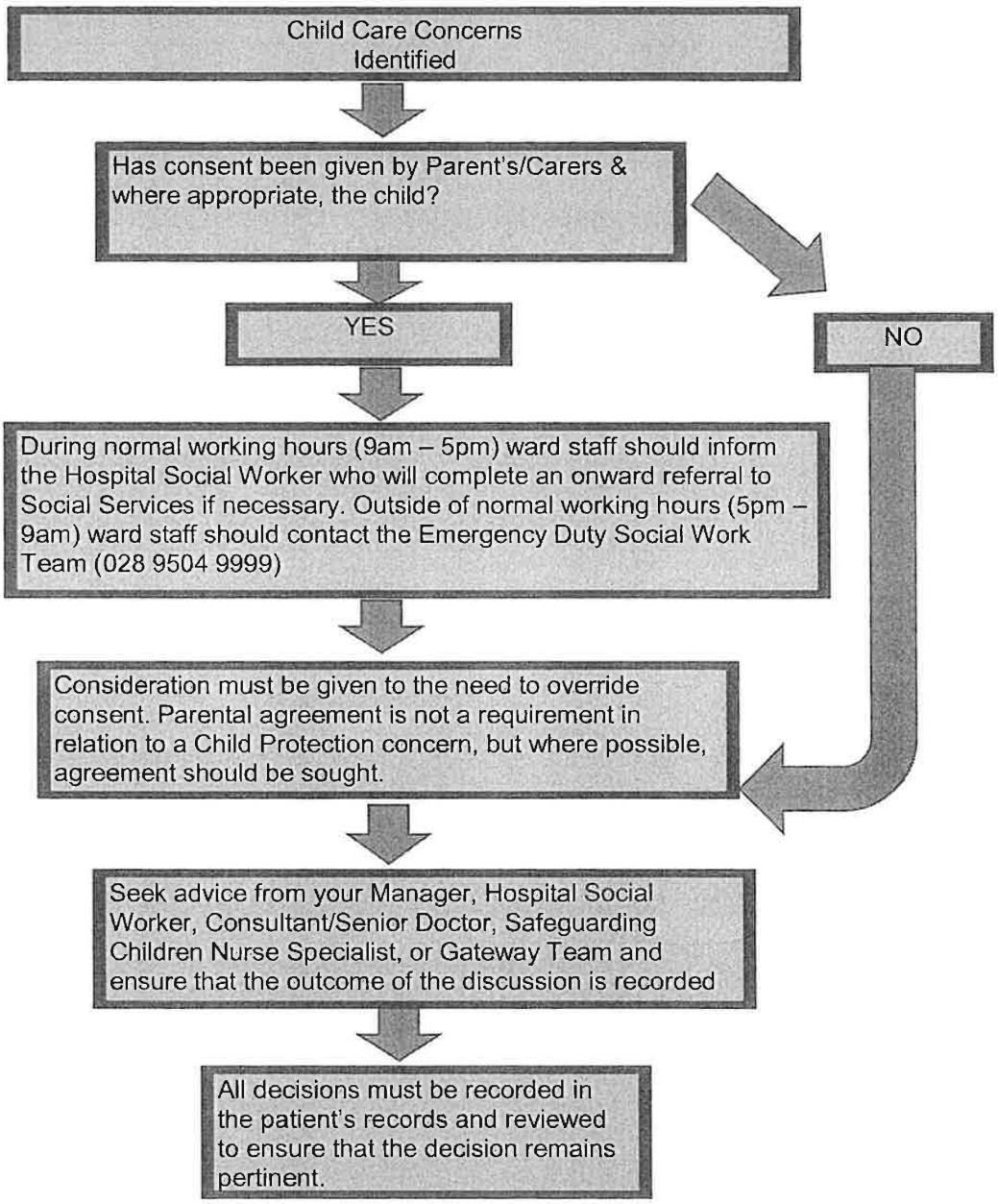
Section 4b: Referral Consent	
Child(ren) / Young Person(s)	
Is the Child(ren) / Young Person(s) subject to this referral aware the referral is being made?	Yes ☐ No ☐
Does the Child(ren) / Young Person(s) consent to the Referral?	Yes ☐ No ☐
If NO, please explain	
Parent/ Carer	
Is the Parents/ Carers aware that Referral has been made?	Yes ☐ No ☐
Do they consent to the Referral?	Yes ☐ No ☐
If NO, please explain	

Section 5: Additional Information: Agencies Currently Working with Child or Young Person
Agency and Contact Details
Name: **Role:** **Tel No:** **Email:**
Name: **Role:** **Tel No:** **Email:**
Name: **Role:** **Tel No:** **Email:**
Name: **Role:** **Tel No:** **Email:**

Appendix 3- Safeguarding Children Nurse Specialists

If you require advice/ support from Safeguarding team – please contact main phone number below and the relevant Safeguarding nurse/team will be informed.
Monday 9am – 5pm contact the **Safeguarding Children Nursing Team Office – 028 90265870**
Appendix 4- **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



Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 20/19

Title:	**Adult Safeguarding policy and procedure**			
Author(s)	Yvonne McKnight, Adult Safeguarding Lead, Tel: [redacted]			
Ownership:	Marie Heaney, Adult Social and Primary Care Services Director			
Approval by:	Directorate Governance Meeting Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting		**Approval date:**	08/10/2019 03/10/2019 28/08/2019
Operational Date:	October 2019		**Next Review:**	October 2024
Version No.	1	**Supersedes**	BHSCT Adult Protection Policy and Procedures 2013 TP 44/10	
Key words:	Adult Protection, Adult at risk of harm, Adults in need of protection			
Links to other policies	Adult Safeguarding Policy : Prevention and Protection in Partnership (DHSSPS 2015) https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection (NIASP 2016) http://www.hscboard.hscni.net/download/PUBLICATIONS/safeguard-vulnerable-adults/niasp-publications/Adult-Safeguarding-Operational-Procedures.pdf Regional Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016) http://www.hscboard.hscni.net/download/PUBLICATIONS/safeguard-vulnerable-adults/niasp-publications/Protocol-for-joint-investigation-of-adult-safeguarding-cases.pdf			

Date	Version	Author	Comments
28/08/2019	0.1	Marie Heaney Yvonne McKnight	Policy supersedes previous version

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

The Belfast Health and Social Care Trust (BHSCT) is committed to protecting adults at risk of harm caused by abuse, exploitation or neglect. The Trust has a zero tolerance approach to all forms of abuse and exploitation. The Trust is clear that Adult Safeguarding is everyone's business and that safeguarding covers a wide range of activities from prevention through to protection. The Trust Adult Safeguarding Policy previously focused on adult protection and this Policy acknowledges the importance of the continuum of safeguarding from prevention through to protection, as detailed in the new Regional Policy. The Belfast Trust have therefore extended the scope of work in relation to adult safeguarding to include both prevention and protection. The Trust affirms its lead role in relation to protection and its responsibilities in relation to adults in need of protection. The Trust also notes the important role and responsibilities that Trust staff have in relation to prevention and early intervention. It further recognises that a sensitive, proportionate response to adult safeguarding will include a range of alternative safeguarding responses.

This Policy replaces the previous Belfast Trust Adult Protection Policy and Procedures.

1.2 Purpose

The purpose of the Policy is to make clear the requirements of the Trust in relation to Adult Safeguarding. The Policy covers the whole spectrum of safeguarding from prevention through to protection and seeks to set out the Trust expectations in relation to this safeguarding continuum. The Policy is intended to promote good practice and provide guidance for staff in situations where there are concerns that an adult/adults at risk may be subject to harm caused by abuse, exploitation or neglect. Harm caused within the context of this Policy relates to an act/s or omission/s by another person/s and self-neglect is not included within this Policy.

The primary purpose of this Policy is to make clear to all Trust staff that the Belfast Trust has accepted, adopted and implemented the regional policies:

- Adult Safeguarding Policy: Prevention and Protection in Partnership (DHSSPS 2015)
- Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection (NIASP 2016).

Trust staff are required to read this Trust Policy in conjunction with both of the above regional documents and this information should guide their practice.

Other relevant regional Policies and Protocols include:
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)
- Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy (Dept. of Justice 2012).

Other relevant Trust Policy which will interface at times with this Policy and therefore should be considered include:
- BHSCT Policy and Procedure for Management of Comments, Concerns, Complaints and Compliments Policy June 2017;
http://intranet.belfasttrust.local/policies/Documents/Comments, Concerns, Complaints and Compliments - Policy and Procedure for the Management of.pdf
- BHSCT Disciplinary Procedure August 2015;
http://intranet.belfasttrust.local/policies/Documents/Disciplinary Procedure.pdf
- BHSCT Serious Adverse Incident Procedure September 2016;
http://intranet.belfasttrust.local/policies/Documents/Adverse incident - Serious Adverse Incident (SAI) Procedure.pdf
- BHSCT Trust Protocol for the Recruitment and Employment of staff under the Safeguarding Vulnerable Groups (NI) Order 2007 and the Vetting and Barring Scheme, as amended by the Protection of Freedoms Act (2012);
http://intranet.belfasttrust.local/policies/Documents/Recruitment and Selection of Staff Under Requirements of SVGO - Vetting amd Barring Scheme policy.pdf
- BHSCT Policy and Procedural Arrangements relating to Lone Working August 2015;
http://intranet.belfasttrust.local/policies/Documents/Lone working Policy.pdf
- BHSCT A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace November 2015;
http://intranet.belfasttrust.local/policies/Documents/Zero Tolerance Policy.pdf

1.3 Objectives

- To promote zero tolerance of harm to all adults from abuse, exploitation and neglect

- To prevent harm caused by abuse, exploitation or neglect by promoting good practice and early identification and response when harm has or is likely to be caused

- To comply with regional requirements as outlined in the Adult Safeguarding Prevention and Protection in Partnership Policy and the Adult Safeguarding Operational Procedures

- To clarify the roles and responsibilities of those involved in Adult Safeguarding and Adult Protection work

- To seek to ensure that a comprehensive and consistent approach is taken across the Trust in relation to adults at risk of harm and adults in need of protection

- To provide a framework within which all adults at risk will be supported and have their rights protected

- To provide a compassionate, safe, effective response to adults at risk of harm and adults in need of protection
- To promote strong partnership working internally (across professions, service areas and directorates) and externally (with PSNI, RQIA, independent sector organisations and community and voluntary groups).

2.0 SCOPE OF THE POLICY

The Policy is relevant to all staff working within the Trust who either directly or indirectly come into contact with Adults at Risk. The Policy recognises that abuse, exploitation and neglect of Adults at Risk can happen anywhere including community, Hospital, Care Facilities, Supported Living, Day Care and the Policy is therefore applicable in all settings. The Trust as commissioner of services will work with all organisations to ensure identification, early intervention and protection of adults at risk of harm. Inclusion of adult safeguarding regional requirements will be included in Belfast Trust contracts. Where the threshold for an adult protection intervention is met the Trust and or the police will take the lead role in relation to adults in need of protection. .

This Policy does not operate independently of other Belfast Trust Policies and Procedures.

3.0 ROLES / RESPONSIBILITIES

In keeping with policy requirements the Trust have in place a governance structure which supports the work in relation to Adult Safeguarding.

To meet the policy and procedural requirements and achieve the objectives set, there is a need for clarity regarding roles and responsibilities within the Trust.

Trust Board

Trust Board role is to ensure that regional requirements in relation to adult safeguarding are met and that the Trust have policies and procedures in place.

Adult Safeguarding Committee

The Committee is chaired by the Executive Director of Social Work and members include the Trust-wide Adult Safeguarding Champion and other relevant senior staff within the Trust. The Committee is part of the governance framework and is responsible for ensuring delivery of adult safeguarding within the Trust.

Adult Safeguarding Champion

The regional Policy directs that organisations must have an Adult Safeguarding Champion and details the role and responsibilities of the Champion. The Belfast Trust have a named Adult Safeguarding Champion and a number of appointed persons who assist in terms of the Adult Safeguarding champion role and responsibilities, which are specified in the regional Policy.
Service Group: Directors / Co-Directors / Service Managers

The responsibility for ensuring that all staff are familiar with this Policy and Procedure and understand their role and responsibilities rests with their line managers.

Senior managers need to consider the compliment of staff trained as DAPOs, IOs and ABE interviewers and ensure that there are sufficient specialist staff to meet the needs of the service.

There is a responsibility for each service to ensure that staff have access to an Appointed Person (ASC).

The key roles identified in relation to adult protection work are the Designated Adult Protection Officer (DAPO), the Investigating Officer (IO) and the Achieving Best Evidence Specialist Interviewer (ABE). The NIASP regional framework details five levels of training and specifies the training requirements for DAPOs, IOs and ABE Interviewers.

Trust staff

Trust staff are required to:

- Adhere to the Adult Safeguarding Policy and Procedures;
- Attend relevant training;
- Raise issues of concern promptly with their line manager / appointed person;
- To follow reporting procedures;
- To adhere to the protocol for joint investigations in relation to safeguarding cases;
- Regulated services should adhere to all of the above and also comply with Regulation Quality and Improvement Authority reporting procedures.

4.0 KEY POLICY PRINCIPLES

The Belfast Trust reaffirms its commitment to deliver on the five underpinning principles as detailed in the DHSSPS Adult Safeguarding Policy. Trust staff must have a comprehensive knowledge and understanding of the principles contained within the DHSSPS Adult Safeguarding Policy and apply these in relation to Adult Safeguarding and Adult Protection work.
(Appendix 1, pages 8 & 9). These principles include:

- A rights based approach
- An empowering approach
- A person centred approach
- A consent driven approach
- A collaborative approach

4.1 Key definitions

The Belfast Trust has accepted and adopted the definitions of an Adult at Risk of Harm and an Adults in Need of Protection as detailed in the DHSSPS Adult Safeguarding Policy and the NIASP regional Operational Procedures.

This Policy is applicable to the protection of adults who are at risk of harm and adults in need of protection. It covers all types of abuse including neglect and recognises that people at risk cannot always protect themselves.

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 personal characteristics and/or 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.

In keeping with the regional Policy and Procedures the Belfast Trust defines harm as the impact on the victim of abuse, exploitation or neglect. Furthermore the Trust recognise the importance of understanding fully the concept of harm and the role of the HSC Trust staff in terms of conducting professional assessments to ensure a compassionate, sensitive, measured and proportionate outcome for service users.

The Procedures define harm as:
- Physical abuse;
- Sexual violence and abuse;
- Psychological / emotional abuse;
- Financial abuse;
- Institutional abuse;
- Neglect;
- Exploitation

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
- Human Trafficking/Modern Slavery
- Hate Crime

Trust staff are required to recognise and respond to adults at risk of harm and therefore need to have a robust understanding of the types of harm and the associated signs and symptoms

(**See Appendix 2 – Regional Operational Procedures, Pages 7 – 11).**

4.2 Key Policy statements

- The Trust has zero tolerance in relation to harm to adults at risk
- The Trust recognises that prevention of harm is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (independent sector, community and voluntary) to deliver safe, effective and compassionate care
- Staff are expected to recognise and respond to harm caused to an adult at risk
- Trust staff need to report their concerns immediately and contribute to any investigations and / or safety plans were appropriate
- The Trust will need to ensure that staff training in relation to Adult Safeguarding / Adult Protection is commensurate with the individuals role and responsibility
- Human Rights legislation will need to be considered in all cases
- The principles of consent and capacity should be adhered to and the views and wishes of the individual should be central component to the Adult Safeguarding / Adult Protection outcomes
- In all cases the Trust staff need to respond to concerns in relation to harm in a sensitive measured and proportionate manner that considers a range of options.

5.0 IMPLEMENTATION OF POLICY

While lead responsibility for this Policy and Procedures rests with the Executive Director of Social Work and the Trust Adult Safeguarding Champion, implementation is a delegated responsibility within each directorate, service area and profession. That said implementation of the Policy and procedure is a delegated responsibility with each service area being responsible for implementation within their own service area through their existing service area structures.

Implementation will be supported by training. The NIASP Training Framework details regional agreed levels of training:

- Level 1 Induction
- Level 2 Awareness Raising Recognising and Responding
- Level 3 Managers / Appointed Persons training
- Level 4 IO / DAPO training
- Level 5 Joint Protocol training
- Level 6 Achieving Best Evidence Specialist Interviewer Training.

The Belfast Trust social care Learning and Development Team provide training in relation to each of these six levels to social care staff. Each Trust service area will be required to have arrangements in place in terms of meeting training requirements.

It is the responsibility of managers to ensure that staff are made aware of this Policy and Procedures and also to identify the level of training appropriate to their role. Responsibility for sourcing the appropriate level of training rests with line managers and Senior Managers.

In addition to training, implementation will also be supported through the Trust Adult Protection Forums. To ensure ongoing development and support to staff working directly in Adult Protection, 3 practice support groups have been established for Designated Adult Protection Officers, Investigating Officers and staff trained as Specialist ABE interviewers.

Trust best practice guidelines require that DAPO's and IO's attend at least 2 practice support groups annually.

In addition to the ongoing training provided in the Trust, additional sessions will be organised to ensure that specialist staff receive details regarding the updated Policy.

PROCEDURES

The Belfast Trust is committed to delivering on the regional Operational Procedures (Appendix 2, section B) Safeguarding Adults at Risk of Harm. This outlines responsibilities in relation to prevention and early recognition and identification of harm. It also details reporting requirements and the need for Trust staff to conduct professional assessment were a referral relates to a concern that an adult at risk of harm may have been or is likely to be harmed. The Belfast Trust is committed to providing a sensitive proportionate response which focuses on the views and wishes of the individual. Furthermore, the Trust recognise that in certain situations the most appropriate response may be an alternative safeguarding response. The Trust is committed to meeting the requirements as detailed and staff should follow the guidance provided in this section of the regional Procedures. Trust Services/facilities should provide local information in terms of the Adult Safeguarding Champion appointed person/s. A template has been provided to assist with this **(Appendix 3)**. This Policy also includes a referral pathway to support implementation and a template has been provided to assist with this **(Appendix 4)**. That said, it is recognised that facilities may choose to/need to adopt referral pathways to suit their particular areas of work.

The Trust is committed to meeting the requirements as detailed in the regional Operational Procedures (Appendix 2, Section C) Safeguarding Adults in Need of Protection.

5.1 Dissemination

The Policy will be placed on the Trust intranet and a Trust wide notification will be issued to all staff.

5.2 Resources

HSC Trust received no additional funding to support implementation of this Policy. The Adult Safeguarding Committee are committed to delivering on the requirements as detailed but in light of financial constraints are adopting a phased approach to implementation.

5.3 Exceptions

No exceptions.

6.0 MONITORING

6.1 The implementation of this Policy will be monitored and reviewed by senior management and the Adult Safeguarding Committee. Reports to HSCB will be provided in terms of Statutory Functions.

6.2 Statistical information in relation to adults at risk of harm and in adults in need of protection will be collated and shared with relevant senior managers / Adult Safeguarding Committee and HSCB.

6.3 The implementation of this Policy will be audited as directed by the Adult Safeguarding Committee.

7.0 EVIDENCE BASE / REFERENCES

- Adult Safeguarding Prevention and Protection in Partnership (DHSSPS 2015)
- Adult Safeguarding Operational Procedures (NIASP 2016)
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)
- Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy. Department of Justice (2012)
- Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements. (NIO March 2010)
- Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy, Department of Health and Department of Justice (2016)
- Public Protection Arrangements Northern Ireland – Strategic document Multi-Agency Risk Assessment Conference (MARAC)

8.0 CONSULTATION PROCESS

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Adult Safeguarding Prevention and Protection in Partnership (DHSSPS) July 2015;
Appendix 2: Adult Safeguarding Operational Procedures – Adults at Risk of Harm and Adults in Need of Protection (NIASP) September 2016;
Appendix 3: BHSCT Reporting Template;
Appendix 4: BHSCT Adult Safeguarding and Adult Protection Referral Pathway (Sample)

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. ☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

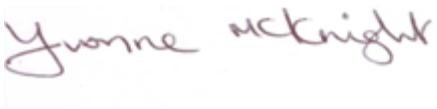
From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the Policy and the identified responsible director).



28 August 2019

_____ **Date:** _____

Yvonne McKnight
Adult Safeguarding Lead

28 August 2019

_____ **Date:** _____

Marie Heaney
Director of Adult Social and Primary Care

28 August 2019

_____ **Date:** _____

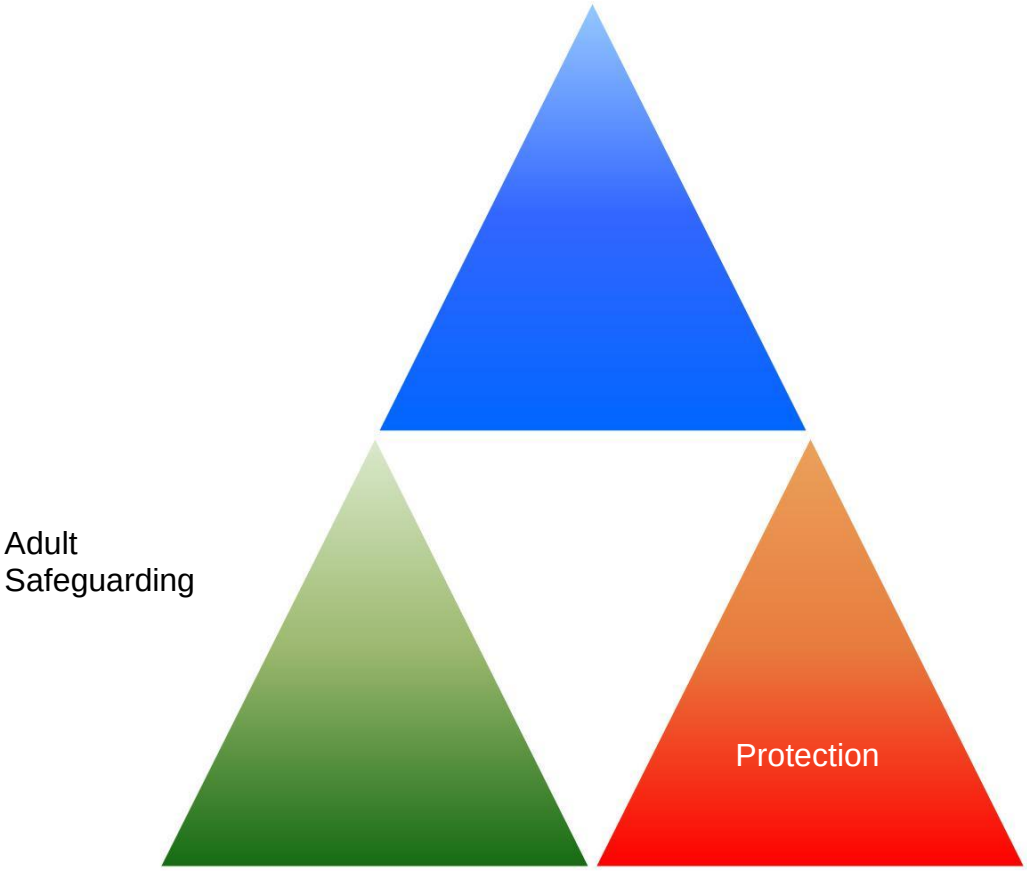
Martin Dillon
Chief Executive

Appendix 1

Adult Safeguarding Prevention and Protection in Partnership (DHSSPS) July 2015

Adult Safeguarding

Prevention and Protection in Partnership



Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

July 2015

Table of Contents

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.

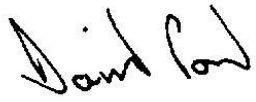
Simon Hamilton MLA
Minister for Health, Social Services and Public Safety

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.

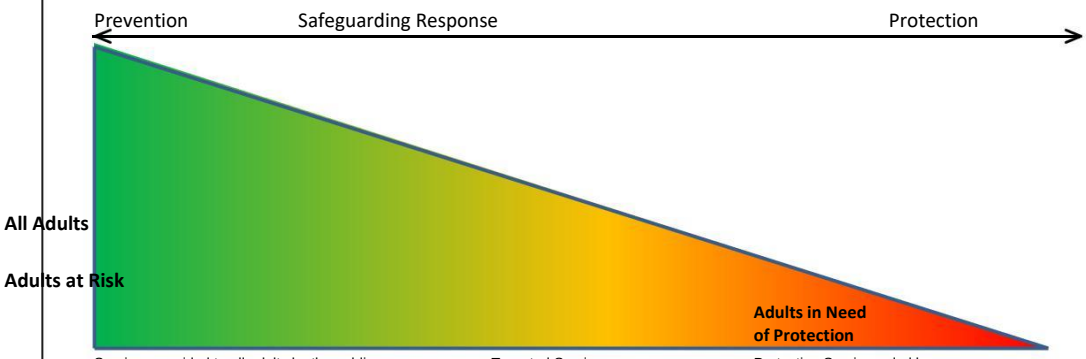
Preventative Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires 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.

Figure 1: **THE ADULT SAFEGUARDING CONTINUUM**



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[1] and enshrined in domestic law by the Human Rights Act 1998[2], acting in accordance with relevant UN and EU Conventions[3] on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991[4]. 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

1 *The European Convention on Human Rights* can be accessed at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

2 The *Human Rights Act 1998* can be accessed at: http://www.legislation.gov.uk/ukpga/1998/42/contents

3 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

4 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;

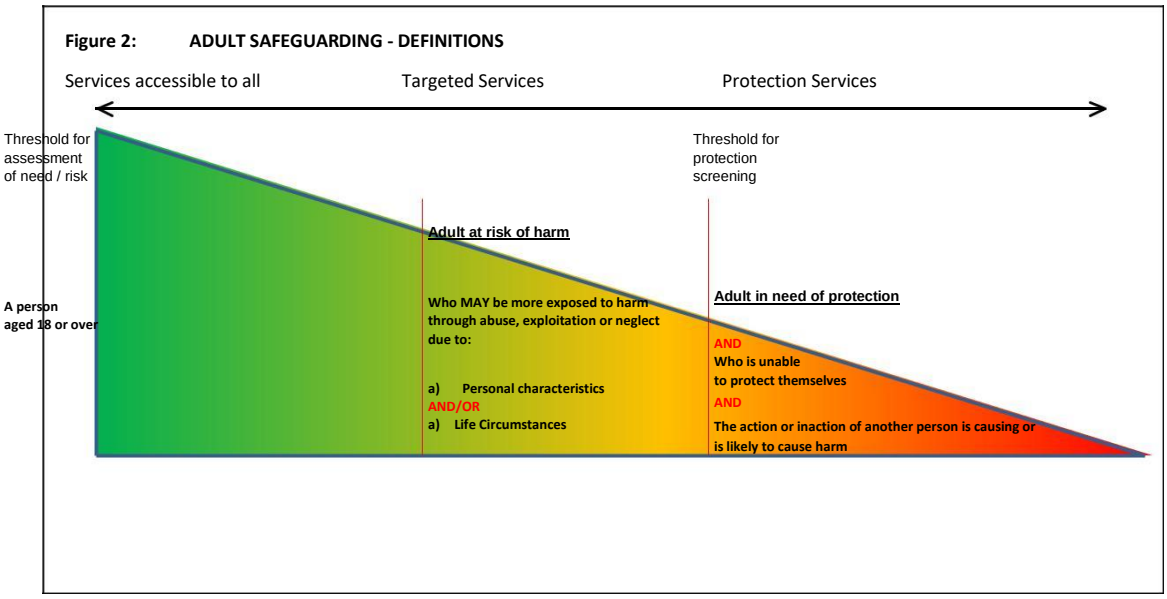
AND

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'[5].

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.

[5] 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/

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[6]. 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.

[6] 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

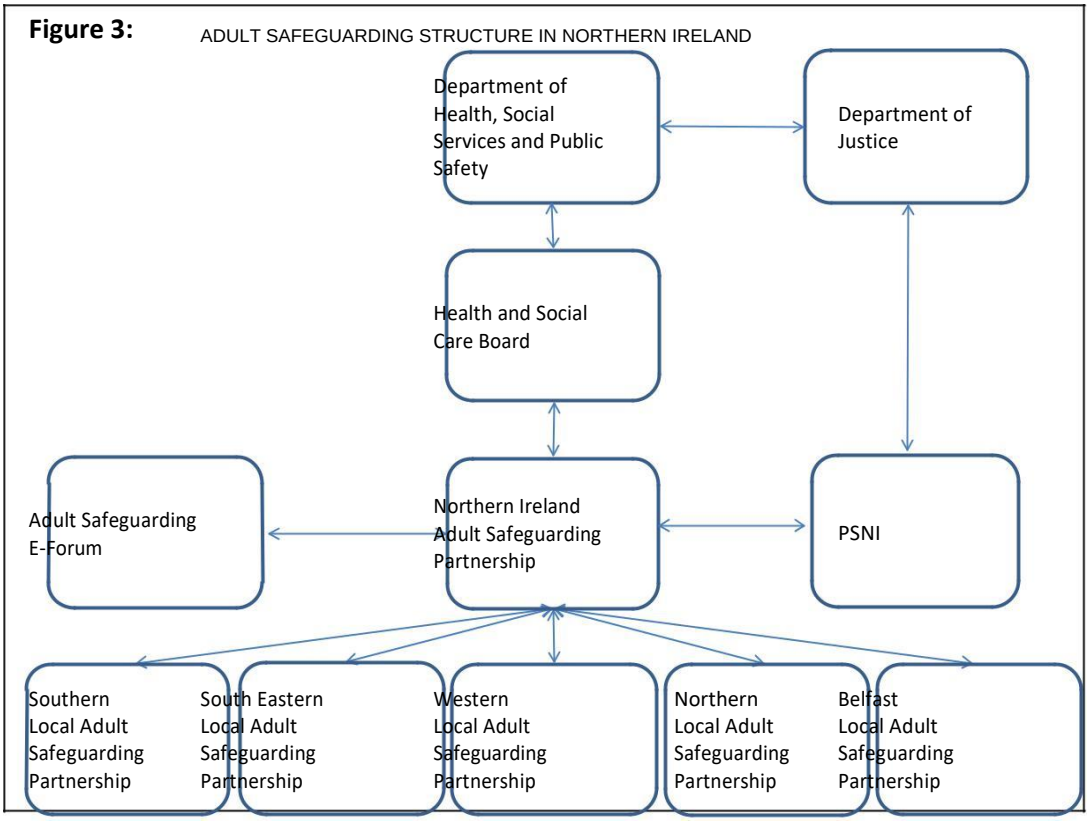
Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

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) [7] . 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[8], 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.

Figure 3: ADULT SAFEGUARDING STRUCTURE IN NORTHERN IRELAND



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

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7 *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

8 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.

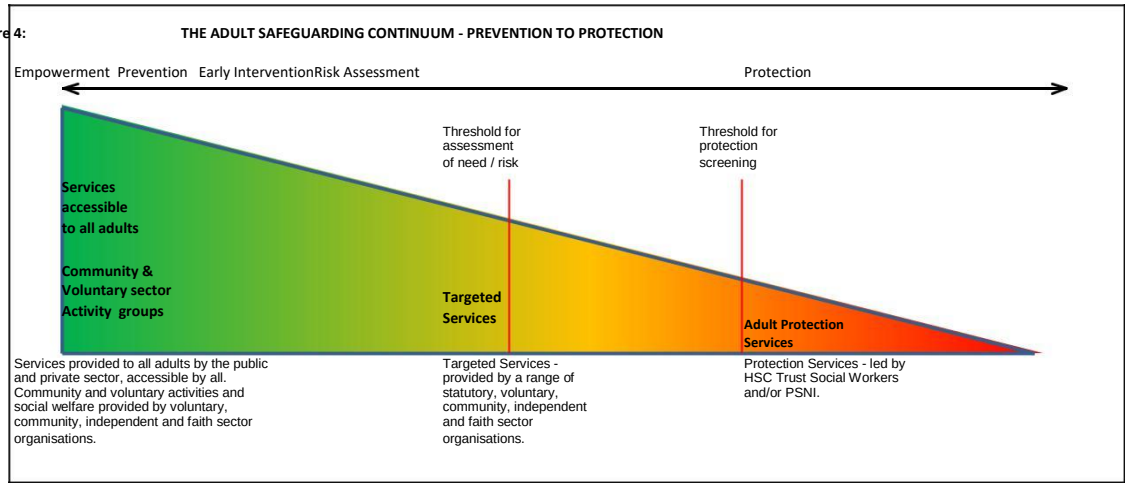
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

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[9]. 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.

[9] The SVG Order can be accessed at: http://www.legislation.gov.uk/nisi/2007/1351/contents

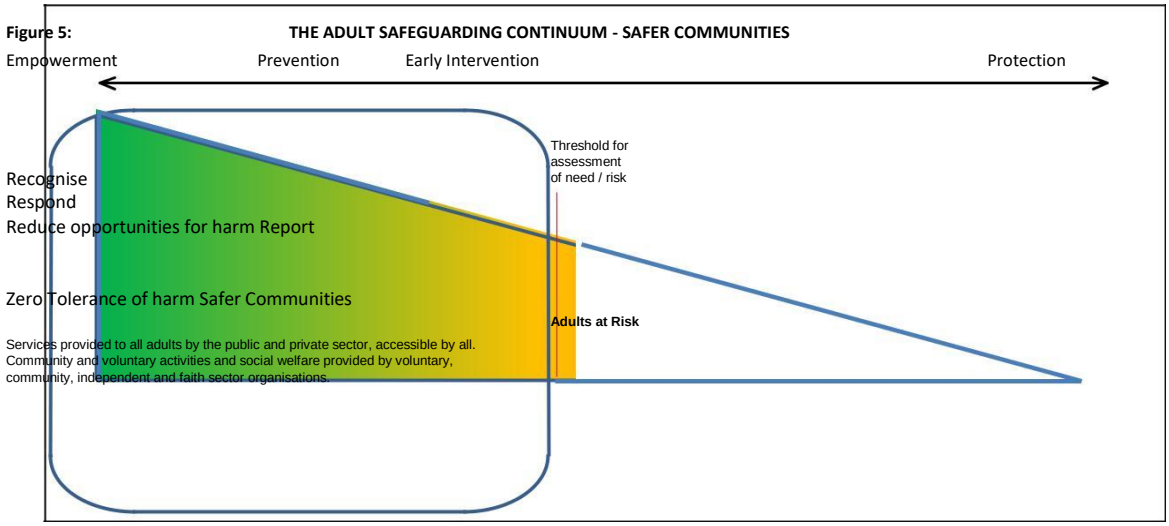
8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

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 [10] 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'[11] 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)[12] 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

10 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/learning_disability_service_framework_june_2013.pdf
http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf

11 http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm

12 Further information on PCSPs can be obtained from www.pcsps.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)[13]. 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

[13]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.

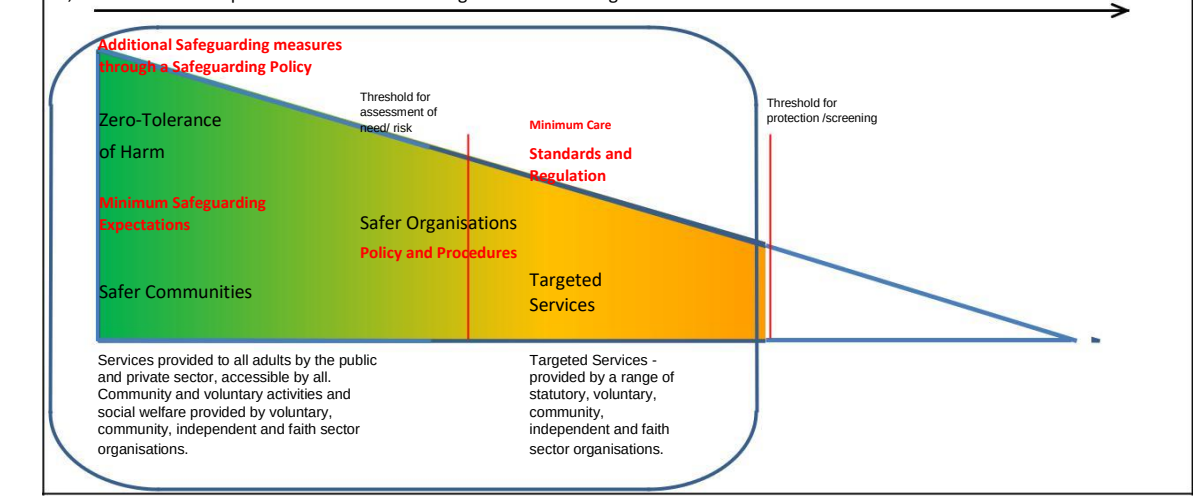
serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- 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.

Figure 6: **SAFER COMMUNITIES AND SAFER ORGANISATIONS**



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**[14] (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[15] 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.

14 Information on the Disclosure and Barring Service can be accessed at: http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults

15 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[16].

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.

[16] RQIA publications are available on www.rqia.org.uk

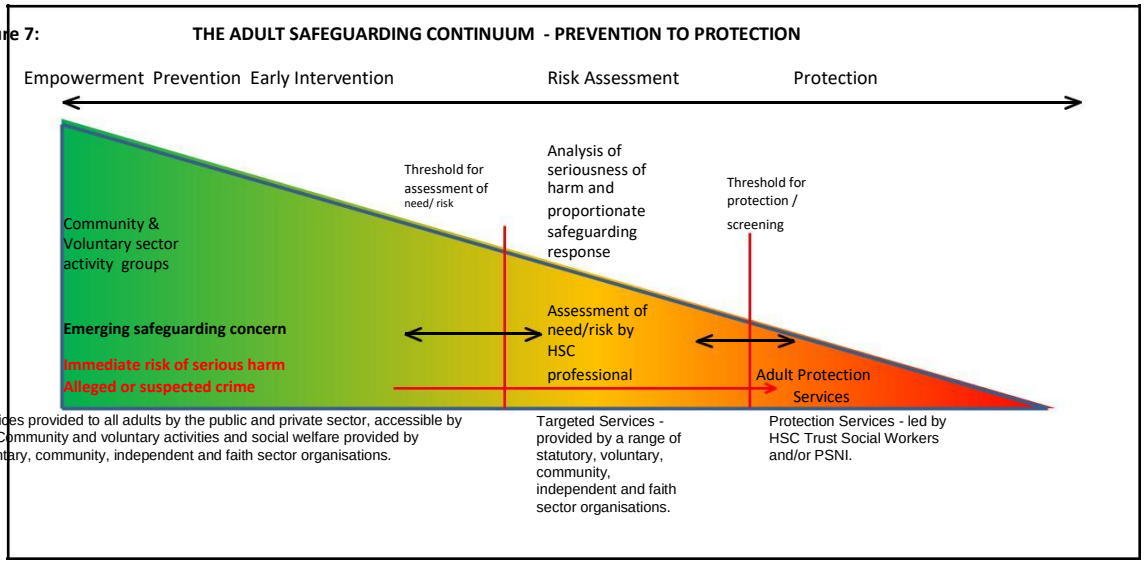
10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

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.

Figure 7: THE ADULT SAFEGUARDING CONTINUUM - PREVENTION TO PROTECTION



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.

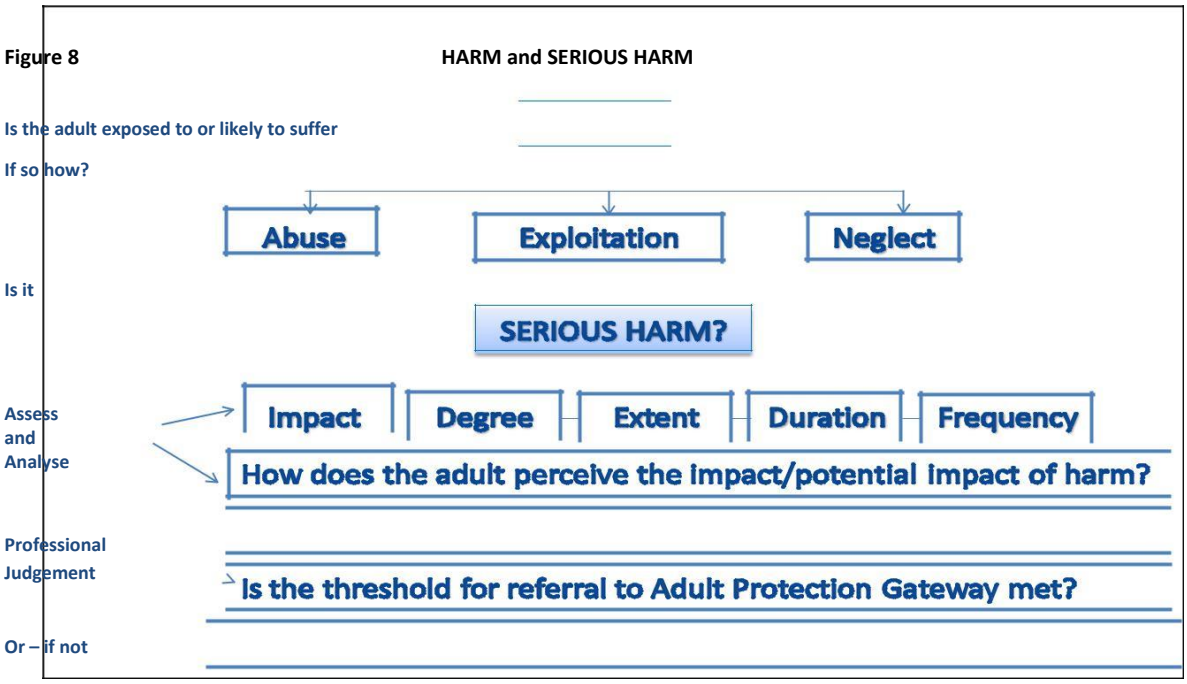
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity 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:

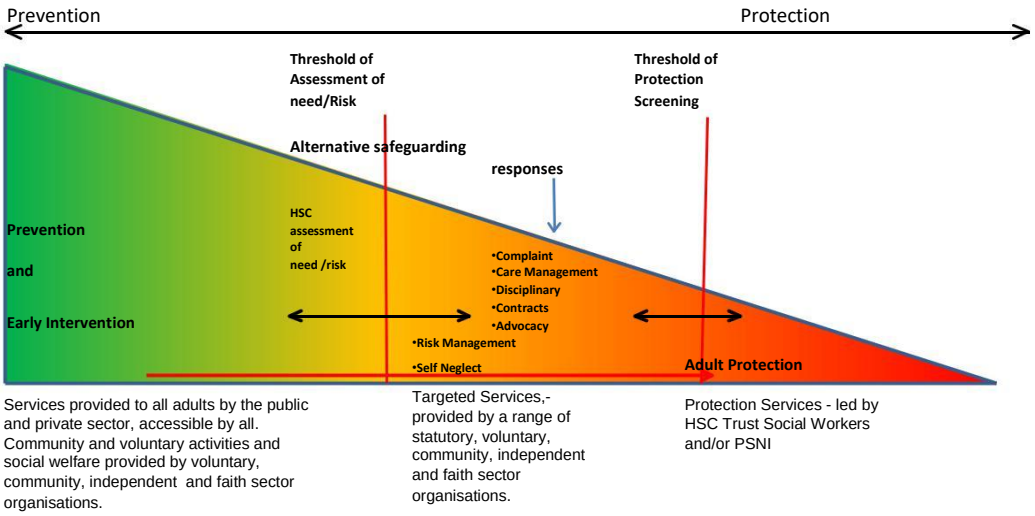
a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to 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.

Figure 9 **ADULT SAFEGUARDING THRESHOLDS**

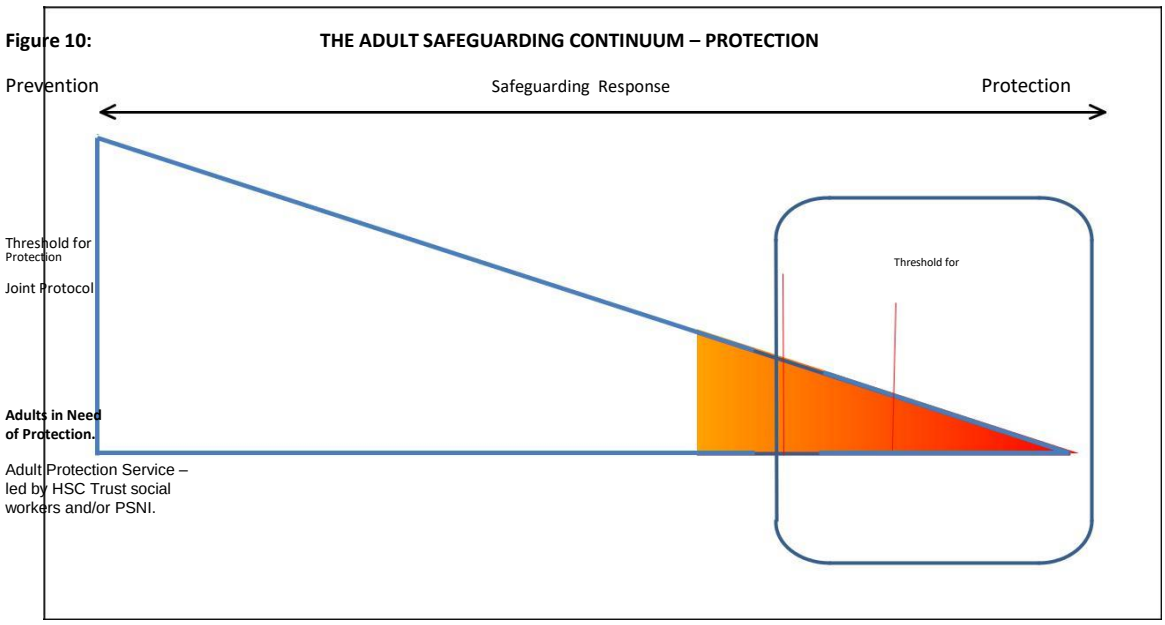


Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency 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.

Figure 10: **THE ADULT SAFEGUARDING CONTINUUM – PROTECTION**



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[17].

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

[17] 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.

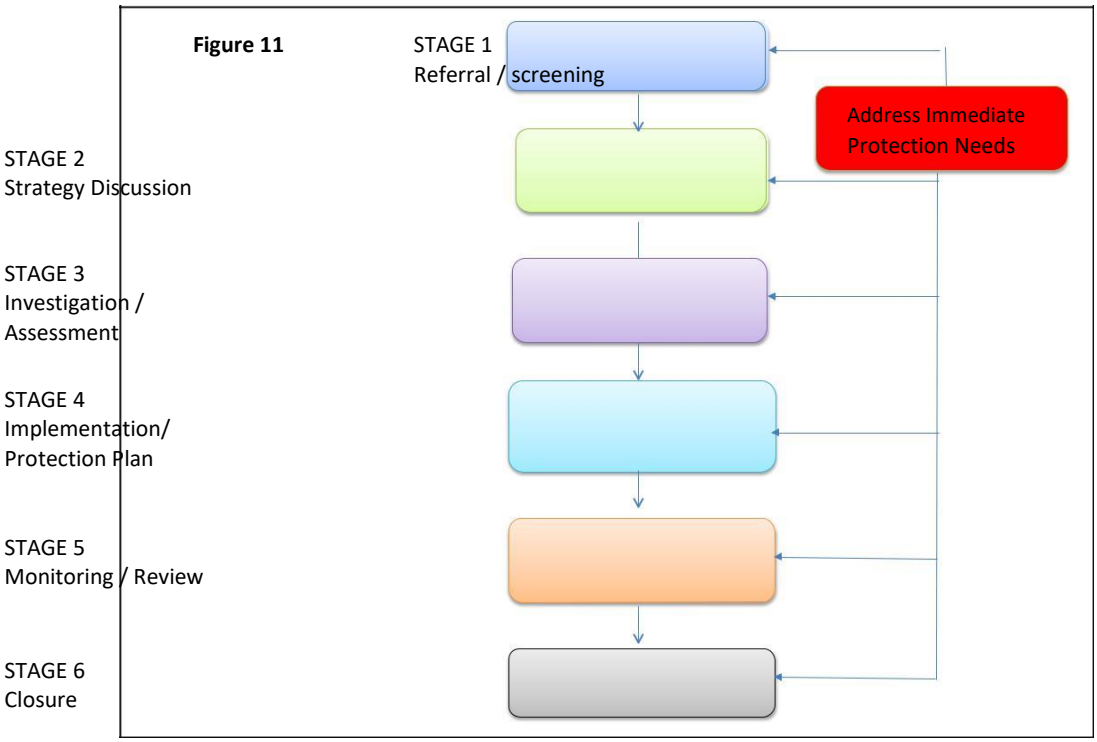
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

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:

o Multi Agency Risk Assessment Conference (MARAC) o Domestic and sexual violence services
o Public Protection Arrangements in Northern Ireland framework (PPANI)
o Human trafficking procedures
o Hate Crime Practical Action Scheme
o The Office of Care and Protection (or equivalent) o Child Protection Gateway Service
o 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 h ave a n o pportunity 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[18], 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;

18 A leaflet on special measures is available at 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[19] 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.

[19] Further information on Victim Support NI can be found at: 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' [20] 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'[21]. 'Good Management

20 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998: http://www.legislation.gov.uk/ukpga/1998/29/section/2

21 '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'[22] 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 [23] 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[24] 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.

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22 'Good Management Good Records' can be accessed at: http://www.dhsspsni.gov.uk/index/gmgr.htm

23 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

24 The 'Privacy Notices Code of Practice' can be accessed at: 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 **Adult Protection Gateway Service** 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 **Child Protection Gateway Service** 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 N orthern Ireland ap art f rom t he judiciary. It a lso 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: • be social work qualified; • be working in a minimum of a band seven; • have first line m anagement r esponsibilities, or in a senior practitioner role;

	• be suitably experienced; and • have undertaken the necessary training.
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: • The Belfast Trust • The South Eastern Trust • The Southern Trust • The Northern Trust • The Western Trust.
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 pr actice a nd em phasises the ne ed to involve a ll other relevant ag encies i n i nformation sharing, ear ly as sessment and t he planning pr ocess. 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	Personal data means data which relate to a living individual who can be identified – (a) from those data, or (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. 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”. The d efinition also s pecifically includes op inions ab out the individual, or what is intended for them.
PPANI	Public P rotection 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	Sensitive Personal Data means personal data consisting of information as to— (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or o ther b eliefs of a s imilar nature, (d) whether he is a member of a trade union (within the meaning of the M1Trade Union and La bour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any pr oceedings f or 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. 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.

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.

Document Title	Author
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

Health and Social Care Board

Appendix 2

Adult Safeguarding Operational Procedures – Adults at Risk of Harm and Adults in Need of Protection (NIASP) September 2016

NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP

Adult Safeguarding Operational Procedures

Adults at Risk of Harm and Adults in Need of Protection

September 2016

CONTENTS

SECTION A

INTRODUCTION

1. Introduction

1.1 Scope of the Operational Procedures

The responsibility for enacting the procedures to protect adults from harm caused by abuse, neglect or exploitation is principally the responsibility of Health and Social Care Trusts (HSC Trusts) and, where a crime is suspected or alleged, the Police Service of Northern Ireland (PSNI).

However, **safeguarding is everyone's business.**

These procedures are intended for use by all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. This includes paid staff and volunteers.

They describe what organisations need to do to provide a safe environment and how to respond appropriately to situations where an adult is at risk of being harmed or abused.

These procedures should be read in conjunction with all other relevant policies, such as:

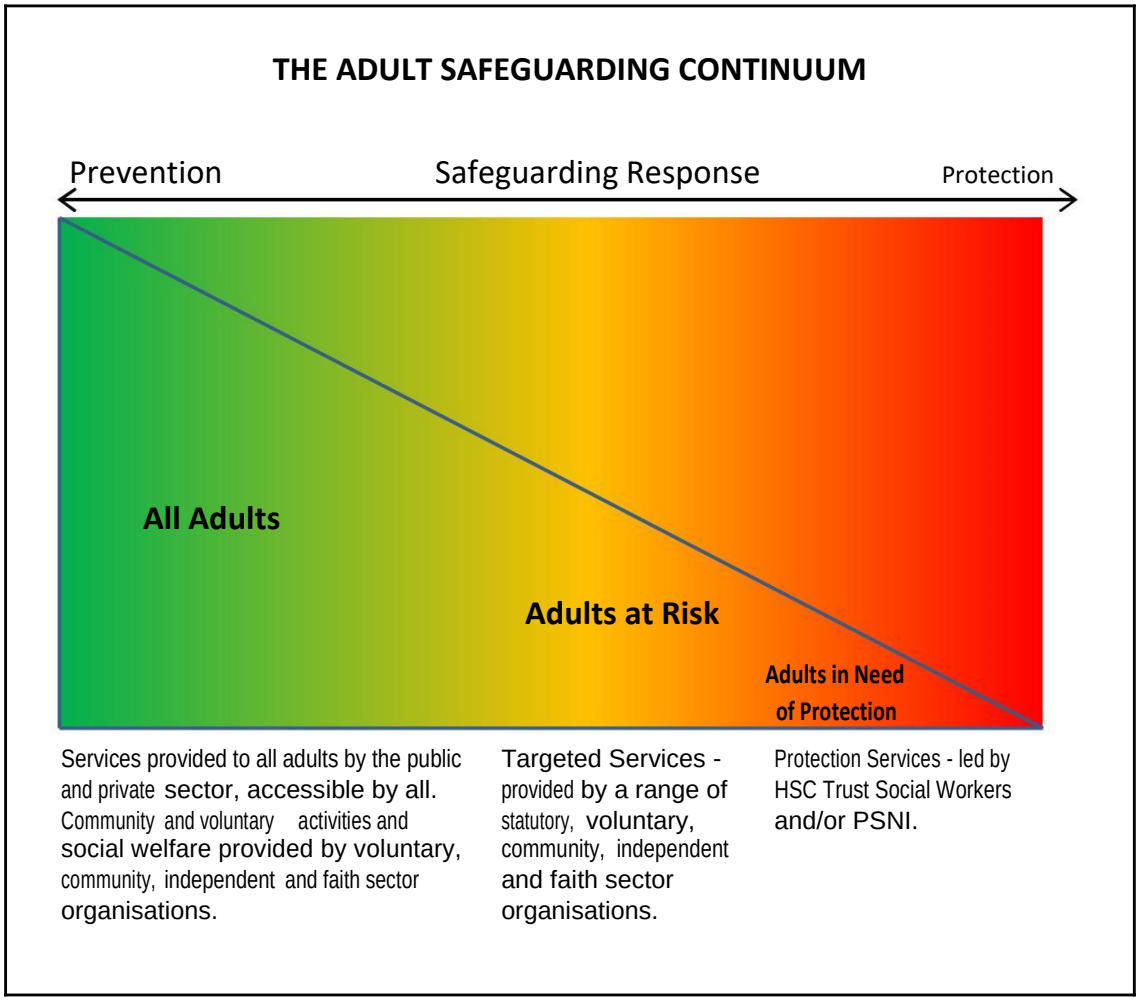
β) Adult Safeguarding: Prevention to Protection in Partnership Policy (DHSSPS 2015)

χ) Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)

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.

Safeguarding includes activity which **prevents** harm from occurring and activity which **protects** adults at risk where harm has occurred.

The diagram overleaf outlines this continuum



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. This is the first and crucial step to ensuring that services are high quality. 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.

These procedures outline the actions needed to respond to adults at risk of abuse or harm.

1.2 How to Use the Operational Procedures.

These procedures set out broad principles of good practice when responding to situations where adults are at risk or in need of protection. They place the adult at the centre of the safeguarding process and provide some practical guidance on how specific roles such as the Adult Safeguarding Champion should be implemented.

The procedures support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Each response should be tailored to meet the needs of that individual, working towards the achievement of their preferred outcome.

The procedures do not describe every potential safeguarding scenario and some, such as those involving Domestic Violence or Modern Slavery, require more specialist responses. Guidance on these responses is available elsewhere and practitioners should refer to such detailed advice as necessary.

2. Definitions

2.1 What is Abuse?

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'[1].

Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

The main forms of abuse are:

Physical abuse

[1] 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/

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. Female genital mutilation (FGM) is considered a form of physical **AND** sexual abuse.

Sexual violence and abuse

Sexual abuse is 'any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability). [2]

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,

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d) The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' are from "Stopping
Domestic and Sexual Violence and Abuse in Northern Ireland, A seven year strategy. March 2016.

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 Health and Social Care (HSC) provision. 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.

Neglect

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.

The Safeguarding Adults: Prevention and Protection in Partnership Policy does not include self-harm or self-neglect within the definition of an 'adult in need of protection'. Each individual set of circumstances will require a professional 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

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 neither 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.

2.2 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 or abuse is 'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member'. 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.

The response to any adult facing this situation will usually require a referral to specialist services such as Women's Aid or the Men's Advisory Project. In high risk cases a referral will also be made to the Multi- Agency Risk Assessment (MARAC) process. Specialist services will then decide if the case needs to be referred to a

HSC Trust for action under the safeguarding procedures. If in doubt, anyone with a concern can ring the Domestic and Sexual Violence helpline (0808 802 1414) to receive advice and guidance about how best to proceed.

Human Trafficking/Modern Slavery

Human trafficking/modern slavery 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/ modern slavery 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.

The response to adults at risk experiencing human trafficking/modern slavery will always be to report the incident to the Police Service.

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.

The response to adults at risk experiencing hate crime will usually be to report the incident to the Police Service.

2.3 Adult at Risk of Harm

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 personal characteristics and/or 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.

2.4 Adult in Need of Protection

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:

e) personal characteristics

and/or

f) life circumstances

AND

who is unable to protect their own well-being, property, assets, rights or other interests;

AND

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).

In most situations HSC Trusts will make decisions regarding the degree of risk and level of harm an adult may be facing and decide on the most appropriate action to take. 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.

If you think a crime has occurred where medical or forensic evidence might still be present consider the need for an urgent referral to the police service and be cautious not to touch or disturb possible evidential material.

SECTION B

ADULTS AT RISK OF HARM

3. The Adult Safeguarding Champion

3.1 Which Organisations Need an ASC?

Adult Safeguarding: Prevention and Protection in Partnership (2015) sets out the requirement for organisations to have an Adult Safeguarding Champion (ASC). If the organisation or group does not have staff or volunteers who require to be vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation.

Targeted services include organisations that have staff or volunteers who are subject to **any** level of vetting under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.
All providers of targeted services are required to have an ASC and an adult safeguarding policy which demonstrates a zero tolerance of harm to adults.

Members of the public, voluntary and community groups NOT required to have an Adult Safeguarding Champion (ASC) should report all adult at risk or in need of protection safeguarding concerns directly to the HSC Trust Adult Protection Gateway Service. They can do so by phoning the Trust's single point of contact telephone number (see Appendix 2).

3.2 The Role of ASC

The ASC should be within a senior position within the organisation and should have the necessary training, skills and experience to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy.

The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters. Each organisation should, therefore, ensure that arrangements are in place to provide appropriate cover in the ASCs absence.

The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

β) Recognising that adult harm is wrong and should not be tolerated

χ) Being aware of the signs of harm from abuse, exploitation and neglect

δ) Reducing opportunities for harm, abuse, exploitation and neglect to occur

ε) Knowing how and when to report adult safeguarding concerns to HSC Trusts and / or the PSNI

3.3 Key Responsibilities of the ASC

11) To provide information, support and advice for staff and/or volunteers on adult safeguarding within the organisation.

12) To ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation.

13) To advise the organisation regarding adult safeguarding training needs.

14) To provide advice to staff or volunteers who have concerns about the signs of harm and ensure a report is made to HSC Trusts where there is a safeguarding concern.

15) To support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about risks of serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision making.

16) To establish contact with the HSC Trust Designated Adult Protection Officer (DAPO), PSNI and other agencies as appropriate.

17) To ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken.

18) To compile and analyse records of reported concerns to determine whether a number of low level concerns are accumulating to become more significant. These records must be available on request for inspection or by way of service level agreements or contract review meetings.

In larger organisations the ASC may delegate the operational day to day responsibility for safeguarding to an appointed person(s) within their organisation. For example, a provider with a number of Nursing Homes throughout Northern Ireland may choose to delegate some of the tasks of an ASC to a member of staff in each facility. They will then report to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Organisations who delegate operational tasks to appointed person(s)

must have sufficient numbers to ensure they are accessible to all service areas in the organisation as a source of advice and guidance.

In smaller organisations the ASC may be responsible for all actions relating to adult safeguarding situations, including working with the adult at risk and making referrals to PSNI and/or HSC Trusts.

Contact details for the HSC Trust Adult Safeguarding Gateway Services are contained in Appendix 2.

3.4 Information to be Monitored by an ASC

Most ASCs will already have daily access to a great deal of information that will assist the organisation or group improve the services it provides to adults at risk or in need of protection.

To meet the governance requirements set out in the Policy, the ASC will compile an annual Adult Safeguarding Position Report using the following core data:

7 Number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;

8 Number of adult safeguarding discussions where the decision taken was to **not** refer to HSC Trust;

9 Any untoward event that triggered an adult protection investigation;

10 Adult safeguarding training opportunities provided and uptake across staff groups; and

11 Any action that your organisation plans to take to ensure it is compliant with Adult Safeguarding: Prevention and Protection in Partnership and to implement the organisation's own adult safeguarding policy.

3.5 The Adult Safeguarding Position Report

The Position Report is an important overview and governance tool for all organisations and groups supporting adults at risk or in need of protection. It will contain significant information for the organisation or group's Senior Management Team and/or Trustees. It should be scrutinised by them on an annual basis.

It would also be appropriate to provide core information from the Position Report in any organisational annual reports or updates.

The Position Reports should be made available for any external audit purposes, for example any audits undertaken by the Local Adult Safeguarding Partnership, and to demonstrate compliance with policies as specified within any contracts with HSC Trusts.

Services that are externally regulated, e.g. by RQIA or CJINI, may also be subject to inspection on adult safeguarding arrangements. The Position Report will be central in demonstrating that the organisation is complying with the requirements of the regional adult safeguarding policy.

If the service or group is contracted to provide services by the HSC normal contract monitoring processes should be used to provide confirmation to the relevant Trust(s) that the safeguarding Position Report is available for scrutiny.

4. Recognising and Responding to Adult Safeguarding Concerns

Staff or volunteers who are concerned about someone who may be experiencing harm or abuse must promptly report these to their line manager or person in charge.

There are a variety of ways that you could be alerted that an adult is suffering harm:

7. They may disclose to you;
8. Someone else may tell you of their concerns or something that causes you concern;
9. They may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
10. Their demeanour/behaviour may lead you to suspect abuse or neglect;
11. The behaviour of a person close to them makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
12. Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that adults are safeguarded and it is important that all concerns about possible abuse are taken seriously and appropriate action is taken.

4.1 When an Adult at Risk Discloses Abuse

In cases where an adult discloses abuse to a staff member or volunteer, it is vital that staff/volunteers know how to react appropriately.

All staff/volunteers should be made aware of to the following guidelines:

Do

9 Stay calm;

10 Listen attentively;

11 Express concern and acknowledge what is being said;

12 Reassure the person – tell the person that s/he did the right thing in telling you;

13 Let the person know that the information will be taken seriously and provide details about what will happen next, including the limits and boundaries of confidentiality (see leaflet);

14 If urgent medical/police help is required, call the emergency services;

15 Ensure the immediate safety of the person;

16 If you think a crime has occurred be aware that medical and forensic evidence might be needed. Consider the need for a timely referral to the police service and make sure nothing you do will contaminate it;

17 Let the person know that they will be kept involved at every stage;

18 Record in writing (date and sign your report) and report to the Line Manager/person in charge/Adult Safeguarding Champion at the earliest possible time;

19 Act without delay.

Do not

8. Stop someone disclosing to you;
9. Promise to keep secrets;
10. Press the person for more details or make them repeat the story;

9. Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
10. Contact the alleged person to have caused the harm;
11. Attempt to investigate yourself;
12. Leave details of your concerns on a voicemail or by email;
13. Delay.

The line manager or person in charge will take any immediate action required to ensure the adult at risk of harm is safe and make a decision as to when it is appropriate to speak with the adult at risk of harm about the concerns and any proposed actions. They must then report the concerns and any action taken to the services appointed person or Adult Safeguarding Champion.

• Responding to an Adult Safeguarding Concern – the Role of the ASC

When an alert is raised within an organisation in relation to an adult safeguarding concern or disclosure, the ASC or appropriate appointed person, where these tasks have been delegated, will ensure the following actions occur:

- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided whilst being careful not to stray into the realm of investigation.
- **Where immediate danger exists or the situation warrants immediate action** ensure any necessary medical assistance has been sought and refer to HSC Adult Protection Gateway or PSNI.
- Support staff to ensure any actions take account of the adult's wishes.
- Where it has been deemed that it is not a safeguarding issue, other alternative responses should be considered such as monitoring, support or advice to staff or volunteers.
- If it is decided that it is a safeguarding issue, the situation should be reported to the HSC Key Worker where known. If unaware of HSC Key Worker contact details, a referral will be made to HSC Trust Adult Protection Gateway service. The HSC Trust will then conduct a risk assessment and decide what response is appropriate.

- If a crime is suspected or alleged, contact the HSC Adult Protection Gateway Service directly.
- If the concern involves a regulated service, inform RQIA.
- Act as the liaison point for any investigative activity which is required and will ensure easy access to relevant case records or staff.
- Ensure accurate and timely records and any adult safeguarding forms required have been completed.

If an adult at risk does not want a referral made to the HSC Trust or PSNI, the ASC or appropriate person must consider the following:

13 Do they have capacity to make this decision?

14 Have they been given full and accurate information in a way which they understand?

15 Are they experiencing undue influence or coercion?

16 Is the person causing harm a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service?

17 Is anyone else at risk from the person causing harm?

18 Is a crime suspected or alleged?

These factors will influence whether or not a referral without consent needs to be made. If in doubt contact the HSCTrust Gateway service for advice and guidance.

If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and the reasons for not referring to HSC Trust.

The ASC will ensure that records of reported concerns are compiled and analysed to determine whether a number of low-level concerns are accumulating to become significant. If the organisation is regulated by RQIA or other bodies, then the ASC will make records available to them for inspection.

Where the ASC or appointed person 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.

In most circumstances there will be an emerging safeguarding concern which should be referred to the relevant HSC Trust for assessment. HSC professionals will determine whether the threshold for an adult protection intervention has been met, or whether alternative safeguarding responses are more appropriate.

6. Responding to an Adult Safeguarding Concern – the Role of the HSC Trust

6.1 Determining if an adult is at risk

On receipt of the adult at risk referral the HSC Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses.

The line manager must ensure that the adult's immediate needs are met, eg they are in no immediate danger and that any medical assistance required has been sought.

Line managers must refer all cases where there is a clear and immediate risk of harm to the adult or a crime is alleged or suspected, to the PSNI using the emergency police 999 number and the Designated Adult Protection Officer (DAPO) in the HSC Trust Adult Safeguarding Gateway Team. The appropriate documentation should be used (see Appendix 7).

Where the decision is that the adult is potentially at risk of harm the line manager and the keyworker will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm (See Appendix 7). The consent of the adult at risk will be sought (see Section 7:0 below for advice on capacity and consent) and the assessment will include the wishes and views of the adult at risk and where appropriate their family and carers. The keyworker will inform the referrer of the outcome of the assessment and care plan.

6.2 Determining if the Threshold for Referral to the Adult Protection Gateway Service is met

Where a risk assessment concludes that the adult is at risk of or has experienced serious harm, the next step is to consider whether the threshold for referral to the HSC Trust Adult Protection Gateway Service has been met.

Where the line manager determines that the threshold for an adult in need of protection is met, the keyworker refers the concern to the HSC Trust Adult Protection Gateway service (See Section C). The keyworker will advise the adult in need in protection of the decision to refer.

The following thresholds are intended as a guide only. It should be noted that 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.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

NB: In the majority of cases where serious harm has been identified, the threshold for referral to the HSCTrust Adult Protection Gateway Service will have been met. However, in a limited number of circumstances referral to this service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is a concern. In such circumstances, an alternative response may be more appropriate (see below)

6.3 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:

- escalation to the service manager to address any issues about the quality of service provision;
- 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;
- 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;
- action taken under complaints procedures;
- action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
- referral to an advocacy service;

- referral to another service;
- a risk management intervention in relation to self-neglect;
- a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
- no further action required;

or a combination of two or more of the above.

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 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.

7. Human Rights, Consent and Capacity

Adults at risk of harm should be central to decisions regarding any actions to prevent or protect them from harm. The adult's reasons for refusal to consent to a referral to the HSC Trust for assessment and support should be explored with them. Consent may be over-ridden in some cases, for example, where the individual lacks the capacity to appreciate the nature of the concerns and the potential consequences to them of not addressing those concerns; where there is a potential risk to others or in the public interest.

If you have any concerns that the adult at risk may not have capacity to consent or may be coming under pressure to refuse consent you should refer to the HSC Trust key worker or HSC Trust Adult Protection Gateway team.

Human Rights, Consent and Capacity, the European Convention for the Protection of Human Rights and Fundamental Freedoms (Human Rights Act 1998)

The Human Rights Act 1998 has been fully effective from 2nd 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 sets out the main Convention Rights enshrined in the 1998 Act.

Decisions taken not to comply with the wishes of the adult in need of protection/adult at risk may constitute a breach of Human Rights legislation. Where consideration is being given not to comply with the wishes of the adults in need of protection adult/adult at risk, the decision taken must be lawful, proportionate and in keeping with what is in the public interest.

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. Reporting a relevant offence, as defined in the Criminal Law Northern Ireland Order (1967), is not only lawful but a legal requirement on public authorities.

Proportionate means the proposed action is viewed by any reasonable person as fair, necessary and the least restrictive in order to benefit the individual.

Necessary in a democratic society means

Does it fulfil a pressing social need?

Does it pursue a legitimate aim? And

14 Is the proposed action in the public interest taking into consideration whether other Adults at risk or children may be at risk of harm?

7.1 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?

10. Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
11. 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).
12. Is the restriction required for legitimate purposes?
13. 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 human 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.

7.2 Consent

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse. Where a crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection.

The consent of the adult in need of protection for contact with the PSNI should be sought as a first step.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision regarding how they wish the situation to be handled. They should be fully advised by the Trust key worker and/or Designated Adult Protection Officer (DAPO) of the Protocol for Joint Working process and of their right to have a referral made to the PSNI. The adult in need of protection should also be informed if this is a referral to PSNI for action, or whether consultation on the need for a Joint Agency approach is required.

The adult in need of protection should be advised that agreeing to a Joint Agency consultation does not in itself constitute agreement to a full PSNI investigation. The benefits of a Joint Agency consultation in terms of information gathering should be explained. Their entitlement to full consultation and involvement at each stage in the

Joint Protocol process should also be emphasised. All staff involved must ensure that this person centred approach is strictly adhered to.

Details of all supports available to an adult in need of protection as outlined in 'Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy' (2012) should also be provided.

In the majority of cases where the adult in need of protection is deemed to have capacity, the PSNI will only proceed to a full investigation with the consent of the adult in need of protection. In practice this will mean that the adult in need of protection should be willing to make a complaint to the PSNI. However, there are some exceptions to this.

7.3 Dispensing with Consent

In exceptional circumstances, the DAPO may need to consider over riding the wishes of an adult in need of protection if they do not consent to a joint agency consultation with the PSNI. These include situations where:

- There is reasonable evidence or information to indicate that a possible relevant offence has been committed and the Trust have a legal obligation to report to the PSNI.
- There is a significant query regarding the individual's capacity to make an informed decision and therefore their ability to give or withhold consent is in question. Actions taken must be proportionate to the level of concern and the views of substitute decision makers.
- Information available clearly demonstrates that the individual is subject to substantial undue influence or coercion.
- There is a significant risk to other adults at risk and/or children.
- The likelihood of further harm is high and there is a substantial opportunity to prevent further crime.

The PSNI also have the authority to investigate alleged or suspected criminal abuse where this is agreed to be in the best interests of the adult in need of protection and or others.

The above list indicates possible situations where the DAPO may need to consider overriding the wishes of an adult in need of protection adult. The list is not exhaustive. Cases will need to be assessed on a case by case basis and requirements in relation to making decisions which are lawful, proportionate and necessary in the public interests are applicable.

7.4 Acting without Consent in Emergency Situation

In situations where the adult in need of protection is in imminent danger it may not be possible to discuss with them their wishes and obtaining a valid consent may not be achievable. Trust staff, under these circumstances, should take whatever action they feel is appropriate to protect the adult in need of protection, including seeking medical and/or PSNI intervention.

Where there is no information and/or clarity regarding the wishes of the adult in need of protection and it is safe to do so, consideration should be given to deferring a decision re a joint agency consultation until such time as the adult in need of protection's views and permission can be sought. The DAPO will need to consider this on a case by case basis, mindful that a number of factors will need to be taken into account. Where a decision is taken to consult with the PSNI and the adult in need of protection has not consented to this, a detailed rationale for this decision should be recorded.

7.5 Capacity

There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, the DAPO should ensure a capacity assessment is completed.

Capacity assessments/reassessment should determine:

- the extent to which the adults in need of protection/adult at risk is able to make informed decisions about their safety and protection.

16 whether the adults in need of protection adult/adult at risk is able to make a complaint to the PSNI and/or give legal instruction.

17 whether the adults in need of protection adult/adult at risk has the capacity to be interviewed by the PSNI.

Capacity assessments will also inform the assessment of the needs of the adult at risk or in need of protection.

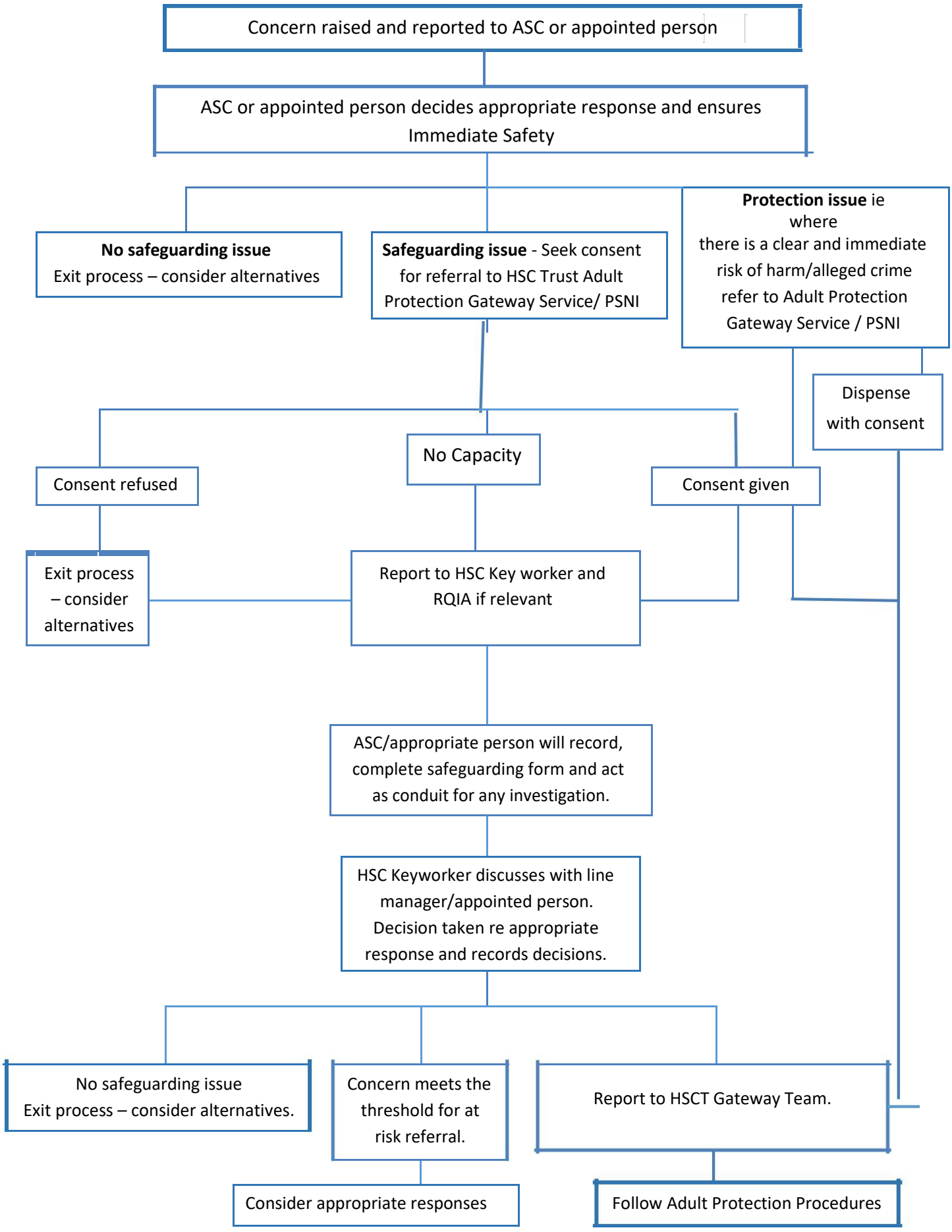
Formal capacity assessments should be carried out by an appropriately trained professional. In cases where the adult in need of protection is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

It is important to remember that an individual's capacity to consent to any course of action, decision or intervention may fluctuate. A capacity assessment should not, therefore, be considered as a one-off event. DAPOs should ensure that issues of capacity are constantly borne in mind throughout any safeguarding or protection interventions.

The onus is on professionals such as nurses and social workers to ensure that any intervention where the individual is considered to lack capacity is respectful of the person's human rights and that actions are both proportionate and lawful.

It is important to note that any and all information provided by an adult in need of protection is relevant and should be considered in a safeguarding context.

PATHWAY FOR DEALING WITH CONCERNS



SECTION C

SAFEGUARDING ADULTS IN NEED OF PROTECTION

Introduction:

These procedures set out the process to be followed in reporting and responding to concerns that an adult is at risk of harm and may be in need of protection (see Appendix 3, Six Stages of the Adult Protection Process).

8. Roles and Responsibilities

Safeguarding is everyone's business and includes the decision to make a referral when there is a concern relating to an adult in need of protection. There will however be more specific roles and responsibilities within the process and these will be discussed in more detail in the relevant section of the protection process (see below).

8.1 Designated Adult Protection Officer

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 service teams.

Every DAPO must:

- Be a qualified social worker at Band 7 seniority or above;
- Have first line management responsibilities, or in a senior practitioner role;
- Be suitably experienced; and
- Have undertaken the required training as outlined in the Northern Ireland Adult Safeguarding Partnership Training Framework (2016).

The role of the DAPO is to

- Complete an initial screening against the thresholds for serious harm. Where this threshold has not been met, the DAPO should consider all alternative safeguarding responses
- Manage and coordinate the adult protection intervention;
- Provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer;
- Analyse the adult safeguarding data within their service area and contribute to 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 and modern slavery 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;
- 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 and there is no need to conduct an investigation; 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 Regulation and Quality Improvement Authority (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.

Where there are multiple adults in need of protection the DAPO will also

- Liaise and agree with other potential DAPOs who will take lead responsibility.
- Agree joint working and feedback arrangements as necessary.

This is critical:

12. In cases where there is more than one programme of care involved in delivering a service.
13. If the adult in need of protection is in a care environment outside their home e.g. Acute Care.
14. Where there is more than one Trust involved in the provision of care (Ref Section 10 on Large Scale and Complex Investigations).

8.2 The HSC Investigating Officer

The Investigating Officer must be a HSC Trust professionally qualified practitioner (Band 6 and above). Investigating Officers **must** receive specific training as set out in the NIASP Training Framework prior to undertaking the role.

Their role is to carry out an assessment of risk, collate and analyse all available information, determine how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support.
The Investigating Officer, alongside relevant professionals, will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

While carrying out these duties, the Investigating Officer will be guided and supported by the DAPO. The Investigating Officer will:-

- Meet with the adult in need of protection and carer/relative separately to establish the preliminary information.
- Investigate allegations and concerns as directed by the DAPO. The investigation should take the form of an assessment of risk, needs and, where appropriate, a carer's assessment. This will inform the review and updating of the interim protection plan.
- Inform the adult in need of protection of expressed concerns and the Adult Protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.
- Inform the adult in need of protection of his/her rights to protection under law.
- Support the adult in need of protection through the assessment process.

- Keep the adult in need of protection informed and updated throughout the investigation process to ensure informed decision making.
- Identify needs and supports which may be required by the person alleged to have caused the harm and, where appropriate, refer on for professional input and support.
- Commission medical or other specialist assessments, where appropriate.
- Inform and liaise with relevant professionals and significant others as appropriate.
- Make a clear record of the investigation process.
- Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- Provide an investigation report for a case conference/review. This report must include an analysis of the findings with a conclusion and, where appropriate, make recommendations.
- Ensure the implementation of any care and protection plan as agreed with the DAPO.

8.3 The HSC Achieving Best Evidence Interviewer

The specialist Achieving Best Evidence (ABE) Interviewer must be a professionally qualified Social Worker. Specialist Interviewers must have completed Investigating Officer training, Joint Protocol training and ABE training prior to undertaking the role.

The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in “Protocol for Joint Investigation of Adult Safeguarding Cases (2016)” and “Achieving Best Evidence in Criminal Proceedings” (2012).

The Pre Interview Assessment, where possible, will be conducted by the same person conducting the ABE Interview. (See also Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and Achieving Best Evidence in Criminal Proceedings (2012)).

8.4 Line Manager

On receiving an allegation or concern of abuse the line manager must ensure that the adult's immediate needs are being met; i.e. that they are in no immediate danger and that medical assistance if required is sought. The line manager must consider the need for emergency PSNI intervention. For example, where there remains immediate risk of harm to the adult in need of protection or others the line manager must contact the emergency PSNI number, 999.

Line managers must refer all cases where there is a clear and immediate risk of harm or a crime is alleged or suspected regarding an adult at risk to the PSNI or the DAPO in the HSC Trust Gateway Service using the relevant regional referral and recording systems, including where there are concerns that physical harm has occurred, a body map or diagram completed by an appropriately trained person.

In most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust for a professional assessment of risk. It will be a matter for the HSC professional to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate.

In circumstances where the care manager for the service user is from another HSC Trust, the referral should be made to the Adult Safeguarding Gateway Service in the placing HSC Trust. The line manager must also notify the host Trust for information purposes as this may be relevant to other current concerns (refer to section 15.2). In instances where the person who has allegedly caused the harm is also an adult at risk the line manager should ensure necessary arrangements are in place to support them.

In instances where the allegations are made against a member of staff, the line manager will be responsible for the instigation of appropriate protection measures which may involve staff such as redeployment, being placed on restricted duties or precautionary suspension and any subsequent disciplinary procedures. The line manager must consult with the responsible DAPO to ensure that Disciplinary Procedures run parallel to the adult protection investigation. It is essential in these circumstances that close communication and sharing of information is maintained

between the line manager, DAPO and Human Resources. (See section on Guidance on the Co-ordination of Adult Protection Investigations with Human Resource and/or PSNI Investigations)

8.5 HSC Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency social work service outside normal office hours including weekends and public holidays. These are 5pm to 9am Monday to Thursday and 5pm on Friday to 9am on Monday. There is 24 hour cover over public holidays.

The RESWS responds to a wide range of people in crisis and deals with situations which cannot be left until the next working day. People in crisis can include older people, people with mental health issues, learning disabilities, physical disabilities, potential victims of human trafficking and children and young people.

There are a number of situations in which the RESWS will become involved or work with other agencies to ensure the safety of an individual and others who may be at risk. Examples of emergency situations are where:

- There are immediate significant protection and welfare concerns in relation to an adult at risk and/or an adult in need of protection;
- There are immediate significant protection and welfare concerns in relation to children and young people;
- Urgent advice and/or support is required by families or carers;
- Older people are at risk;
- There is consideration that compulsory admission to hospital under the Mental Health Order (NI) 1986 is required.

Staff within RESWS will provide an adult safeguarding and adult protection service where required and Managers within the RESW will fulfil the role of Designated Adult Protection Officers (DAPOs) when required RESWS will respond to all elements of the role in emergency situations which require an urgent response.

8.6 Role of Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (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.

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[3].

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

9. Adult Protection Procedures

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.

10. Stage 1 Screening the Adult Protection Referral

On receipt of a referral the DAPO will take the following actions:

- Consider immediate safeguards for the adult and take appropriate action to meet identified safety needs.
- Ensure that a face to face contact with the adult in need of protection is completed without undue delay.
- Clarify basic facts and determine if the adult meets the definition of an adult in need of protection.

• RQIA publications are available on www.rqia.org.uk

- Determine whether the threshold for serious harm (Appendix4) and the threshold for referral to the HSC Trust Adult Protection Gateway Service are met. This 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 consider 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 in need of protection;

  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 adequately addressed.

- If referral does not meet the above protection thresholds, the DAPO will advise referrer and agree appropriate alternative safeguarding responses. At all times the least intrusive and most effective response should be made.

- Where the HSC Trust Adult Protection Gateway Service DAPO determines that an alternative course of action is appropriate, there must be mechanisms in place to ensure that the outcomes of this action is reported back to the DAPO;

- 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. If the person has no suitable family or friend who can be consulted with regarding their best interests, an advocate may be appointed.

- Where there is a query regarding the capacity of the adult to consent to the referral, the DAPO should screen the referral into the adult protection process pending the completion of a capacity assessment. The absence of a capacity assessment must not delay the protection of an adult in need. It is important that a capacity assessment is undertaken as soon as possible. It may be established that with the appropriate support, the adult in need of protection is able to make their own decisions.
- 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, the DAPO may decide to progress a case 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 relevant and reportable 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.

- The DAPO must ensure that the HSC staff member communicating with the adult in need of protection has sufficient knowledge of the Protocol for Joint Investigation of Adult Safeguarding Cases to provide relevant

information in order that the adult in need of protection can make an informed decision in relation to PSNI involvement.

- If the allegation is a potential crime there must be consideration of the application of the Protocol and immediate liaison with the PSNI to avoid contamination of evidence.
- Consider if there are other adults or children in need of protection.
- Consider any indicators of potential human trafficking or modern slavery and, if relevant, refer to regional guidance.
- Inform other relevant organisations of the nature of the allegation and the actions being taken.
- Complete the relevant electronic information system.
- Complete the relevant documentation advising the referrer of outcomes of the screening decision. The referrer, if appropriate, notifies service user / family with due regard to maintaining the safety of the service user in need of protection.
- Where appropriate, the Gateway DAPO will forward the screened referral to the most appropriate DAPO within core operational services to take the lead role in initiating, convening and chairing a strategy planning meeting/discussion. Feedback should be given to the person who made the referral, taking into account confidentiality and data protection issues.

10.1 Supporting an Adult at Risk Who Makes Repeated Allegations

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated without prejudice. Each allegation must be responded to and recorded under these procedures. A risk assessment must be undertaken respecting the rights of the individual and measures taken to protect staff and others and a case conference convened, where appropriate.

10.2 Responding to Family Members, Others Who Make Repeated Allegations

Allegations of abuse made by family members or others should be investigated without prejudice. However, where repeated allegations are made and there is no foundation to the allegations and further investigation is not in the best interests of the adult in need of protection, then the appropriate HSC Trust Director should make a determination in consultation with relevant others about an appropriate response.

10.3 If a Referral is Received after an Adult in need of protection has Died:

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required. If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

10.4 Outcome of Screening:

There is Insufficient Information to Determine if an Investigation is Required

Additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

The Threshold of Adult in Need of Protection IS NOT MET

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.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights 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.

A decision to close the Adult Protection process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

The Threshold for Referral to Adult Protection Gateway Service is Met: -

The DAPO will proceed with the management of the protection process.

11. Stage Two: Strategy Discussion

11.1 Purpose of the Strategy Discussion

Strategy meetings provide a forum for professionals and agencies to work together to ensure a coordinated investigation and protection response. They are an opportunity to address any potential conflicts between agencies at an early stage. They also provide the opportunity for clarification of roles and responsibilities in relation to HSC Trust, PSNI, RQIA and where applicable an employing organisation.

In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts. However, there may be occasions when a telephone discussion would be more appropriate and proportionate, eg emergency situations. There must be careful consideration about the most appropriate way to ensure the wishes of the adult in need of protection are at the centre of the decision making at a strategy discussion.

Every effort should be made prior to the meeting to explain its purpose to the adult in need of protection to find out their concerns, what they want to happen and how they want to be involved in what is decided. This can be done either by the keyworker or the Investigating Officer, or both if this is deemed most appropriate.

11.2 Supporting the Adult in Need of Protection:

The wishes of the adult in need of protection are central to the process and will, as far as possible, direct any decision-making. However, there may be circumstances in which the person concerned about the adult in need of protection may not be best placed to seek their consent to a referral being made, or the person clearly states 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 mean this may not be possible, for example, where there appears to be undue influence or

coercion or another person is suspected to have influenced the adult's decision or other people may be at risk or it constitutes a relevant offence.

The strategy meeting will consider the wishes of the adult in need of protection as to who will support them throughout the adult protection process if this is required. During this process those involved must:

- ο) Ensure that the adult in need of protection is given every opportunity to speak in private regarding their concerns, taking care not to place the adult in need of protection at greater risk.
- π) Inform the person of advice, support, assistance or services available.
- θ) Offer the use of an advocate if this would be beneficial.
- ρ) Decide what information legally can be shared with next of kin. This may vary in differing circumstances either due to consent and capacity issues or through the choices of the adult in need of protection. The principles of best interests and information sharing apply. Good practice will evidence the rationale for the decision to share such information.
- σ) Promote the human rights of the adult in need of protection.

11.3 Role of DAPO at the Strategy Discussion

The DAPO must ensure that an adult protection strategy discussion is convened and chaired, and minutes taken and circulated. The DAPO will invite those who will provide critical or relevant information that will inform decision making to attend and/or provide a written report. This may include, for example, the PSNI or RQIA. The DAPO will also invite those who will be required to implement the various elements of any protection plan. In respect of regulated services this will include the Regulator. If the allegation involves a member of staff or paid carer, the strategy discussion will be attended, where appropriate, by:

13. PSNI
14. RQIA
15. The authorised officer for contracts
16. The HSC Trust commissioning manager/Contracts Manager
17. The Human Resources officer
18. The line manager of the member of staff

12.2. A senior manager of the employing organisation

Where a formal strategy meeting is convened of any individual requested to attend should treat the request as a priority. In exceptional circumstances, iIf no one from the organisation is able to attend, they should provide written information as requested and ensure it is available at the meeting.

In most cases it would be deemed to be good practice for a strategy discussion to take place as soon as possible. It is important that each adult protection intervention is conducted without undue delay, and remains outcome focused, rather than process driven. 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. HSC Trusts must ensure that the timeliness of interventions will be monitored and reviewed at an appropriately senior level.

11.4 Role of Line Managers in Strategy Planning

Line Managers may be required to take part in a strategy discussion in relation to service delivery and /or in relation to a member of staff. The Line Manager will be asked to contribute information about potential risk to inform the protection plan.

Line managers will implement any actions agreed and, in conjunction with the DAPO, they will agree what information will be shared with the person raising the concern and the adult in need of protection. Line managers may also be responsible for taking protective actions in relation to the person who has allegedly caused the harm. They will record all conversations, meetings with the person who allegedly has caused the harm, feedback to the DAPO, refer to HR for advice and notify appropriate professional and regulatory bodies as required.

NB where a PSNI investigation has commenced, it will be necessary to seek PSNI permission prior to interviewing a member of staff under disciplinary procedures, in case this interferes with PSNI procedures.

11.5 Adult Protection Strategy Discussion

The strategy discussion must demonstrate the following actions have been undertaken.

- Review the screening decision, including any requirement to refer to PSNI
- Consider the wishes of the adult in need of protection
- Clarify the mental capacity of the adult in need of protection to make decisions about their own safety. Arrange for an assessment by the most appropriate person, if required
- If the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, and/or who is a suitable person to act in the person's best interests.
- Consider the use of advocacy if appropriate
- Identify any communication needs of the adult in need of protection
- Discuss the nature of the concerns and review preliminary risk assessment and interim protection plan
- Consideration should be given to the safety and wellbeing of other adults or children. Where appropriate, refer to children's Gateway Service and/or Adult Gateway service.
- Consider the human rights for both the adult in need of protection and the person alleged to have caused the harm who may also be an adult at risk.
- Review and record available, relevant information and determine any further information required. Discussions should include decisions about sharing of information.
- Agree the most appropriate way of responding to the concerns identified, e.g. Single agency PSNI investigation; Single agency HSC Trust investigation; Joint Protocol investigation; disciplinary investigation; family group conference; care planning; risk management meeting; or formal complaint in order to create and implement a protection plan. The detailed rationale for this decision must be recorded and will be subject to audit.

- Where a decision has been made that an investigation will take place, agree an investigation plan to include timescales for same and how it should be conducted and by whom.
- Agree a clear rationale for the actions to be undertaken and by whom.
- Agree a communication strategy including who should inform service user/carer/advocate of outcome of strategy discussion.
- Consider the need to inform other regulatory/professional bodies.
- Circulate minutes to all invitees within ten working days using the appropriate regional pro forma (Appendix 6).
- If the investigation is likely to be prolonged, other strategy meeting(s) must be held to ensure that actions are progressed and the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary).
- Full cooperation will be afforded to police investigations and in such cases the DAPO must ensure appropriate care and protection plans are in place to protect and safeguard the adult in need of protection. It will be necessary to consult with PSNI before proceeding with any internal organisational investigations such as disciplinary proceedings
- Regular contact should be maintained between the DAPO and the PSNI representative during the PSNI investigation process, and the position communicated to the staff member's manager and HR representative (particularly as the suspension/transfer decision must be reviewed every 4 weeks).

11.6 Coordination of Adult Protection and Disciplinary Investigations:

The focus of a Disciplinary Investigation is to determine if a staff member has breached disciplinary rules, which may require disciplinary action to be taken. The threshold for decision-making is whether there is a case to answer 'on the balance of probabilities'.

The different focus of protection and disciplinary investigations will require separate reports to be prepared. However, coordinating the process by which each investigation gathers information will make the best use of the Trust's skills and expertise, avoid duplication, and avoid undue delay.

11.7 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is Also an Adult at Risk

The primary focus of the strategy meeting or discussion is the adult in need of protection. However, it may be necessary to hold a separate multi-agency meeting to address the needs and behaviour of the person causing the harm. Decisions that will need to be taken at the strategy meeting in relation to the person causing the harm will include:

14. How to co-ordinate action in relation to the adult at risk causing the harm.
15. Identification and allocation, of a separate care manager/keyworker in order to ensure that the needs of the adult at risk causing the harm are met and that a care plan is devised to ensure that other adults at risk are not also put at further risk from that person's actions.
16. Whether there is likely to be a criminal prosecution (if known at this point).
17. What information needs to be shared and with whom.

The DAPO will maintain communication with those concerned with the care of the adult at risk who is also alleged to be the person causing harm.

In all situations, the care manager/key worker representing the adult at risk and the relevant staff working with the person causing the harm must be informed of any risk management issues immediately and be closely involved at all stages of the investigation

Where the person alleged to have caused the harm is under 18 years of age, a referral should be made to the relevant HSC Trust Children's Services

.

The strategy discussion should demonstrate how the needs of the person who has allegedly caused the harm have been supported during the adult protection investigation.

Throughout the Adult Protection process, people alleged to have caused harm must be treated and spoken to without prejudice.

The person allegedly causing harm has a right to information about any allegations made. However, their right to information must be balanced with the rights of the adult in need of protection and/or any other safety concerns.

Where a decision is taken not to inform the person alleged to have caused harm of an allegation there must be a clear rationale for this decision which must be recorded and kept under review. Where a crime is alleged or suspected, advice should be sought from PSNI before information is shared.

11.8 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Member of Staff/Volunteer

If the person alleged to have caused the harm is a member of staff or a volunteer and an immediate decision is needed, the line manager should notify those with responsibility for Human Resource functions in the relevant organisation of the concern and liaise with the relevant manager for a decision on whether precautionary suspension/transfer/restricted duties of the staff or volunteer is necessary and appropriate. The employer should inform the person in broad terms of the nature of the allegations in line with HR Procedures.

There is a requirement in these circumstances to ensure that the rights of the adult in need of protection and the rights of a member of staff/ volunteer are fully considered and all actions taken at this stage are without prejudice in order to facilitate the investigation/s taking place.

11.9 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Family Member, Friend or Carer.

Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, information may need to be given to the person alleged to have caused harm to ensure they understand how poor care practices can become abusive. A carer may also require a carer's assessment.

In cases where a crime is alleged or suspected, advice on what can or should be shared should be sought from the PSNI.

11.12 Outcomes of Strategy Discussion

The strategy meeting/discussion must decide who will inform the adult in need of protection of the decisions and outcomes reached at the meeting. There are a number of outcomes that may be determined at the strategy (see Appendix 5). The relevant outcome should be recorded in the minutes of the meeting.

i. Insufficient Information to Determine if an Investigation is Required

It is agreed that additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

- **Threshold of Adult in Need of Protection is not met**

Where the threshold of "an adult in need of protection" is not 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:


Escalation to the service manager to address any issues about the quality of service provision;


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;


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;


Action taken under complaints procedures;


Action taken under HR/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;


Referral to an advocacy service;


Referral to another service or agency;

A risk management intervention in relation to self -neglect;

A strategy to manage risks within a complex group living environment

and the management of challenging behaviour;

- No further action required; **or**

a combination of any of the above.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights 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.

A decision to discontinue the Adult Safeguarding process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

15. The Threshold for an Adult in Need of Protection is Met

If the threshold is met and it is determined that investigation is required then consideration should be given as to the most appropriate type of investigation. This may be either a single agency (HSC Trust or PSNI) or alternatively a Joint Protocol Investigation.

Where the threshold is met and the adult in need of protection has capacity to withhold consent for an adult protection investigation, the expressed wishes of the adult will be respected and the investigation will not proceed provided there are no other adults at risk or concerns which may constitute a relevant and reportable offence.

In such circumstances, practitioners must be confident that the adult at risk is making this decision without undue influence, threats and intimidation. If there are no other people at risk from the person causing the harm, there will be no further action under the procedures at this time. In this situation there should be a written record, confirming their decision not to proceed with an investigation.

The adult at risk should be given information about abuse and neglect, possible sources of help and support and who to contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.
If protection concerns persist the strategy meeting must consider other types of intervention to be offered, including a risk management plan, care plan or Family Group Conference or legal powers available to intervene with the person(s) causing the harm. This must be shared and agreed in writing with the adult in need of protection.

11.13 Single Agency PSNI Investigation

Where a single agency PSNI investigation is considered to be the appropriate response, PSNI officers should refer to Police Service Procedures. During a single agency PSNI investigation the HSC Trust will ensure, where appropriate, any adult safeguarding or protection issues are addressed.

HSC Trusts will give full co-operation to police investigations and in such cases the DAPO must ensure appropriate risk and protection plans are in place to protect and safeguard the adult in need of protection.

The PSNI and HSC Trust should continue to liaise throughout the investigation in relation to any protection issues. The HSC DAPO will continue to hold strategy discussions throughout the PSNI single agency investigation to ensure that the protection plan is reviewed and those involved are updated on the progress of the PSNI investigation.

11.14 Joint Agency Investigations

Refer to Protocol for Joint Investigation of Adult Safeguarding Cases (2016).

In cases where an investigation is proceeding under the Protocol, clarity should be sought at the strategy meeting as to whether any element of a Trust protection investigation can commence (to include review of documentary evidence; meeting with adult in need of protection; meetings with witnesses; meetings with the person alleged to have caused the harm) in parallel with the PSNI investigation. Criminal investigations by the PSNI will take priority over all other investigations. Any internal investigation should not proceed without the knowledge and agreement of the

PSNI. This will ensure that the criminal investigation is not jeopardised or prejudiced by internal enquiries.

11.15 HSC Trust Single Agency Investigation

Where the decision is taken to continue with a single agency HSC Trust investigation under the protection procedures, the DAPO will be responsible for the management of the protection investigation, including the following::

14.2. The appointment of a HSC Investigating Officer(s).

14.3. Ensure the adult in need of protection is aware of the allegation of abuse;

14.4. Ensure the wishes of the adult in need of protection are recorded;

14.5. Agree methodology and terms of reference for the investigation. This should reflect agreed management of other possible forms of harm which may become apparent during the investigation.

14.6. Is the response proportionate?

14.7. Agree documentation to be reviewed.

14.8. Consider needs of other adults at risk/children.

14.9. Consider HR/other investigatory processes. If there are going to be a number of investigations, running alongside adult protection, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place.

14.10. Identify an indicative timeframe in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion without undue delay.

14.11. Is there any medical evidence or record of the impact of the abuse?

14.12. Has there been a disclosure? Is it signed and dated?

14.13. Have the human rights of both the adult in need of protection and the person alleged to have caused the harm been considered?

14.14. Is there any documentary evidence available? E.g. bank statements, accident reports.

14.15. Has the adult in need of protection been contacted about the alleged abuse?

14.16. Have the holistic ‘best interests’ of the adult in need of protection remained paramount in the decision making process?

14.17. Have the wishes of the adult in need of protection been recorded?

- Has the adult in need of protection's capacity to consent been considered and is there any report regarding capacity where appropriate?
- Are there risks to other adult in need of protection or children? If so, agree a referral to the children's services and who will make the referral.
- Have appropriate regulatory and professional bodies been informed, e.g. RQIA, NISCC?
- Has consideration been given to notifying other relevant agencies, e.g. other departments, trusts, providers?
- If the alleged offender is an employee Human Resources should be consulted.
- Has consideration been given to ensuring appropriate supports are available for the adult in need of protection accounting for cognitive ability, comprehension and communication needs?
- Has consideration been given to appropriate supports for carers during the investigation?
- Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these.
- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- Agree how communication will be maintained during the investigation.
- Identify who will be the responsible person within each participating organisation for any agreed actions.
- If the situation indicates that the adult in need of protection is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the DASH risk assessment and make the referral (NB The MARAC process does not replace the Adult Protection process, but adds benefit to any risk assessment).
- If the alert was made by a service user or a member of the public about abuse or neglect within an organisation, the organisation's complaints procedure may form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the

complaints process is suspended pending the outcome of protection investigation.

Agree the need for further strategy reviews during the investigation and agree dates.

- ## Stage Three: Investigation/Assessment

12.0 Purpose of the Investigation

A single agency adult protection investigation is a professional assessment which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

The purpose of the investigation is to:

- Establish the facts and contributing factors leading to the referral.
- Determine and manage the level of risk to an adult in need of protection and or others and update the care and protection plan as required.

The investigation must:

- Be open to the possibility of the presence of other forms of harm.
- Reflect the wishes of the adult in need of protection
- Produce an investigation report.

12.1 The Investigating Officer Role

The Investigating Officer will:-

- Meet with the adult in need of protection and carer/relative separately where appropriate to establish the preliminary information.
- Investigate allegations and concerns when appointed by DAPO. The investigation should take the form of an assessment of risk and needs. This will inform the review and updating of the interim protection plan.
- Inform the adult in need of protection of expressed concerns and the adult protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.

- Inform the adult in need of protection of his/her rights to protection under law.
- Support the adult in need of protection through the assessment process.
- Keep the adult in need of protection, or their representative, informed and updated throughout the investigation process to ensure informed decision making.
- Consider whether there is a need to refer the person alleged to have caused the harm on for professional input and support.
- Commission medical or other specialist assessments, where appropriate.
- Inform and liaise with relevant professionals and significant others.
- Investigating officer may require other information, action and support from other disciplines, agencies and organisations to assist with and adult protection or criminal investigation.
- Make a clear record of the investigation process.
- Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- Provide an investigation report for a case conference/review. This report must include an analysis of the findings and a conclusion and recommendations.
- Keep personally identifiable information concerning the adult in need of protection, the person causing the harm and any third parties to a minimum.
- Ensure the implementation of any care and protection plan as agreed with the DAPO.

12.2 The Investigation Report

The investigation report must clearly set out the following:

- Context of the referral and detail of the alleged concerns;
- A pen picture of the adult in need of protection and his/her circumstances, including formal and informal networks of support.
- An assessment of the adult in need of protection's capacity to consent.
- Information about the person alleged to have caused the harm.
- A brief account of the methodology for the investigation.
- The investigation findings, including:

a professional assessment of the impact of the harm on the adult in need of protection **AND**

analysis of the evidence giving consideration of the impact of decisions on the person's rights and the need to balance competing rights as positively as possible


The report must reach conclusions on the balance of probability, determining whether harm occurred.


Make recommendations where appropriate.

12.3 Undertaking the Investigation

Timescales

The Investigating Officer will make contact with the adult in need of protection and begin the investigation immediately following receipt of the referral and an initial discussion with the DAPO. The investigation should be conducted without undue delay. The Investigating Officer must keep the DAPO informed of the progress of the investigation and any change to the investigation plan. If for any reason the investigation plan cannot be completed within the agreed timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached between the DAPO and other relevant organisations and clearly recorded.

The DAPO can take a professional decision to close the investigation process where additional information identified throughout the investigation demonstrates that there is no requirement to proceed with a protection investigation. The DAPO must communicate the rationale for closing the investigation in writing to the strategy planning group. Any disagreements should be recorded on the regional adult protection closure documentation.

12.4 If the Adult in Need of Protection Moves During the Adult Protection Process

The DAPO must:

17. Contact and reach agreement with a senior manager or DAPO in the new host Trust about future action, roles and responsibilities.
18. Send fully documented and relevant information and summaries as appropriate.

Other organisations that have been involved in the investigation must also be advised if the adult need of protection has moved to another area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently.

12.5 If the Person Alleged to Have Caused the Harm Moves During the Adult Protection Process

If the person allegedly causing the harm is an informal carer or member of the public, any information on a change of address or location should be shared with the PSNI. If the person allegedly causing the harm is a paid worker or a volunteer, the line manager should also follow appropriate Human Resources advice.

12.6 If a Referral or Complaint is Received After an Adult in Need of Protection Has Died

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required.

If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

12.7 Resolution of disagreements

Where there are disagreements at any stage in the process that cannot be resolved by discussions between those responsible for decision making, these should be escalated to senior managers within the HSC Trust and/or PSNI, who will make a determination. At all times participating agencies should avoid delay resulting from

inter-agency disagreement and ensure that the wellbeing of the person in need is prioritised.

13. Stage 4 Implementation / Protection planning

Following the completion of the final draft investigation report consideration must be given by the DAPO to the most appropriate method for sharing and agreeing the final outcomes of the investigation and the process for managing the next steps or recommendations with the adult in need of protection.
The forum for decision-making and managing any outstanding risks must be carefully considered and fully person-centred. It might involve, for example, a risk management meeting, a Family Group Conference, a family meeting held in the person's own home a case discussion or a case conference.

When the adult in need of protection lacks capacity, the DAPO must take the complexity of the case and interagency involvement into consideration when deciding on the most appropriate forum for sharing information and agreeing the protection plan.

13.1 Planning the Meeting

The case conference meeting should take place after the completion of the protection investigation. Some parallel investigations may not be completed, for example, a criminal prosecution or Human Resources process but this should not be considered grounds to delay the meeting. The DAPO should ensure that a suitable meeting is convened without undue delay. The DAPO will Chair and ensure arrangements are in place to have the meeting minuted. The Investigating Officer should submit their investigation report to the Chair of the case conference prior to the meeting. Copies will also be made available to all attendees. Representatives invited to and attending the meeting should have the delegated authority to agree to provide services to contribute to the reviewed protection plan if their organisation has a role to play.

13.2 Purpose of the Case Conference

The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability (see above).

The aim of this meeting is to:

- Consider the information contained in the investigating officer's report.
- Consider the evidence and, if the allegation of abuse/serious harm is substantiated, plan what action is indicated.
- Agree and plan further action(s) if required.
- Consider whether there are legal or statutory actions indicated.
- Make a decision about the levels of current risks to the adult in need of protection or others and a judgement about any likely future risks.
- Analyse and evaluate the findings of the investigation report and agree a consensus decision as to the conclusions reached; i.e. substantiated; unsubstantiated; partially substantiated; inconclusive. Record any disagreements/amendments within the minutes of the meeting.
- Agree an ongoing protection plan if required including how this will be reviewed and monitored.

These aims must be met irrespective of whether the meeting is a formal case conference or a meeting with the adult in need of protection within their family home.

13.3 Sharing the report

The content of the draft report and care and protection plan should be shared with the adult in need of protection and their family where appropriate prior to the case conference in order to ascertain their views on the findings and reflect these at the case conference.

A copy of the draft report should also be shared with the person who was alleged to have caused the harm and the relevant employer where the person is a member of staff. This provides an opportunity for a right to reply and the report may either be amended to reflect comments, correct inaccuracies, or to register disagreements. Any decision not to share this draft report must be recorded including the rationale for this decision.

When deciding to share the draft report, the DAPO should carefully consider any possibility of escalating risk to the adult in need of protection or others inclusive of

staff whistleblowing requirements. The rationale for all decisions must be recorded by the DAPO.

All parties, where appropriate, have a right to a copy of the **final** written investigation report except where to do so would place the adult in need of protection or others at greater risk of harm. The adult in need of protection and provider organisations should be advised of the confidential nature of the report.

13.4 Outcomes of the Case Conference

The meeting must reach a decision, based on the balance of probabilities, as to whether the harm occurred. The meeting must agree whether there is a need for an ongoing protection plan with associated roles and responsibilities for implementation t agree any recommendations that should be taken forward. The meeting must make a decision as to whether the case should be closed under Adult Protection Procedures.

The protection plan will focus on the adult in need of protection. Actions arising in relation to the person causing the harm should be taken forward by the keyworker under normal care planning arrangements.

Possible recommendations of the case conference may include the following:

- The case conference should consider requirements to refer to other regulatory or professional bodies.
- Consider any systemic, contractual or practice issues that must be referred to the relevant organisation for action.
- Consider the need for further or additional information to be shared with Human Resources.

13.5 Minutes

The minutes record the decisions of the meeting and evidence how these decisions were made. The minutes will be shared with those present and those contributing to the protection plan. The protection plan will be attached to the minutes of the meeting.

Where the adult in need of protection has not been in attendance at the meeting the outcome should be shared with them as soon as possible and the protection plan discussed and agreed. If the person does not have capacity, a decision should be made in their best interests and shared appropriately.

Where there is information that cannot be shared outside the case conference meeting, it should be redacted from versions of documents sent out. It is imperative that Data Protection Act 1998 principles are adhered to. Whether or not minutes of the meeting are shared with the adult in need of protection, the DAPO will decide the best person to feed back to them on the outcome of the meeting. This should take place as soon as possible afterwards. The adult in need of protection should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed/agreed.

13.6 Feedback to the Person Alleged to Have Caused the Harm

A decision must be made in the meeting about what feedback should be provided to the person alleged to have caused harm and the organisation that employs that person (if relevant), as well as who should provide it. Due consideration must be given to any potential risk this might pose to the adult in need of protection. The rationale for any decision not to feedback to the person alleged to have caused the harm must be clearly recorded and agreed by the case conference. If the person alleged to have caused the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

14. Stage Five: Monitoring/Review of the Protection plan

14.1 Purpose of the Review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed. Additional concerns of abuse or neglect would be considered as a new alert/referral.

The review should

- Review the risk assessment
- Decide about ongoing responsibility for the protection plan

- Decide, in consultation with the adult need of protection or their personal representative, what changes, if any, need to be made to the protection plan to decrease or manage the level of risk
- Decide whether there is need for a further review and, if so, set a date
- Decide whether to close the Adult Protection Plan.

14.2 Recording and Feedback

- Record any decisions, agreed actions and those responsible for contributing to the implementation of the protection plan.
- Ensure that all involved in the review of the protection plan have a copy of the review notes, including the adult in need of protection or their personal representative (with the permission of the adult in need of protection and where it is safe and appropriate to do so).
- Reach agreement about feedback arrangements, in accordance with the adult in need of protections best interests, if they do not have mental capacity and do not attend the review. This feedback should be provided as soon as possible after the review meeting.

15. Stage Six: Closing the Adult Protection Process

The Adult Protection process may be closed at any stage if it is agreed that further investigation is not needed or if the investigation has been completed and a protection plan is agreed and put in place. In most cases a decision to close the Adult Protection process is taken at the case conference or case conference review where the protection plan is reviewed.

The DAPO must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. Where there is disagreement this should be escalated to the senior managers within the relevant organisations for resolution. The closing process must be signed off by the DAPO and/or a Senior Manager in the case of a serious/complex Adult Protection situation.

15.1 Actions on Closing

The DAPO should ensure that, on conclusion of the process:

- All necessary and agreed actions are completed or are in progress.

- Case records contain all relevant information and forms are satisfactorily completed.
- The person in need of protection knows that the process is concluded and where/who to contact if they have any future concerns about abuse.
- Responsibility for the review of the protection plan transfers to the operational team.
- All those involved with the person are informed about the closure and know how to re-refer if there are renewed or additional concerns.
- Referral is made to appropriate professional and regulatory bodies and/or notifiable occupation schemes where necessary.
- The referrer is notified of completion.
- The necessary monitoring forms and all data monitoring systems are completed.

16. Investigation of Large Scale, Organised or Multiple Abuse Cases

A large-scale adult protection investigation is likely to involve a range of organisations and potentially a number of individual adult protection interventions. 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 person alleged to have caused the abuse 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 of abuse.

Such abuse occurs 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 or community 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 become involved; its investigation is time-consuming and demanding work which requires specialist skills from PSNI and HSC Trust staff.

Each investigation of organised or multiple abuse will be different, according to the

characteristics of each situation and the scale and complexity of the investigation. 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. However, every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) in need of protection and the adult(s) at risk involved.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Gateway Service DAPO must immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, **if it is considered necessary,** establish a Strategy Management Group (SMG) to oversee the process of investigation. Core members of an SMG are:

- PSNI;
- HSC Trust DAPO;
- a senior manager from the relevant HSC Trust 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.

16.1 Functions of the Strategic Management Group

The SMG will:

- Establish the principles and practice of the investigation and ensure regular review of progress against that plan;
- Prioritise and allocate expedient resources to establish an Investigative Team within their respective agencies;
- Ensure co-ordination between the key agencies and the Investigative Team within the HSC Trusts and PSNI. This includes resolving any interagency operational interface challenges between various established processes;
- Ensure decisions of the strategy planning group are actioned in a timely manner;

- Act in a consultative capacity to those professionals who are involved in the investigation;
- Draw up a media strategy to respond to public interest issues and agree who will take responsibility for responding to media enquiries;
- Have oversight of the agreed communication strategy/liaison with adults in need of protection/families and carers involved in the 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;
- The closing process must be signed off by the SMG in the case of a serious/complex Adult Protection situation.

16.2 Working Across Trust Boundaries

It should be recognised that there may be an increased risk to the adult in need of protection whose care arrangements are complicated by cross boundary considerations. These situations may arise in residential, nursing or hospital placements where funding or commissioning responsibility lies with one HSC Trust (Placing), but the concerns about potential harm or exploitation subsequently arise in another Trust area (Host).

The scenarios most likely to arise in cross boundary adult protection investigations are:

Scenario A: where allegations relate to one individual only, in which case the responsible Placing HSC Trust undertakes the investigation and informs the Host HSC Trust of the concerns and outcomes for information and any necessary relevant contractual actions.

Scenario B: If, during the course of the investigation, there are emerging concerns about systemic practice potentially leading to harm for other residents, the Placing Trust must notify the Host Trust. The Host Trust must assume responsibility by convening a strategy meeting with a view to extending the investigation.

Scenario C: If an incident arises within an acute hospital it is the responsibility of the DAPO within that acute setting to respond by taking any necessary immediate actions and referring to the Trust of residence as appropriate. If the disclosure

relates to an incident prior to admission, the DAPO will link with the resident Trust to respond as appropriate.

16.3 Responsibilities of the Host Trust

The Host Trust will always take the initial lead on responding to a referral. This will include taking any necessary immediate action to protect the adult/s in need of protection, and where appropriate, making initial contact with the PSNI. Where there are concerns regarding more than one adult in need of protection the HSC Trust where the harm occurs will have overall responsibility for co-ordinating the adult protection investigation.

In all cases, it is vital that, when a referral is received, there is open communication between Host and Placing Trusts to ensure that:-

- Any immediate risks are identified and acted upon;
- There is a single, timely response to the referrer;
- Strategy discussions to co-ordinate the investigation are commenced without delay; and
- The individual's on-going case management needs are addressed.

The Host Trust will also co-ordinate initial information gathering, including systems checks to determine services that have been or are involved and ensures prompt notification to any other relevant agencies.

It is the responsibility of the Host Trust to identify all adults at risk within a regulated facility or service who may have been victims of the person alleged to have caused the abuse and to notify the Placing Trusts, or where the adult at risk's usual place of residence is outside Northern Ireland, the relevant Local Authority in Great Britain or the Health Service Executive in the Republic of Ireland. This includes those adults at risk not known to any HSC Trust.

In those instances where Joint Protocol/ABE social work interviewers are required these will be provided by the Placing Trust or by agreement with the Host Trust.

16.4 Responsibilities of the Placing Trust

- Attend any Strategy Meeting(s).
- Identify the Investigating Officer who will be part of the wider investigation team.
- Provide any necessary support and information to the Host Trust in order for a prompt and thorough investigation to take place.
- Exercise a continuing duty of care to the adult at risk/in need of protection.
- Inform families of investigation and ensure ongoing communication as agreed throughout.
- Devise and implement an Individual Protection plan.
- Act on the case conference recommendations.

Appendices

Appendix 1

References

Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy. Department of Justice (2012)

Adult Safeguarding: Prevention and Protection in Partnership
Department of Health Social Services and Public Safety and Department of Justice (2015)

Northern Ireland Adult Safeguarding Partnership Training Framework
NIASP (2016)

Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy
Department of Health and Department of Justice (2016)

Protocol for Joint Investigation of Adult Safeguarding Cases
NIASP (2016)

Appendix 2

Glossary of Terms

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'. Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

ABE (Achieving Best Evidence) Interviewer – The Specialist Achieving Best Evidence Interviewer must be a professionally qualified Social Worker. The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding cases" and "Achieving Best Evidence in Criminal Proceedings."

Adult Protection Gateway Service – is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.

Adult Safeguarding - encompasses 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.

Adult at risk of harm – A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

i) **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*);

and/or

ii) **life circumstances** *(may include, but are not limited to, isolation, socio-economic factors and environmental living conditions).*

Adult in need of protection - An adult at risk of harm (above):

i) who is **unable to protect** their own well-being, property, assets, rights or other interests;

and

ii) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

ASC (Adult Safeguarding Champion) - The ASC should be within a senior position within the organisation and should be suitably skilled and experienced to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Case Conference - The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability.

CRU (Central Referral Unit) – The central point of referral to PSNI in relation to adult protection is based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland) - an independent legal 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.

Domestic 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.

Designated Adult Protection Officer (DAPO) – the person 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 service teams. The DAPO will provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer; 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.

DBS (Disclosure and Barring Service) - helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Exploitation - 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.

FGC (Family Group Conferencing) - A family group conference is a process led by family members to plan and make decisions for a person who is at risk. People are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

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.

Harm - 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.

Investigation Officer (IO) - is a HSC Trust professionally qualified practitioner. Their role is to establish matters of fact, how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer alongside relevant professionals will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

The Protocol – (Protocol for Joint Investigation of Adult Safeguarding Cases) - - 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 (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.

Modern Slavery - 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.

NIASP (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.

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

NMC (Nursing and Midwifery Council) – is the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. NMC sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

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.

Registered Intermediary - RIs have a range of responsibilities intended to help adult witnesses who are in need of protection, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

RQIA (Regulation 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.

SAI (Serious Adverse Incident) - an adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people.

Serious Harm – is a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome.

Single Agency Investigation – a single agency adult protection investigation is a **professional assessment** which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

Special Measures - the measures specified in the Criminal Evidence (NI) Order 1999, as amended, which may be ordered in respect of some or all categories of eligible witnesses by means of a special measures direction. The special measures are the use of screens; the giving of evidence by live link; the giving of evidence in private; the removal of wigs and gowns; the showing of video recorded evidence in chief, and aids to communication.

SMG (Strategic Management Group) – has responsibility to oversee the process of investigation. Core representatives of SMG are: PSNI; HSC Trust nominated Adult protection Gateway DAPO; a senior manager from the relevant adult programme of care; and RQIA (where the allegation relates to a regulated service).

Strategy Meeting - In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts.

Appendix 3

HSC Trust Adult Safeguarding Contact Details

HSC Trust	Adult Safeguarding Number
Belfast	028 9504 1744
Northern	028 2563 5512
Western	028 7161 1366
South Eastern	028 9250 1227
Southern	028 3741 2015/2354

Regional Emergency Social Work Service (RESWS)

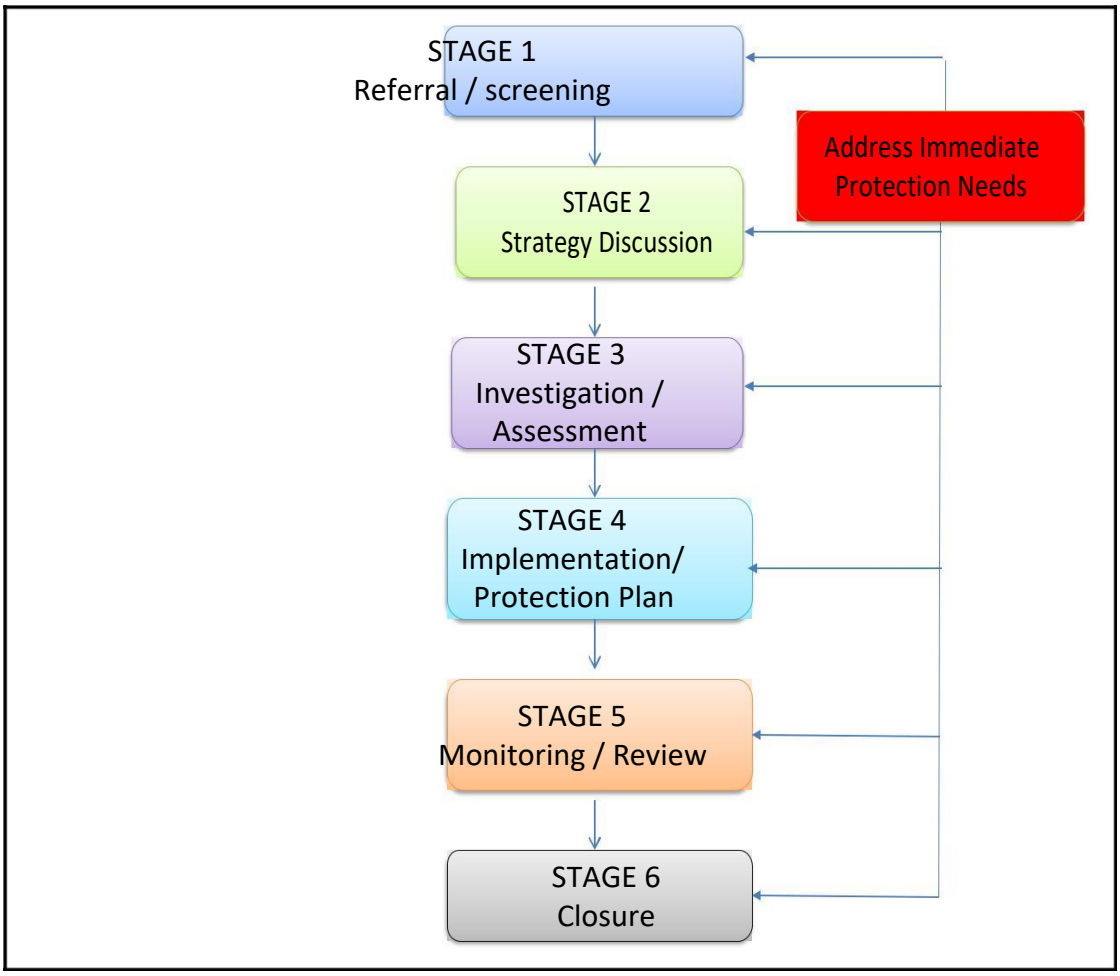
Tel: 028 9504 9999 (Mon-Fri 5pm-9am; Saturday & Sunday)

HSC Trust Child Protection Contact Details

HSC Trust	Child Protection Gateway Number
Belfast	028 9050 7000
Northern	0300 1234 333
Western	028 7131 4090
South Eastern	0300 1000 300
Southern	0800 7837 745

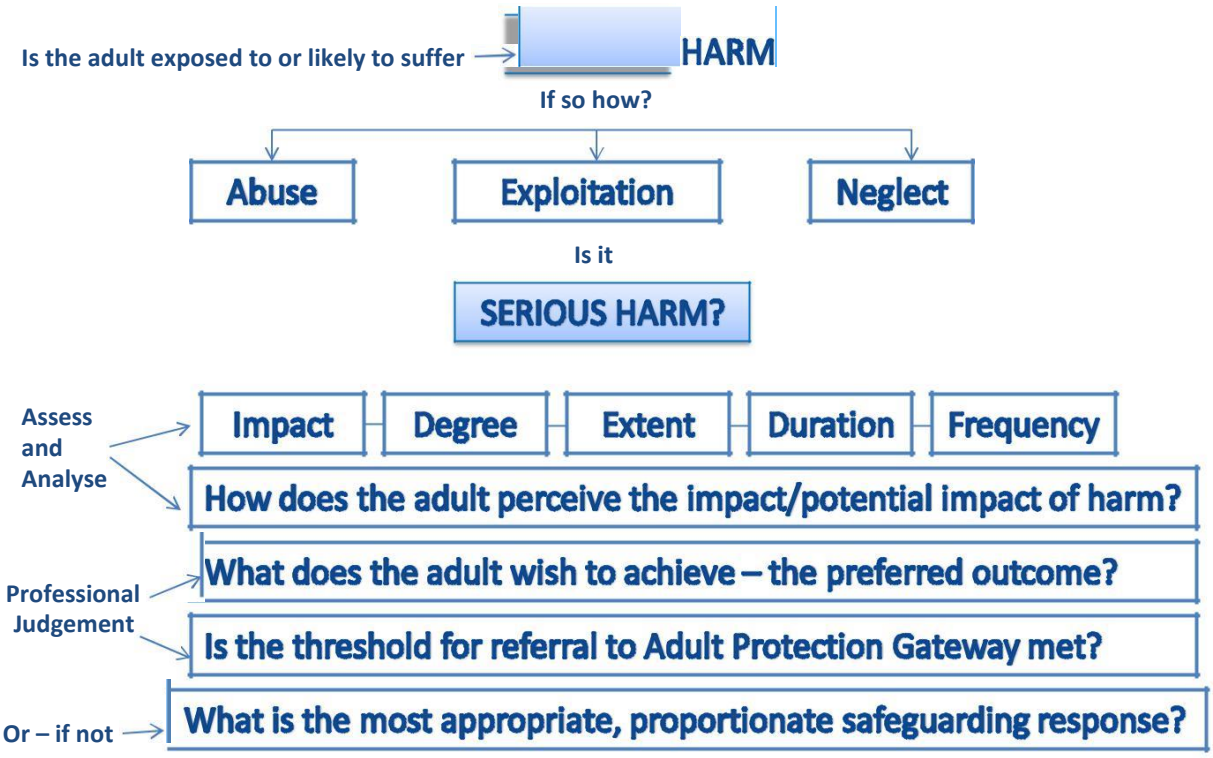
Appendix 4

Six Stages of Adult Protection Process



Appendix 5

Factors for Consideration in Determining whether Harm has become Serious Harm



Appendix 6

Possible Outcomes

Possible Outcomes for the adult in need of protection	
Protection Plan	**Actions**
Increased monitoring	Referral to advocacy service
Removal from property	Referral to counselling services
Application to the Office of Care and Protection	Assessment/support/advice/services
Application to change Appointee-ship	Referral to MARAC
Referral under the "Family Homes and Domestic Violence (Northern Ireland) Order 1998" re use of non-molestation or Occupancy Order	Seek legal advice regarding use of "The Mental Health (Northern Ireland) Order 1986" Guardianship; or application to the High Court for a Declaration of Best Interests
Review of Self-directed Support/Direct Payments	

Possible outcomes for the person alleged to have caused the harm	
Protection Plan	**Actions**
Referral under Joint Protocol Procedures	Assessment/support, advice, services
Removal from property	Continued monitoring
Management of access to adult in need of protection	Counselling/training
Action by RQIA	Disciplinary action
Action by contract compliance	Referral to a regulatory/Professional body/ISA
	Referral to court-mandated treatment
	Referral to PPANI
	Action under “The Mental Health (Northern Ireland) Order 1986”

Appendix 7

HSC Trust 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. The decision regarding the most appropriate professional to undertake the assessment will be determined by the nature of the need/risk identified, for example where the concern relates to pressure ulcers the most appropriate professional to assess and respond is likely to be from nursing and/or tissue viability.

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 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.

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 having carried out a professional assessment they should escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust.

Consideration must also be given to the vulnerability of the person who is alleged to have caused harm. It is possible that a risk assessment may also be required for the person who is alleged to have caused harm.

Appendix8

Adult Protection Regional Documentation

APP1 FORM

REGIONAL ADULT PROTECTION PROCEDURES

APP1(a) REFERRAL / SCREENING INFORMATION

For completion by HSC staff and contracted providers

PLEASE ENSURE SECTIONS 1 & 2 ARE FULLY COMPLETED BEFORE REFERRAL TO TRUST DAPO

Name:	Date of Birth: *(if not known, please give approximate age)*	Date of Referral:
Address: Postcode:	Gender: M ☐ F ☐	Service/Client Group:
Telephone No:	Is the person known to the Trust? Yes ☐ No ☐	Reference No:

SECTION ONE

Section 1 – completed by Referrer

Source Of Referral			
☐ Carer	☐ Other Trust	☐ RQIA	☐ Regulated Care Home
☐ GP	☐ Other Health Professional	☐ Adult Mental Health Unit	☐ Other Regulated Facility *Specify*
☐ Hospital Staff	☐ Anonymous	☐ Self	☐ Learning Disability Hospital
☐ PSNI	☐ Social Worker	☐ MARAC	☐ Other *Specify*
☐ DHSS	☐ Care Manager/Care or Homecare Worker	☐ Adult Safeguarding Champion	
☐ Vol. Organisation	☐ Housing Association	☐ Acute General Hospital	

Details Of Referrer (*the person who brings the concerns to the attention of your agency*)	
Name:	Relationship to adult at risk of harm:
Job title and agency:	Contact number:

Who Was The First Person To Note Concern		
Name:	Relationship to adult at risk of harm:	Contact number:

APP1 FORM

Key Contacts			
	Name	Address	Contact number:
Key Worker			
Care Manager			
G.P			
Family/Carer			
Significant other			
Other			

What Is The Main Form Of Suspected, Admitted Or Known Abuse?			
☐ Physical	☐ Sexual	☐ Institutional Abuse	☐ Human Trafficking
☐ Financial	☐ Neglect	☐ Psychological	☐ Domestic Violence
☐ Discrimination	☐ Exploitation		

Incident Report

Background Information: *(To include factors precipitating referral, home circumstances, support available, including issues of capacity)*

Incident Report – Location / Date / Time of Incident *(Please give exact details of what has been reported and if appropriate include names of any witnesses and note injuries on the attached body chart)*

Details Of Any Witnesses

Name: **Name:**

Address: **Address:**

Contact No: **Contact No:**

APP1 FORM

Describe The Impact Of The Incident On the Adult At Risk of Harm

The Adult At Risk of Harm Usual Living Arrangements

Does the adult at risk of harm live alone? ☐ Yes ☐ No

Does the person who is suspected to have caused harm live with the adult at risk of harm? ☐ Yes ☐ No

Is the adult at risk of harm present location different from home address? ☐ Yes ☐ No *If Yes give present location*

Have You Taken Any Action Due To Emergency Situation To Avoid Immediate Serious Risk?

Was immediate protection needed for adult at risk of harm? ☐ Yes ☐ No

If Yes give details:

Are there any children or other adults at risk? ☐ Yes ☐ No

If Yes give details:

Was immediate protection required? ☐ Yes ☐ No

If Yes give details:

Adult At Risk of Harm's Knowledge Of Referral

Does the adult at risk of harm know that a referral may be made? ☐ Yes ☐ No

Is the adult at risk of harm able to give informed consent? ☐ Yes ☐ No ☐ N/K

Has the adult at risk of harm consented to a referral? ☐ Yes ☐ No

APP1 FORM

Details of Person/Persons Suspected of Causing Harm		
Name:	Date of Birth:	☐M ☐F
Address:		

Does the person/persons suspected of causing harm know that an allegation has been made against them? ☐ Yes ☐No ☐ N/K

Is the person/persons suspected of causing harm known to the adult at risk of harm? ☐Yes ☐ No ☐ N/K

If yes please specify below:

☐ Family member ☐ Another service user ☐ Paid carer ☐ Trust employee

☐ Other *(specify)*

Any Additional Information Relevant To The Referral
(Please note the views of others you have consulted and note any difference of opinion)

Signature:	Date:

SECTION TWO

Completed by Appointed Person

Have 'Alerts' been checked to establish if previous APP1s are recorded? ☐ Yes ☐ No ☐ N/K

Have previous APP1 alerts been recorded? ☐ Yes ☐ No ☐ N/K

If yes give summary of previous APP1s

Actions Agreed By Appointed Other

Further information required prior to a decision being made and If yes, What information is required and who will action ☐ Yes ☐ No

Answer EITHER

(a. HSC Trust Line managers)

Consultation with core team DAPO re adult at risk of harm ☐ Yes ☐ No

OR

(a. Adult Safeguarding Champion managers)

Consultation with key worker if known / or Adult Protection Gateway service re adult at risk of harm ☐ Yes ☐ No

Referral of Adult in need of protection to Trust Adult Protection Gateway Services ☐ Yes ☐ No

No further action under Adult Protection Procedures ☐ Yes ☐ No

Is there a need to refer to or notify?

☐ Professional Community Assessment ☐ Quality Assurance Team ☐ Care Management

☐ Contracts ☐ Human Resources ☐ Adverse incident reporting ☐ RQIA ☐ PSNI

Is there a need to consider any immediate Human Rights issues? ☐ Yes ☐ No

(Please refer to drop down of Convention Human Rights or manual form)

Details of Decision Making

This should prioritise issues of Risk/ Harm/ Possible Criminal Offence

Signature:	Date:

APP1(b) - Initial Screening by Trust Adult Protection Service

SECTION THREE

- *Section 3 – completed by Trust DAPO*

Outcome of Initial Screening and Actions Agreed by DAPO under Adult Protection Procedures	Date:
Details of Decision Making	

☐ Referral does not meet criteria for Trust Adult Protection Procedures
☐ Decision pending further information
☐ Referral forwarded to Trust core team for investigation as Adult at Risk of Harm
☐ Referral accepted for Investigation under Adult Protection Procedures
☐ Referral being considered under Joint Protocol

Are there any considerations for allocation of referral?

Has the adult in need of protection any preferences relating to who should carry out the investigation? *(e.g. gender)* ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Has the adult in need of protection any special requirements? ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Are there issues of safety for the worker? ☐ Yes ☐ No ☐ N/K
If Yes, state what safeguards are in place

Will the service user (adult in need of protection) be visited on the same day as referral received? ☐ Yes ☐ No
If no, state reasons

APP1 FORM

Details of Decision Making

Is immediate action required to protect the adult in need of protection?

Urgent medical attention required?	☐ **Yes**	☐ **No**
Additional care resources or staff required?	☐ **Yes**	☐ **No**
Protection or respite admission required?	☐ **Yes**	☐ **No**
Any other action required	☐ **Yes**	☐ **No**

Details of decision making:

Is there a possible criminal offence? ☐ **Yes** ☐ **No** ☐ **N/K**

Is there a need to preserve possible forensic evidence? ☐ **Yes** ☐ **No**

Is there a need for immediate report to the PSNI? ☐ **Yes** ☐ **No**

Is Joint Agency Consultation required? ☐ **Yes** ☐ **No** ☐ **Pending more information**
If Yes, please complete AJP1

Outcome of Report to PSNI / Joint Agency Consultation: *(Lead agency to record all decisions on AJP documentation)*

PSNI lead Investigation	☐ **Yes**	☐ **No**	
Trust Lead Investigation	☐ **Yes**	☐ **No**	
Joint Protocol Investigation	☐ **Yes**	☐ **No**	
PIA required	☐ **Yes**	☐ **No**	
ABE interview required	☐ **Yes**	☐ **No**	☐ **N/K**

Are the criteria met for Not-Reporting to PSNI? ☐ Yes ☐ No

If criteria are met for Not-Reporting complete section below:

In making the decision NOT to report to the PSNI please ensure that all criteria have been met. (ALL boxes must be ticked):

☐ The victim has capacity to make an informed decision and does not want to make a complaint to PSNI / or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf
(Refer to Joint Protocol Appendix 7 Consent/Capacity/Human Rights)

and

☐ The Trust is not required by law to make a referral to PSNI
If the incident does not meet the threshold of relevant offence under section 5 of the Criminal Law Act (NI) 1967
(Refer to Joint Protocol Appendix 2 Definition of Relevant Offence)

and

☐ It is a minor incident
A comprehensive assessment of all the factors must be taken into consideration
(Refer to Joint Protocol Appendix 8 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm)

and

☐ The situation is being managed through an Adult Protection process and/or there are other protective measures in place

Are there any Human Rights issues? ☐ Yes ☐ No
(Please refer to drop down of Convention Human Rights or manual form)

Do the RQIA need to be informed? ☐ Yes ☐ No ☐ N/K
If yes:-

Name of Inspector: **Date:**

Does the Trust need legal advice? ☐ Yes ☐ No ☐ N/K

Date of Contact:

Are there any other potential DAPOs to be consulted? ☐ Yes ☐ No ☐ N/K
If Yes give details:

Details Of DAPOS:

Name:	**Name:**	**Name:**
Trust:	**Trust**	**Trust:**
Service Area:	**Service Area :**	**Service Area:**
Contact No:	**Contact No:**	**Contact No:**

Has a discussion taken place? ☐ Yes ☐ No

If Yes record any joint working and feedback arrangements agreed between Managers/DAPOs (NB: This is critical when there is more than one Service area or one Trust involved).
Details of discussion:

Signature of DAPO:	**Date:**

HSC

APP1 FORM

Trust Adult Protection Investigation Commenced	Date:

Referral allocated to:

DAPO: Contact No:

Investigating Officer: Contact No:

Allocated By: Date:

SOSCARE ADMIN BOX: SCREENING DECISION	DO DECISION AS PER CODES
MULTIPLE INCIDENT	
NO OF CLIENTS INVOLVED	
ALLEGED ABUSE	
STAFF INVOLVED	
ADULT PROTECTION PLAN INITIATED	
DATE AP PLAN INITIATED	
LEGAL STATUS OF CLIENT	
DATE OF JOINT AGENCY CONSULTATION	
OUTCOME OF JA CONSULTATION	
DATE SCREENING COMPLETED	
REASON SCREENING COMPLETED	

APP1 BODY MAP

ADULT PROTECTION PROCEDURES

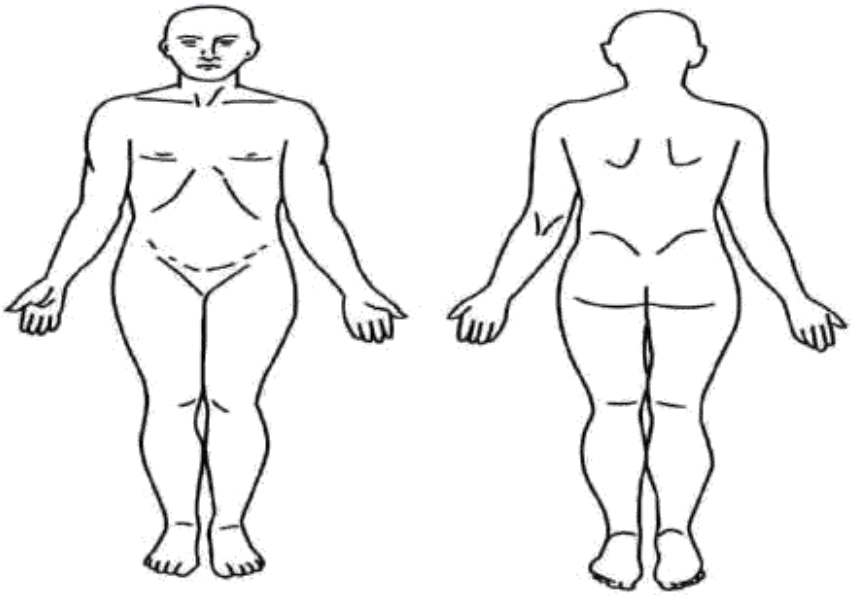
REFERRAL FORM – BODY MAP

Name: **Date of birth:**

Health & Social Care Number *(if known)*

APP1(a) Body Map is to be used in conjunction with the APP1Referral form by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care. Where used, the completed APP1(a) Body Map should be submitted with the APP1 Referral form.

Please mark with numbers drawn on the body map in black ink to indicate the different injuries, and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows (a ruler is provided to assist with measurement):



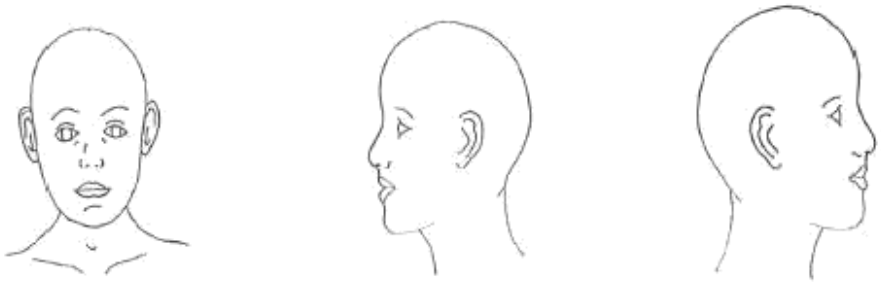
No	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments
1					
2					
3					
4					
5					
6					

APP1 BODY MAP

Body Map notes:

Note any other details, such as anything the vulnerable adult discloses on examination (verbatim), or information received from any other source regarding injuries.

Front & Side Views – Head



Number	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments

Timing of Injury:	
Date when the Injury happened *(if Known)*	
Date Injuries above were first observed *(if this is different to the original date)*	

Completed By:	
Printed Name/designation of person completing Body Map form	
Signature of personal completing Body Map form	
Contact details of person completing Body Map Form	
Date/time of completion	

(NB. When used, completed APP1 Body Map form should be attached to completed APP1 Referral form)

APP2

REGIONAL ADULT PROTECTION PROCEDURES

ACKNOWLEDGEMENT OF REFERRAL

To be completed by the DAPO and returned to Referrer within 2 days

NAME:	ADDRESS:	DATE OF BIRTH:
		DATE OF REFERRAL:
	TELEPHONE NO:	

OUTCOME OF REFERRAL RECEIVED

Referral not appropriate for Adult Protection Investigation ☐

Adult Protection Investigation commenced ☐

Name of Designated Adult Protection Officer

Contact telephone number

Contact email address

Name of Investigating Officer (if appointed at this stage)

Address

Contact telephone number

SIGNATURE OF DAPO

DATE ☐

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

Introduction

This risk assessment and management tool should be used when a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances **AND** who is unable to protect their own wellbeing, property, assets, rights or other interest **AND** where the action or inaction of another person or persons is causing or is likely to cause him/her to be harmed. The assessment should be used to inform and support but not replace professional decision making.

Risk assessment and management planning should include key individuals that can contribute to the assessment of risk and/or the management response. This may necessitate the investigating officer commissioning specific risk assessments from relevant others which will be included in the overall risk assessment. Wherever possible this should always include the person who is at risk and in need of protection. If they decline to be involved or it is not appropriate for them to contribute, their views, as far as possible, should be included and feedback provided. If for reasons of mental capacity the person is unable to make decisions about their safety and welfare, it may be necessary to consider opinions from others who can represent them such as family, friends or an independent advocate.

List all risks that require to be considered. These are the risks that are or may leave the person open to harm through abuse, exploitation or neglect. There may be other risks that are managed effectively and therefore do not need to be included in this assessment. Sometimes the concerns emerge because of the persons at risk not accepting or engaging about the risks they are facing. If this is the case, seek to understand the reasons for this and how support can be offered in a manner acceptable to them.

The nature and degree of risk may change, over time, for a variety of reasons. It should not be assumed that the risk management plan will always remain necessary but it should at all times be proportionate, tailored and mindful of the Human rights of the person at risk and others as appropriate.

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

(To be completed by INVESTIGATING OFFICER)

SECTION 1

NAME:	**ADDRESS:** **POSTCODE:**	**DATE OF BIRTH:**
REFERENCE NUMBER:	**TEL NO.**	**GENDER:** M ☐ F ☐

NAME OF WORKER (S) AND JOB TITLE COMPLETING THE RISK TOOL & THOSE CONTRIBUTING TO THE ASSESSMENT

Background: *(are there factors that may mean the person is more at risk of harm from others due to personal characteristics and / or life circumstances and is unable to protect themselves. Include existing strengths and protection factors precipitating referral, home circumstances, support available, high levels of carer stress or summary / outcome of previous investigations)*

Wishes of adult in need of protection: *(is the person aware of alleged abuse? If so what is their perception of the impact/potential impact of harm? Do they understand the risks around the situation they are in? What do they see as the benefits for them in taking the risk? What protective steps do they wish to consider? Do they want to remain in their current environment? Do they wish to involve police?)*

Capacity / consent to issues under investigation: *(Please include statement as to consent of adult in need of protection for information about risks to be shared; relevant reports / opinions and bear in mind how client's capacity might be enhanced, are the views of others required?)*

APP3

Section 2. Please complete separately for each risk identified	
Current Risk of abuse / harm identified.	**Specific evidence of risk of abuse / harm**
What has been the impact of the harm on the adult's independence, health, general wellbeing?	**Specific evidence demonstrating impact**
Assess evidence demonstrating Pattern / frequency of risk of abuse / harm for each identified risk. ***(consider repeated acts of omission / neglect that compromise safety)***	**Outcome** Isolated ☐ Occasional occurrence ☐ Repeated occurrence ☐ Established pattern ☐
Evidence demonstrating probability of reoccurrence or escalation for each identified risk	**Outcome** Unlikely ☐ Likely ☐ Highly probably ☐ Certainty ☐
Assess the Severity of degree, extent and duration of risk of abuse / harm for each identified risk	**Outcome** Serious ☐ Moderately Serious ☐ Very Serious ☐ Extremely serious / Death ☐
Detail evidence which suggests the risk may constitute a potential criminal offence?(include relevant reference to coercion; threatening behaviour; abuse of trust / position)	Specific evidence demonstrating risk
Has there been an impact on other adults at risk / in need of protection or children?	☐ Yes ☐ No (If yes record what appropriate action has been taken to protect?)
Positive factors that minimise each identified risk of abuse / harm	

APP3

Section 3

Human Rights Considerations:

Identify which Human Rights have been considered:
(see attached European Convention guidance and please give details)

Risk analysis summary:

View of Professional

View of adult in need of protection / carer

Explain reasons for any disagreements to the risk assessment and by whom

Completed by: Date:

Adult in need of protection signature Date:

Carer signature Date:

Review Date:

APP4

REGIONAL ADULT PROTECTION PROCEDURES

PROTECTION PLAN

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should
Be notified to the Chairperson within 7 days: otherwise it
Will be assumed that the reports are agreed.

NAME:	DATE CREATED:	DATE OF COMMENCEMENT:	DATE OF REVIEW:

RISK	ASSESSED NEED	INTERVENTION	BY WHOM	REASON FOR NOT TAKING ANY ACTION
1.				
2.				
3.				
4.				
5.				
6.				

APP4

UNMET NEED AND UNRESOLVED ISSUES: *(If there are unmet needs or unresolved issues, identify the alternative services that have been provided)*

ARE ANY OF THE FOLLOWING ACTIONS REQUIRED (tick all appropriate boxes)

☐ *REFERRAL TO THE OFFICE OF CARE AND PROTECTION*	☐ *APPLICATION FOR GUARDIANSHIP M.H.O.*
☐ *ADMISSION TO A CARE FACILITY*	☐ *ADMISSION FOR ASSESSMENT M.H.O.*
☐ *NON-MOLESTATION ORDER*	☐ *REFERRAL TO MARAC*
☐ *DASH FORM*	☐ *CARER'S ASSESSMENT*

ADULT IN NEED OF PROTECTION / CARER COMMENTS:

WILL THIS CASE BE MONITORED UNDER THE ADULT PROTECTION PROCEDURES ☐ **YES** ☐ **NO**

IF YES, BY WHOM:

WHAT IS THE FREQUENCY OF MONITORING:

WILL THE MONITORING BE MANAGED VIA:

☐ **PROFESSIONAL SUPERVISION** **DATE**

☐ **CASE DISCUSSION/CONFERENCE DATE**

IF NO,

☐ **THE INVESTIGATING OFFICER WILL CONTINUE IN A KEY WORKER ROLE**

☐ **CASE TRANSFERRED TO OTHER KEY WORKER / SERVICE**

(please specify)

☐ **CLOSE CASE UNDER ADULT PROTECTION**

☐ **OTHER (please specify)**

ADULT IN NEED OF PROTECTION'S SIGNATURE:	**AND/OR CARER / ADVOCATE / REPRESENTATIVE'S SIGNATURE:**
DATE:	**DATE:**
KEY WORKER SIGNATURE:	**DESIGNATED ADULT PROTECTION OFFICER SIGNATURE:**
DATE:	**DATE:**

APP5

REGIONAL ADULT PROTECTION PROCEDURES

STRATEGY / CASE DISCUSSION MINUTES

PRIVATE AND STRICTLY CONFIDENTIAL

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This provides a template to record who attended the meeting, reports submitted and future review arrangements. The DAPO will also include a minute of the essential facts, discussion and decisions taken at the meeting.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:	**POSTCODE:**	**GENDER:** M ☐ F ☐
VENUE:	**DATE**	
DAPO CHAIR:		

WAS THE SERVICE USER INVITED? YES ☐ NO ☐
WAS THE SERVICE USER IN ATTENDANCE? YES ☐ NO ☐
(if not give details)

OTHERS INVITED (ADVOCATE OR CARER)

NAME IN ATTENDANCE YES ☐ NO ☐
NAME IN ATTENDANCE YES ☐ NO ☐

IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON

APP5

NAME OF THOSE PRESENT	TITLE

LIST OF APOLOGIES RECEIVED

WRITTEN REPORTS SUBMITTED BY:

Free-text Minutes

Prompt: *please evidence due consideration of Human Rights issues through completion of risk assessment.*

INTRODUCTIONS / PURPOSE OF MEETING

- *Synopsis of referral and immediate actions taken to safeguard the individual(s)*

PROFESSIONAL REPORTS

- *Key worker*
- *PSNI*
- *RQIA*
- *Human Resources(if applicable)*
- *Professional*
- *Other reports*

DISCUSSION – *Record of concerns raised and consideration given to the following as appropriate in making multiagency decisions: -*

- *Consent / capacity*
- *Undue influence / coercion*
- *Crime prevention*
- *Human Rights Considerations*
- *Best interests Concept*
- *Proportionate Response*
- *Wishes of the Adult in Need of Protection*
- *Safeguarding of other adults at risk of harm and children*
- *Supports for adult in need of protection and family through investigation process*
- *Employee Relations issues / Contracts Dept. External Providers*

APP5

INVESTIGATION STRATEGY

- *Process of Investigation – single/joint (include detail of methodology – Medical / structured meetings / documentary evidence to be reviewed / Joint Interview)*
- *Appointment of Investigating Officer*
- *Who will conduct interviews / structured meetings / when / with whom*
- *Requirement for ABE Joint Protocol interview*
- *Arrangements for special needs, race, culture, gender, language, communication etc.*

REVISED CARE PLAN *including Actions to be taken / when / by whom*

- *Services, treatment or therapy to be accessed*
- *Modifications in services*

REVIEW OF PROTECTION PLAN (record on ***APP4)***

- *Steps to be taken to ensure future safety, incl. When and by whom.*
- *Support services through the legal process*
- *Updated risk assessment and management including actions to be taken*

OTHER ACTIONS

- *Reporting to other bodies. I.e. RQIA, Professional Regulators, DBS*
- *Reporting back arrangements and communication strategy.*
- *Record of reasons for not proceeding where there is no significant indicator of risk or insufficient evidence to substantiate concern(s)*
- *Decision to terminate protection plan and close involvement on SOSCARE module.*
- *Date for next meeting following completion of the investigation or earlier if required.*

SOSCARE ADMIN BOX: UPDATE VA STRATEGY PLANNING	
1 Date of Meet/Discussion	
2 Type of Contact (Select from coded list)	
3 Location of incident	
4 Alleged Abuse (Select from coded List)	
5 DAPO	
6 Method of Discussion (Select from coded list)	
7 Location of Meeting	
8 Other Staff involved (Soscare number)	
9 Other Agencies (select from coded list)	
10 Initiate/Review APP	(Y ☐ or N ☐)
11 Outcome	
12 Date Next meet/Discussion	
13 Clarification Meeting	
14 Date	
15 Date of Investigation	

APP5

SOSCARE ADMIN BOX: VA CASE DISCUSSION STAGE (Complete for every Discussion/Review)		
4	Other agencies involved (select from coded list)	
5	Category of abuse	
6	Outcome of case discussion (select from coded list)	
7	Has APP been updated?	
8	Date of Next Discussion/Review	
9	Termination date	
10	Reason for termination	

Signed:

Dated:

APP6

ADULT PROTECTION PROCEDURES

SIGNIFICANT SAFEGUARDING MEETING / EVENT REPORT

PRIVATE AND STRICTLY CONFIDENTIAL

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Be notified to the Chairperson within 7 days: otherwise it
Will be assumed that the reports are agreed.

NAME OF ATTENDEE:	ADDRESS:
(IF APPLICABLE) NAME AND POSITION OF PERSON ACCOMPANYING:	TEL. NO:
ALLEGED VICTIM REFERNCE NO:	
NAMES OF INVESTIGATION STAFF:	
DATE:	TIME: / VENUE:

PURPOSE OF THE MEETING:

(Include Boundaries of Confidentiality; whistleblowing policy & potential use of safeguarding report and information for HR processes as appropriate.)

GENERAL BACKGROUND QUESTIONS:

APP6

SPECIFIC QUESTIONS PERTAINING TO INDIVIDUAL CONTEXT:
(Open ended questions should be relevant to the aspect of care / support being provided and investigated in order to gather the individual's knowledge of the circumstances)

REPORT OF ALLEGED INCIDENT AND COMMENTS FROM THOSE PRESENT:

Summary of Action required:

- To safeguard adults; children or others:
- Is dash form required?
- To forward information to identified and agreed persons.

Signature of investigators **Date**

APP7

ADULT PROTECTION REPORT ON THE INVESTIGATION IN RESPECT OF

DATE:

Designated Adult Protection Officer:

Designation:

Report Authors:

Date report signed off:

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should
Be notified to the Chairperson within 7 days: otherwise it
Will be assumed that the reports are agreed.

APP7

EXECUTIVE SUMMARY

LIST THE MEMBERSHIP OF THE INVESTIGATION TEAM. *(IO (s) and DAPO)*

INVESTIGATION TERMS OF REFERENCE (*What have you been asked to do?)*

INVESTIGATION METHODOLOGY *(How were the concerns investigated. Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.)*

PROVIDE A DESCRIPTION OF INCIDENT/CASE. *(Outline the details of the adult safeguarding concerns including any previous concerns. Include a pen picture of the adult/s in need of protection.)*

APP7

FINDINGS (*This section must include the detail and analysis of the factual evidence identified in the investigation including the source and dates of any meetings where information came to light. Detail must include the weight attributed by the IO to the seriousness of the harm /abuse and the rationale for same. Attach a copy of the risk assessment completed by the IO.*)

CONCLUSIONS (*Were the adult safeguarding allegations substantiated on the balance of probability/not substantiated etc. Include the views of the Adult in Need of Protection and/or their representative.*)

LESSONS LEARNED

RECOMMENDATIONS AND ACTION PLANNING

APP7

DISTRIBUTION LIST

APP8

REGIONAL ADULT PROTECTION PROCEDURES

CLOSURE / TRANSFER SUMMARY MEETING

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:		**GENDER: M☐ F☐**
DATE OF REFERRAL:	**POSTCODE:**	

Adult Safeguarding investigation completed ☐Yes ☐No

Summary of Investigation outcomes discussed at case discussion:

AGREED ACTION

Case to be transferred ☐Yes ☐No
(if yes complete Sections One and Two)

Case closed ☐Yes *(if yes complete Section One)* ☐No

SECTION ONE (CASE TO BE CLOSED TO ADULT PROTECTION SERVICE)

Reason for Closure?	Investigation complete ☐	Client unwilling to proceed ☐
	Refer other agency ☐	Refer other process ☐

Has anyone expressed a contrary view to transfer/closure? ☐Yes ☐No

(if yes specify)

Has the service user been informed in writing? ☐Yes ☐No

Has the referrer been notified of outcome? ☐Yes ☐No

Have relevant others been informed in writing? ☐Yes ☐No

(if yes specify) (include contracts; HR; RQIA; other professionals)

APP8

SECTION TWO (ONGOING SAFEGUARDING ACTIVITY WITH ADULT AT RISK)

☐ Investigating officer will continue with a key worker role in core team

☐ Transfer to other services
(specify) _____ Date of Transfer _____

☐ Transfer to Investigating Officer in different team
(specify) _____ Date of Transfer _____

☐ Transfer to other Trust
(specify) _____ Date of Transfer _____

☐ Other
(specify) _____ Date of Transfer _____

☐ Date SOSCARE completed _____

SIGNED INVESTIGATING OFFICER	**DATE**
SIGNED DAPO	**DATE**

Form forwarded to: Care Manager ☐ GP ☐ PSNI ☐ Care Provider ☐

RQIA ☐ Client/Carer ☐ Relevant other ☐

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:
Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

Appendix 3

BHSCT Reporting Template

BHSCT REPORTING TEMPLATE

The Belfast Trust Adult Safeguarding Champion (ASC) provides strategic and operational leadership and oversight in relation to adult safeguarding for the Trust and is responsible for implementing its Adult Safeguarding Policy. The Adult Safeguarding Champion complies with the responsibilities as laid out in the Regional Adult Safeguarding Operational Procedures but has delegated the day-to-day responsibility for safeguarding to operational managers who are the appointed person(s) within the organisation. The appointed person(s) will report through to existing management structures to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Belfast Trust have adopted this approach to ensure that there are sufficient numbers of appointed persons in order that all services have easy access to appropriate advice and guidance in relation to safeguarding concerns. The following structure outlines the reporting arrangements and the process for escalation of issues of concern. Staff identifying a safeguarding concern should in the first instance report to the Facility Manager / Appointed Person.

Adult Safeguarding Champion (ASC) Structure

Reporting Structure to include escalation of concerns

Name of Facility: _____

Name of Facility Manager/Appointed Person:

Contact Number

Name of Assistant Service Manager/Appointed Person:

Contact Number

Name of Service Manager/Appointed Person:

Contact Number

Name of Trust Adult Safeguarding Champion: **Marie Heaney**

Contact Number: 028 9504 8626

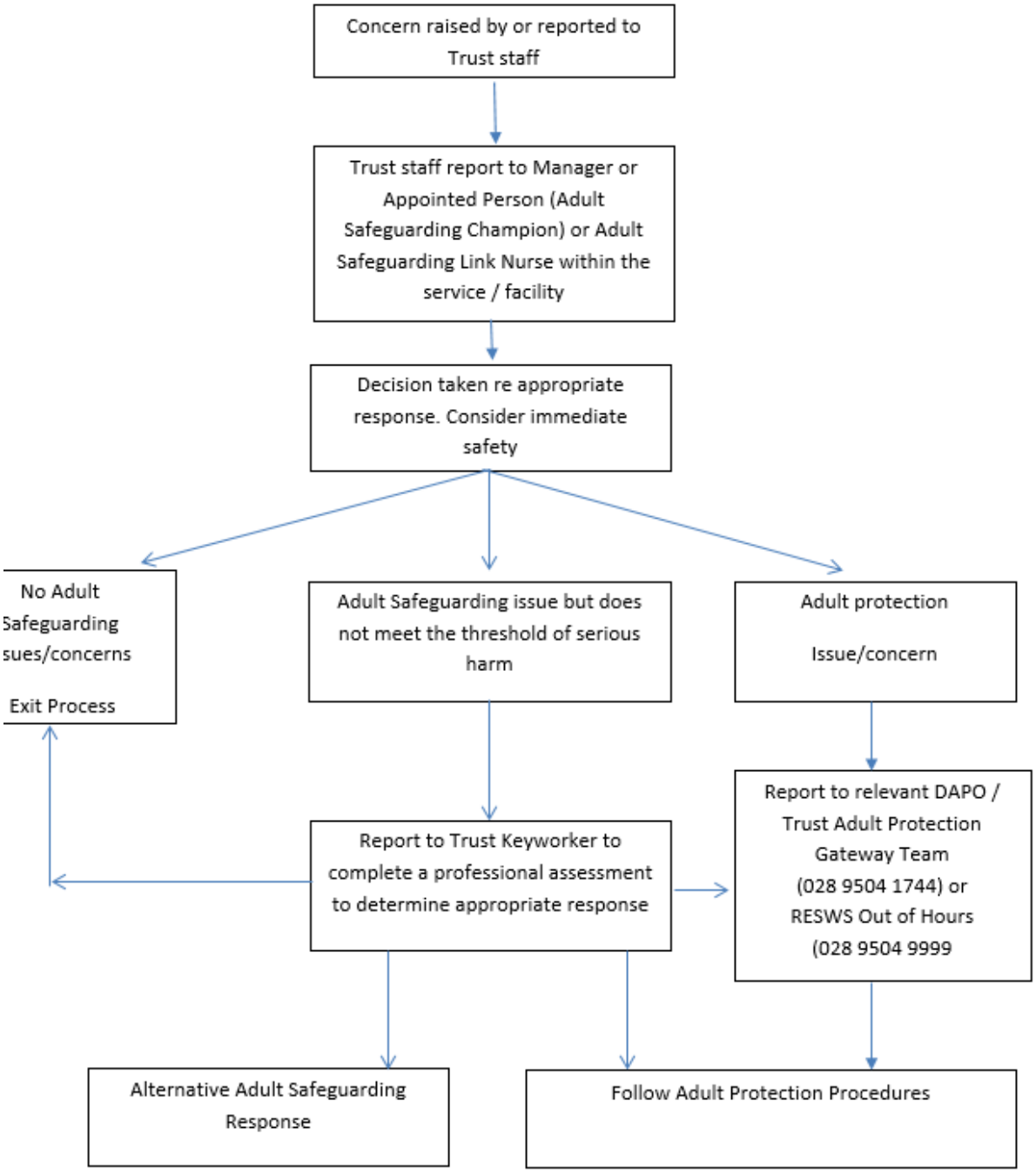
In the absence of the line manager / facility manager / appointed person, escalation should be to the next nominated senior manager. The TASS can also provide advice and guidance in the absence of the Adult Safeguarding Champion – Contact: Yvonne McKnight - 028 9504 6896

Referral pathway should be used by appointed person(s) and or Adult Safeguarding Champion.

Appendix 4

BHSCT Adult Safeguarding and Adult Protection Referral Pathway

(Sample - Information should be used to inform local service-specific Referral Pathways)



PROCEDURE FOR RESPONDING TO ADULT SAFEGUARDING / ADULT PROTECTION CONCERNS

ACTION TO BE TAKEN
• Where staff identify a concern in relation to an adult at risk of harm, they must ensure this is reported to senior staff and that service users' immediate safety is considered. This will include seeking medical attention if required. • It is important that service users' Human Rights are considered and they are informed appropriately about the need to communicate with other professionals. There will be some circumstances when it will be necessary to override the wishes of an individual to prevent significant risk, death or serious harm to the adult at risk of harm.
• In urgent cases, in the absence of the Manager/ASC, the line manager providing cover should be contacted to discuss details of the concern. Where there are immediate safety issues there should be no delay in reporting to the relevant Designated Adult Protection Officer (DAPO), Adult Protection Gateway Team (APGT) or Out of Hours Regional Social Work Team. • The DAPO, APGT or Out of Hours Regional Social Work Team will instruct on what actions need to be taken. This will include an initial judgement based on referral information regarding whether further investigation is appropriate.
Contact the Adult Protection Gateway Team on: **028 9504 1744** or Out Of Hours Duty Social Work on **028 9056 5565** to report the safeguarding concern / incident with a DAPO. This contact can be made by telephone in first instance.
• In all cases the staff member who receives the report, witnesses or suspects harm caused by abuse, exploitation or neglect of an adult at risk, should complete the first section of the ASP1 electronically on Paris. The ASP1 must then be forwarded to the named Manager/ASC. • In most instances, the line Manager/ASC will assess the information to determine whether a safeguarding response is required. If a safeguarding response IS required, the line Manager/ASC will determine whether the threshold for serious harm has been met. If so, they should then forward completed ASP1 to the relevant DAPO/APGT. In all other situations, safeguarding concerns should be referred to the relevant key worker.
Senior staff should also follow normal reporting procedures and where applicable complete a Datix Incident form and RQIA Notification of Events form.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 20/19

Title:	**Adult Safeguarding policy and procedure**			
Author(s)	Yvonne McKnight, Adult Safeguarding Lead, Tel: [redacted]			
Ownership:	Marie Heaney, Adult Social and Primary Care Services Director			
Approval by:	Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting		**Approval date:**	08/10/2019 06/02/2020 12/02/2020
Operational Date:	February 2020		**Next Review:**	February 2025
Version No.	1	**Supersedes**	BHSCT Adult Protection Policy and Procedures (2013) TP 44/10	
Key words:	Adult Protection, Adult at risk of harm, Adults in need of protection			
Links to other policies	Adult Safeguarding Policy: Prevention and Protection in Partnership (DHSSPS 2015) Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection (NIASP 2016) Regional Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)			

Date	Version	Author	Comments
28/08/2019	0.1	Marie Heaney Yvonne McKnight	Policy supersedes previous version

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

The Belfast Health and Social Care Trust (BHSCT) is committed to protecting adults at risk of harm caused by abuse, exploitation or neglect. The Trust has a zero tolerance approach to all forms of abuse and exploitation. The Trust is clear that Adult Safeguarding is everyone's business and that safeguarding covers a wide range of activities from prevention through to protection. The Trust Adult Safeguarding Policy previously focused on adult protection and this Policy acknowledges the importance of the continuum of safeguarding from prevention through to protection, as detailed in the new Regional Policy. The Belfast Trust have therefore extended the scope of work in relation to adult safeguarding to include both prevention and protection. The Trust affirms its lead role in relation to protection and its responsibilities in relation to adults in need of protection. The Trust also notes the important role and responsibilities that Trust staff have in relation to prevention and early intervention. It further recognises that a sensitive, proportionate response to adult safeguarding will include a range of alternative safeguarding responses.

This Policy replaces the previous Belfast Trust Adult Protection Policy and Procedures.

1.2 Purpose

The purpose of the Policy is to make clear the requirements of the Trust in relation to Adult Safeguarding. The Policy covers the whole spectrum of safeguarding from prevention through to protection and seeks to set out the Trust expectations in relation to this safeguarding continuum. The Policy is intended to promote good practice and provide guidance for staff in situations where there are concerns that an adult/adults at risk may be subject to harm caused by abuse, exploitation or neglect. Harm caused within the context of this Policy relates to an act/s or omission/s by another person/s and self-neglect is not included within this Policy.

The primary purpose of this Policy is to make clear to all Trust staff that the Belfast Trust has accepted, adopted and implemented the regional policies:

- Adult Safeguarding Policy: Prevention and Protection in Partnership (DHSSPS 2015)
- Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection (NIASP 2016).

Trust staff are required to read this Trust Policy in conjunction with both of the above regional documents and this information should guide their practice.

Other relevant regional Policies and Protocols include:
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)
- Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy (Dept. of Justice 2012).

Other relevant Trust Policy which will interface at times with this Policy and therefore should be considered include:
- BHSCT Policy and Procedure for Management of Comments, Concerns, Complaints and Compliments Policy June 2017;
http://intranet.belfasttrust.local/policies/Documents/Comments, Concerns, Complaints and Compliments - Policy and Procedure for the Management of.pdf
- BHSCT Disciplinary Procedure August 2015;
http://intranet.belfasttrust.local/policies/Documents/Disciplinary Procedure.pdf
- BHSCT Serious Adverse Incident Procedure September 2016;
http://intranet.belfasttrust.local/policies/Documents/Adverse incident - Serious Adverse Incident (SAI) Procedure.pdf
- BHSCT Trust Protocol for the Recruitment and Employment of staff under the Safeguarding Vulnerable Groups (NI) Order 2007 and the Vetting and Barring Scheme, as amended by the Protection of Freedoms Act (2012);
http://intranet.belfasttrust.local/policies/Documents/Recruitment and Selection of Staff Under Requirements of SVGO - Vetting amd Barring Scheme policy.pdf
- BHSCT Policy and Procedural Arrangements relating to Lone Working August 2015;
http://intranet.belfasttrust.local/policies/Documents/Lone working Policy.pdf
- BHSCT A Zero Tolerance Approach to the Prevention and Management of Violence and Aggression in the Workplace November 2015;
http://intranet.belfasttrust.local/policies/Documents/Zero Tolerance Policy.pdf

1.3 Objectives

- To promote zero tolerance of harm to all adults from abuse, exploitation and neglect

- To prevent harm caused by abuse, exploitation or neglect by promoting good practice and early identification and response when harm has or is likely to be caused

- To comply with regional requirements as outlined in the Adult Safeguarding Prevention and Protection in Partnership Policy and the Adult Safeguarding Operational Procedures

- To clarify the roles and responsibilities of those involved in Adult Safeguarding and Adult Protection work

- To seek to ensure that a comprehensive and consistent approach is taken across the Trust in relation to adults at risk of harm and adults in need of protection

- To provide a framework within which all adults at risk will be supported and have their rights protected

- To provide a compassionate, safe, effective response to adults at risk of harm and adults in need of protection
- To promote strong partnership working internally (across professions, service areas and directorates) and externally (with PSNI, RQIA, independent sector organisations and community and voluntary groups).

2.0 SCOPE OF THE POLICY

The Policy is relevant to all staff working within the Trust who either directly or indirectly come into contact with Adults at Risk. The Policy recognises that abuse, exploitation and neglect of Adults at Risk can happen anywhere including community, Hospital, Care Facilities, Supported Living, Day Care and the Policy is therefore applicable in all settings. The Trust as commissioner of services will work with all organisations to ensure identification, early intervention and protection of adults at risk of harm. Inclusion of adult safeguarding regional requirements will be included in Belfast Trust contracts. Where the threshold for an adult protection intervention is met the Trust and or the police will take the lead role in relation to adults in need of protection. .

This Policy does not operate independently of other Belfast Trust Policies and Procedures.

3.0 ROLES / RESPONSIBILITIES

In keeping with policy requirements the Trust have in place a governance structure which supports the work in relation to Adult Safeguarding.

To meet the policy and procedural requirements and achieve the objectives set, there is a need for clarity regarding roles and responsibilities within the Trust.

Trust Board

Trust Board role is to ensure that regional requirements in relation to adult safeguarding are met and that the Trust have policies and procedures in place.

Adult Safeguarding Committee

The Committee is chaired by the Executive Director of Social Work and members include the Trust-wide Adult Safeguarding Champion and other relevant senior staff within the Trust. The Committee is part of the governance framework and is responsible for ensuring delivery of adult safeguarding within the Trust.

Adult Safeguarding Champion

The regional Policy directs that organisations must have an Adult Safeguarding Champion and details the role and responsibilities of the Champion. The Belfast Trust have a named Adult Safeguarding Champion and a number of appointed persons who assist in terms of the Adult Safeguarding champion role and responsibilities, which are specified in the regional Policy.
Service Group: Directors / Co-Directors / Service Managers

The responsibility for ensuring that all staff are familiar with this Policy and Procedure and understand their role and responsibilities rests with their line managers.

Senior managers need to consider the compliment of staff trained as DAPOs, IOs and ABE interviewers and ensure that there are sufficient specialist staff to meet the needs of the service.

There is a responsibility for each service to ensure that staff have access to an Appointed Person (ASC).

The key roles identified in relation to adult protection work are the Designated Adult Protection Officer (DAPO), the Investigating Officer (IO) and the Achieving Best Evidence Specialist Interviewer (ABE). The NIASP regional framework details five levels of training and specifies the training requirements for DAPOs, IOs and ABE Interviewers.

Trust staff

Trust staff are required to:

- Adhere to the Adult Safeguarding Policy and Procedures;
- Attend relevant training;
- Raise issues of concern promptly with their line manager / appointed person;
- To follow reporting procedures;
- To adhere to the protocol for joint investigations in relation to safeguarding cases;
- Regulated services should adhere to all of the above and also comply with Regulation Quality and Improvement Authority reporting procedures.

4.0 KEY POLICY PRINCIPLES

The Belfast Trust reaffirms its commitment to deliver on the five underpinning principles as detailed in the DHSSPS Adult Safeguarding Policy. Trust staff must have a comprehensive knowledge and understanding of the principles contained within the DHSSPS Adult Safeguarding Policy and apply these in relation to Adult Safeguarding and Adult Protection work.
(Appendix 1, pages 8 & 9). These principles include:

- A rights based approach
- An empowering approach
- A person centred approach
- A consent driven approach
- A collaborative approach

4.1 Key definitions

The Belfast Trust has accepted and adopted the definitions of an Adult at Risk of Harm and an Adults in Need of Protection as detailed in the DHSSPS Adult Safeguarding Policy and the NIASP regional Operational Procedures.

This Policy is applicable to the protection of adults who are at risk of harm and adults in need of protection. It covers all types of abuse including neglect and recognises that people at risk cannot always protect themselves.

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 personal characteristics and/or 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.

In keeping with the regional Policy and Procedures the Belfast Trust defines harm as the impact on the victim of abuse, exploitation or neglect. Furthermore the Trust recognise the importance of understanding fully the concept of harm and the role of the HSC Trust staff in terms of conducting professional assessments to ensure a compassionate, sensitive, measured and proportionate outcome for service users.

The Procedures define harm as:
- Physical abuse;
- Sexual violence and abuse;
- Psychological / emotional abuse;
- Financial abuse;
- Institutional abuse;
- Neglect;
- Exploitation

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
- Human Trafficking/Modern Slavery
- Hate Crime

Trust staff are required to recognise and respond to adults at risk of harm and therefore need to have a robust understanding of the types of harm and the associated signs and symptoms

(**See Appendix 2 – Regional Operational Procedures, Pages 7 – 11).**

4.2 Key Policy statements

- The Trust has zero tolerance in relation to harm to adults at risk
- The Trust recognises that prevention of harm is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (independent sector, community and voluntary) to deliver safe, effective and compassionate care
- Staff are expected to recognise and respond to harm caused to an adult at risk
- Trust staff need to report their concerns immediately and contribute to any investigations and / or safety plans were appropriate
- The Trust will need to ensure that staff training in relation to Adult Safeguarding / Adult Protection is commensurate with the individuals role and responsibility
- Human Rights legislation will need to be considered in all cases
- The principles of consent and capacity should be adhered to and the views and wishes of the individual should be central component to the Adult Safeguarding / Adult Protection outcomes
- In all cases the Trust staff need to respond to concerns in relation to harm in a sensitive measured and proportionate manner that considers a range of options.

5.0 IMPLEMENTATION OF POLICY

While lead responsibility for this Policy and Procedures rests with the Executive Director of Social Work and the Trust Adult Safeguarding Champion, implementation is a delegated responsibility within each directorate, service area and profession. That said implementation of the Policy and procedure is a delegated responsibility with each service area being responsible for implementation within their own service area through their existing service area structures.

Implementation will be supported by training. The NIASP Training Framework details regional agreed levels of training:

- Level 1 Induction
- Level 2 Awareness Raising Recognising and Responding
- Level 3 Managers / Appointed Persons training
- Level 4 IO / DAPO training
- Level 5 Joint Protocol training
- Level 6 Achieving Best Evidence Specialist Interviewer Training.

The Belfast Trust social care Learning and Development Team provide training in relation to each of these six levels to social care staff. Each Trust service area will be required to have arrangements in place in terms of meeting training requirements.

It is the responsibility of managers to ensure that staff are made aware of this Policy and Procedures and also to identify the level of training appropriate to their role. Responsibility for sourcing the appropriate level of training rests with line managers and Senior Managers.

In addition to training, implementation will also be supported through the Trust Adult Protection Forums. To ensure ongoing development and support to staff working directly in Adult Protection, 3 practice support groups have been established for Designated Adult Protection Officers, Investigating Officers and staff trained as Specialist ABE interviewers.

Trust best practice guidelines require that DAPO's and IO's attend at least 2 practice support groups annually.

In addition to the ongoing training provided in the Trust, additional sessions will be organised to ensure that specialist staff receive details regarding the updated Policy.

PROCEDURES

The Belfast Trust is committed to delivering on the regional Operational Procedures (Appendix 2, section B) Safeguarding Adults at Risk of Harm. This outlines responsibilities in relation to prevention and early recognition and identification of harm. It also details reporting requirements and the need for Trust staff to conduct professional assessment were a referral relates to a concern that an adult at risk of harm may have been or is likely to be harmed. The Belfast Trust is committed to providing a sensitive proportionate response which focuses on the views and wishes of the individual. Furthermore, the Trust recognise that in certain situations the most appropriate response may be an alternative safeguarding response. The Trust is committed to meeting the requirements as detailed and staff should follow the guidance provided in this section of the regional Procedures. Trust Services/facilities should provide local information in terms of the Adult Safeguarding Champion appointed person/s. A template has been provided to assist with this **(Appendix 3)**. This Policy also includes a referral pathway to support implementation and a template has been provided to assist with this **(Appendix 4)**. That said, it is recognised that facilities may choose to/need to adopt referral pathways to suit their particular areas of work.

The Trust is committed to meeting the requirements as detailed in the regional Operational Procedures (Appendix 2, Section C) Safeguarding Adults in Need of Protection.

5.1 Dissemination

The Policy will be placed on the Trust intranet and a Trust wide notification will be issued to all staff.

5.2 Resources

HSC Trust received no additional funding to support implementation of this Policy. The Adult Safeguarding Committee are committed to delivering on the requirements as detailed but in light of financial constraints are adopting a phased approach to implementation.

5.3 Exceptions

No exceptions.

6.0 MONITORING

6.1 The implementation of this Policy will be monitored and reviewed by senior management and the Adult Safeguarding Committee. Reports to HSCB will be provided in terms of Statutory Functions.

6.2 Statistical information in relation to adults at risk of harm and in adults in need of protection will be collated and shared with relevant senior managers / Adult Safeguarding Committee and HSCB.

6.3 The implementation of this Policy will be audited as directed by the Adult Safeguarding Committee.

7.0 EVIDENCE BASE / REFERENCES

- Adult Safeguarding Prevention and Protection in Partnership (DHSSPS 2015)
- Adult Safeguarding Operational Procedures (NIASP 2016)
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)
- Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy. Department of Justice (2012)
- Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements. (NIO March 2010)
- Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy, Department of Health and Department of Justice (2016)
- Public Protection Arrangements Northern Ireland – Strategic document Multi-Agency Risk Assessment Conference (MARAC)

8.0 CONSULTATION PROCESS

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Adult Safeguarding Prevention and Protection in Partnership (DHSSPS) July 2015;
Appendix 2: Adult Safeguarding Operational Procedures – Adults at Risk of Harm and Adults in Need of Protection (NIASP) September 2016;
Appendix 3: BHSCT Reporting Template;
Appendix 4: BHSCT Adult Safeguarding and Adult Protection Referral Pathway (Sample)

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. ☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

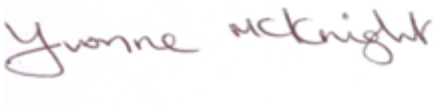
From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the Policy and the identified responsible director).



12/02/2020

_____ **Date:** _____

Yvonne McKnight
Adult Safeguarding Lead

12/02/2020

_____ **Date:** _____

Marie Heaney
Director of Adult Social and Primary Care

12/02/2020

_____ **Date:** _____

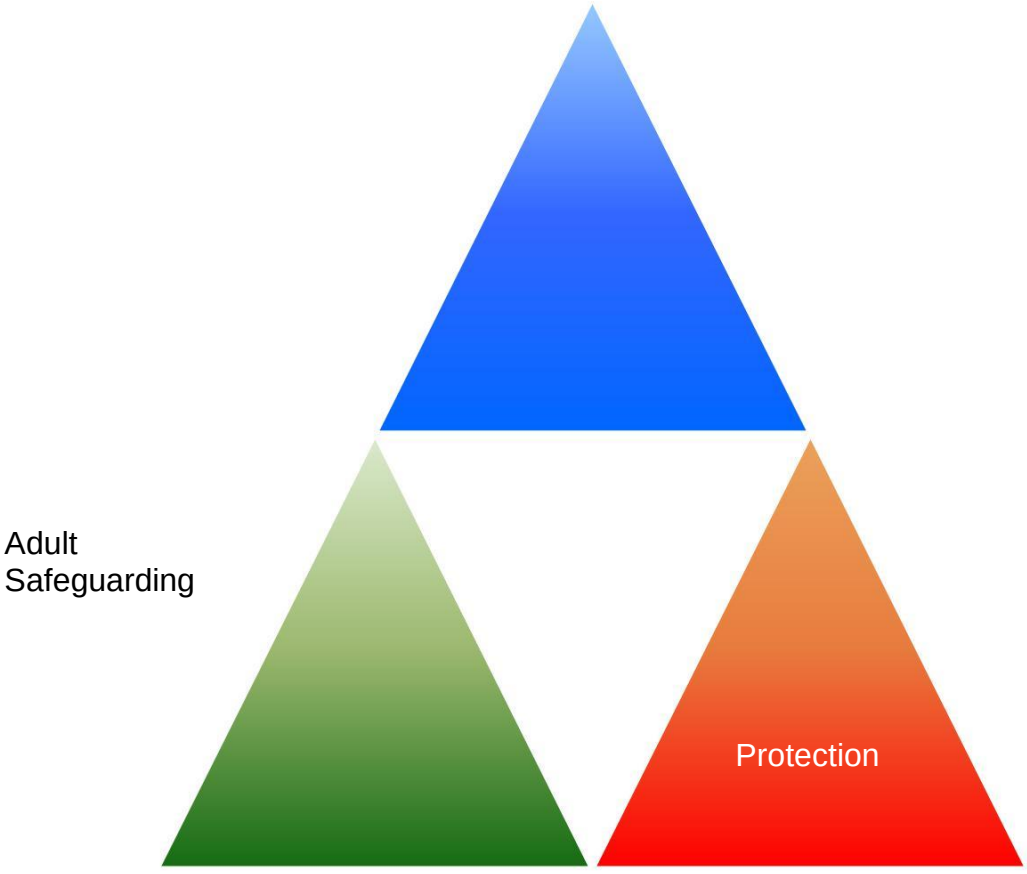
Martin Dillon
Chief Executive

Appendix 1

Adult Safeguarding Prevention and Protection in Partnership (DHSSPS) July 2015

Adult Safeguarding

Prevention and Protection in Partnership



Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

July 2015

Table of Contents

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.

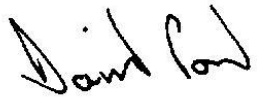
Simon Hamilton MLA
Minister for Health, Social Services and Public Safety

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.

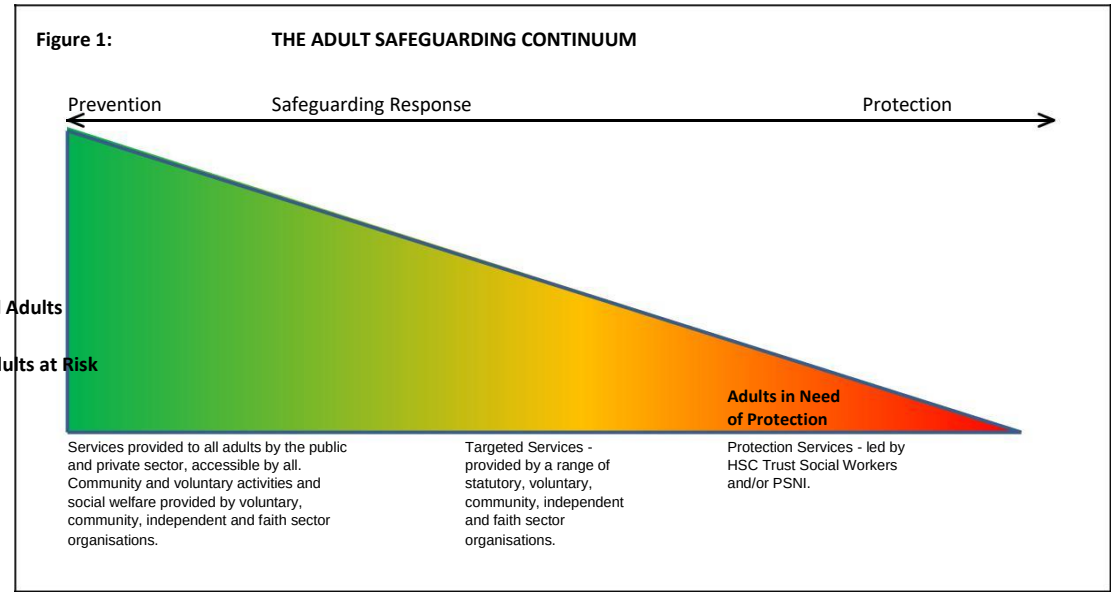
Preventative Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires 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.

Figure 1: **THE ADULT SAFEGUARDING CONTINUUM**



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[1] and enshrined in domestic law by the Human Rights Act 1998[2], acting in accordance with relevant UN and EU Conventions[3] on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991[4]. 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

1 *The European Convention on Human Rights* can be accessed at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

2 The *Human Rights Act 1998* can be accessed at: http://www.legislation.gov.uk/ukpga/1998/42/contents

3 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

4 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;

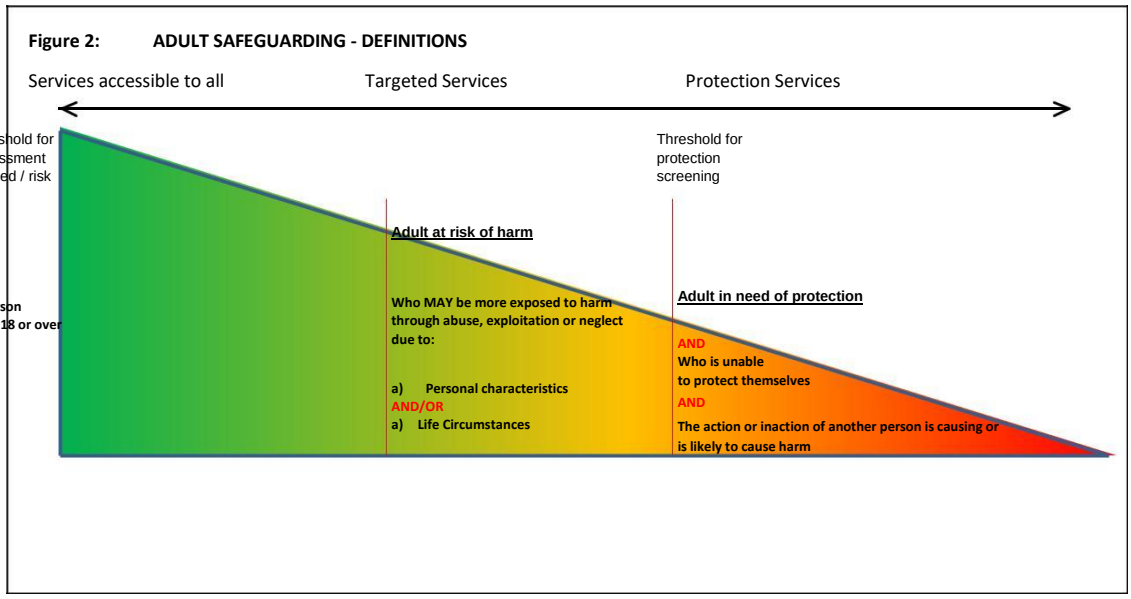
AND

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'[5].

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.

[5] 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/

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[6]. 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.

[6] 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

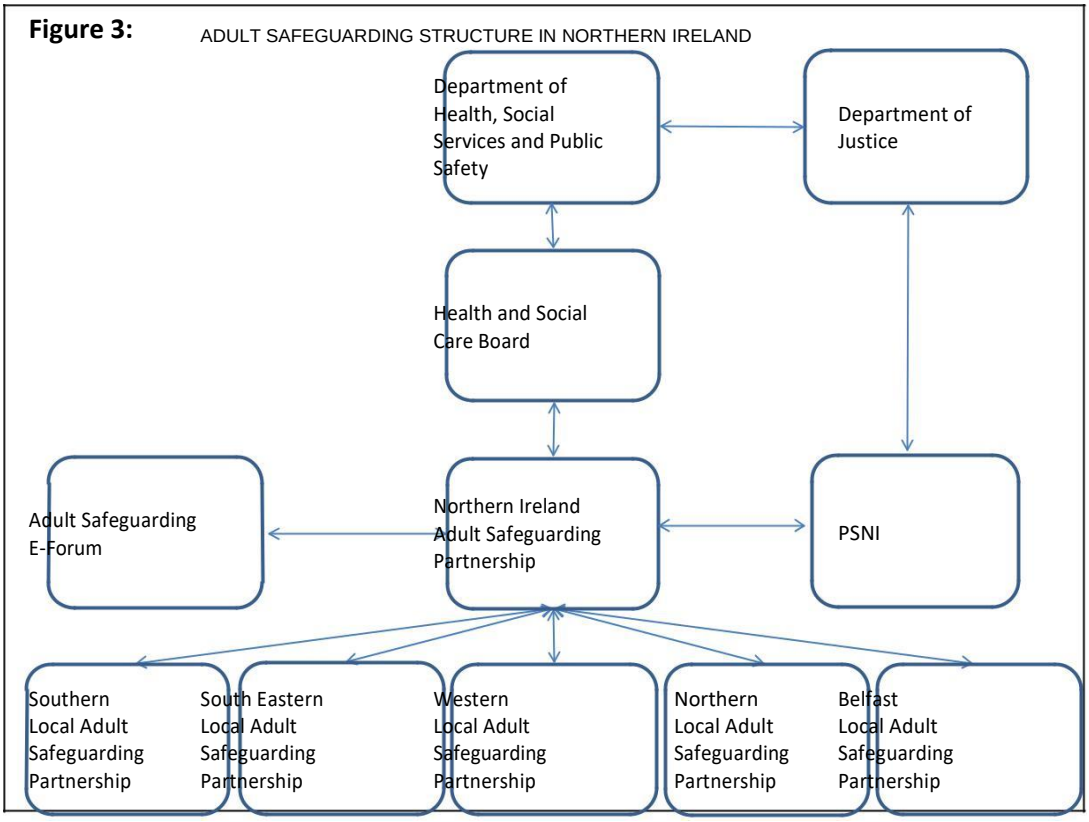
Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

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) [7] . 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[8], 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.

Figure 3: ADULT SAFEGUARDING STRUCTURE IN NORTHERN IRELAND



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

7 *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

8 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.

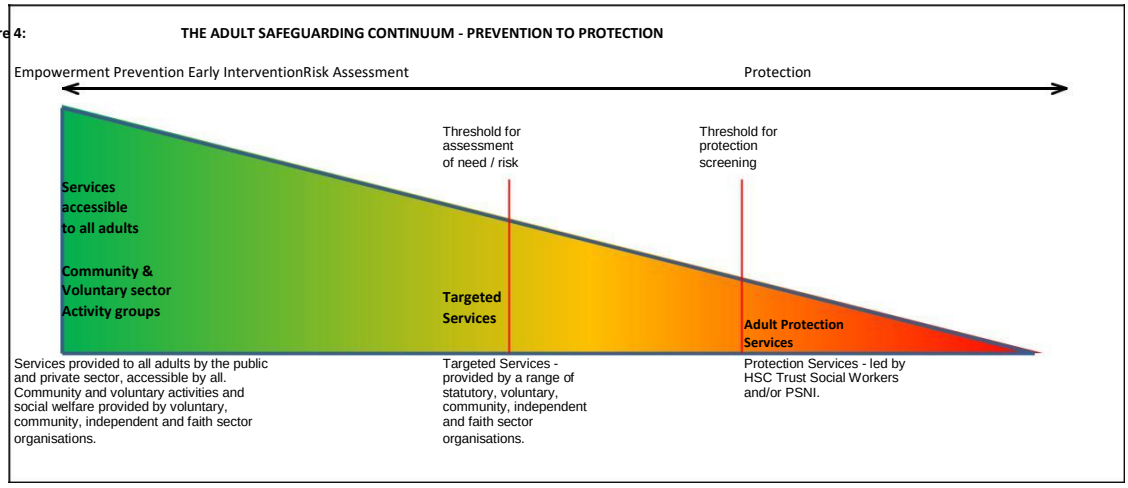
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

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[9]. 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.

[9] The SVG Order can be accessed at: http://www.legislation.gov.uk/nisi/2007/1351/contents

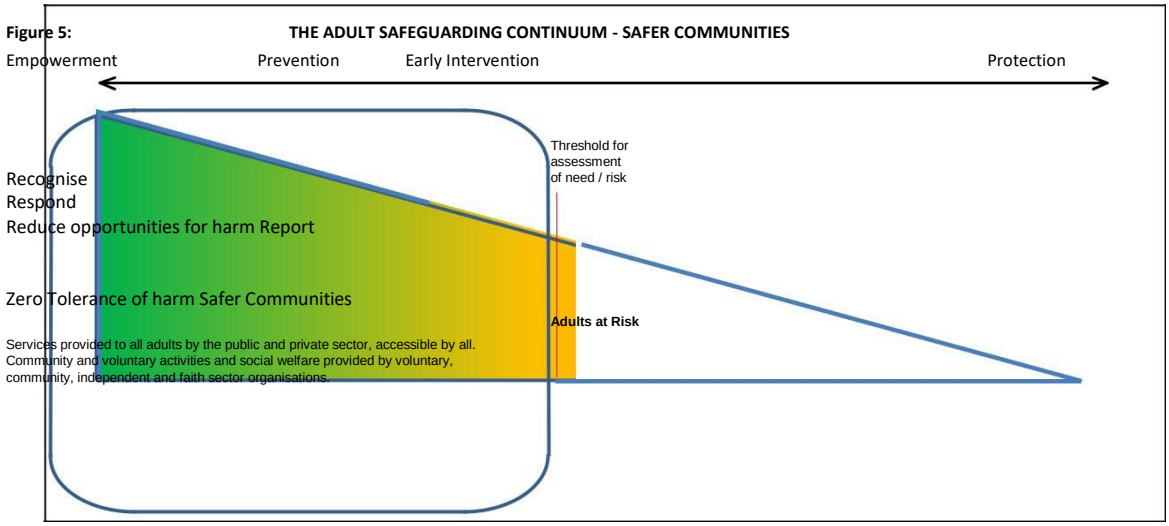
8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

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 [10] 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'[11] 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)[12] 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

10 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/learning_disability_service_framework_june_2013.pdf
http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf

11 http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm

12 Further information on PCSPs can be obtained from www.pcsps.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)[13]. 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

[13]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.

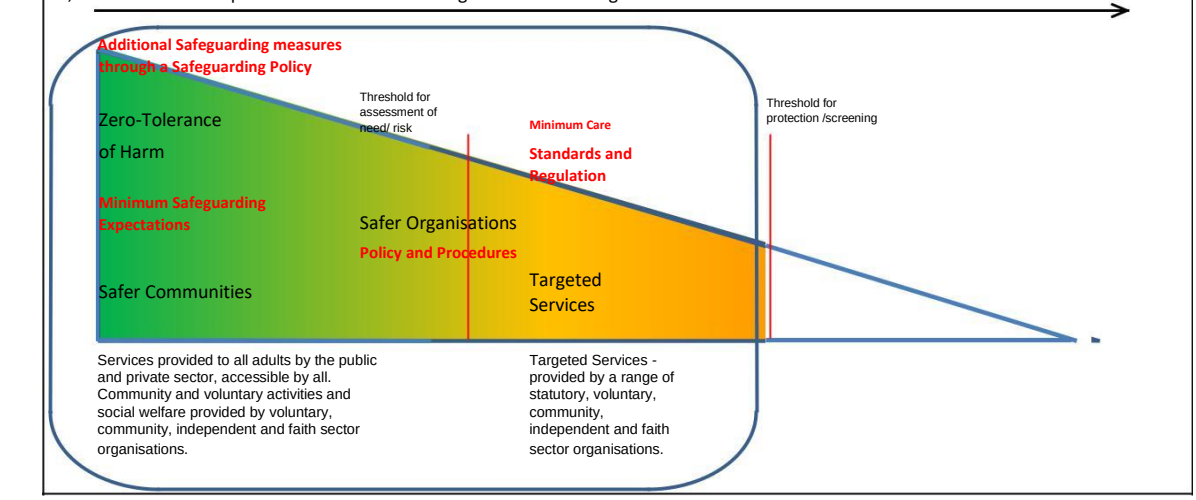
serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- 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.

Figure 6: **SAFER COMMUNITIES AND SAFER ORGANISATIONS**



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**[14] (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[15] 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.

14 Information on the Disclosure and Barring Service can be accessed at: http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults

15 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[16].

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.

[16] RQIA publications are available on www.rqia.org.uk

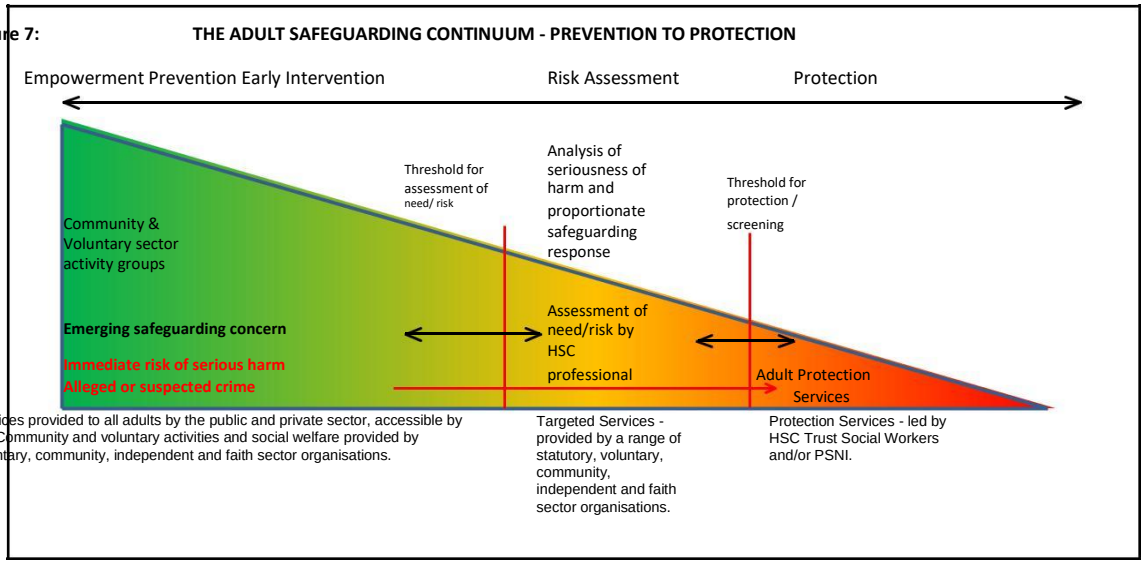
10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

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.

Figure 7: THE ADULT SAFEGUARDING CONTINUUM - PREVENTION TO PROTECTION



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.

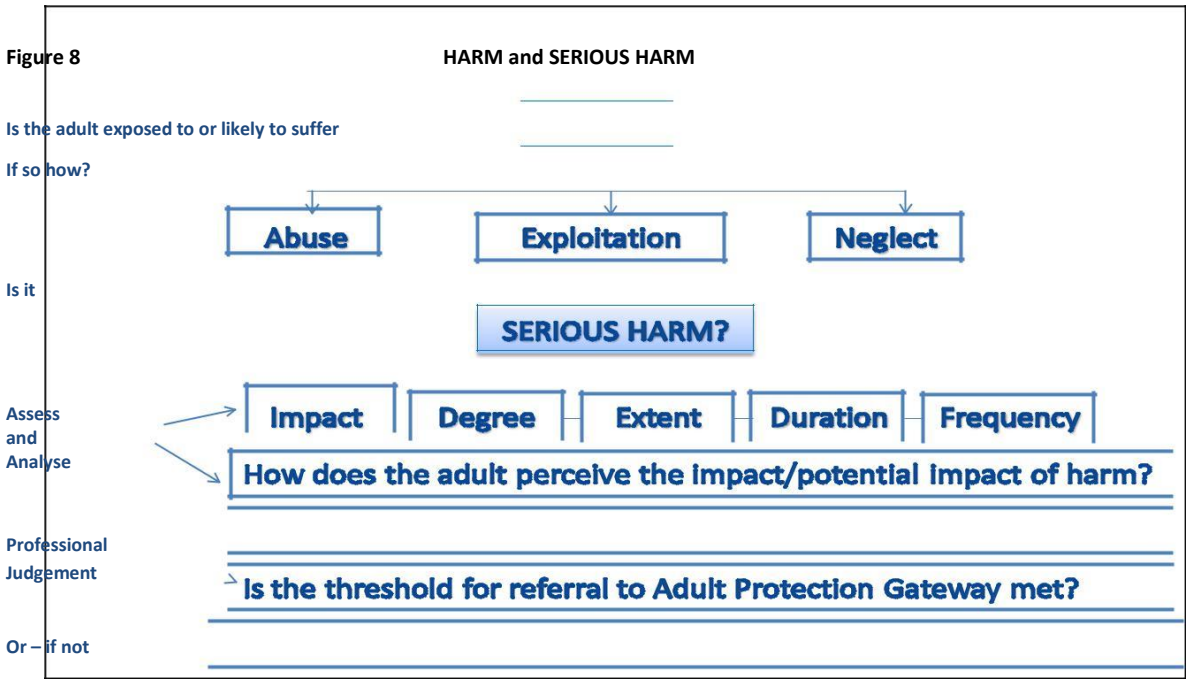
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity 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:

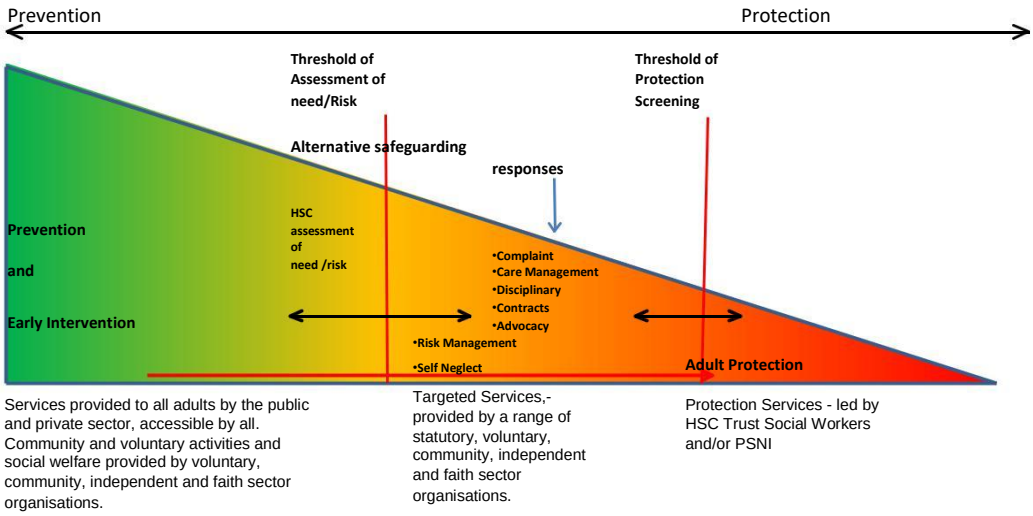
a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to 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.

Figure 9 **ADULT SAFEGUARDING THRESHOLDS**

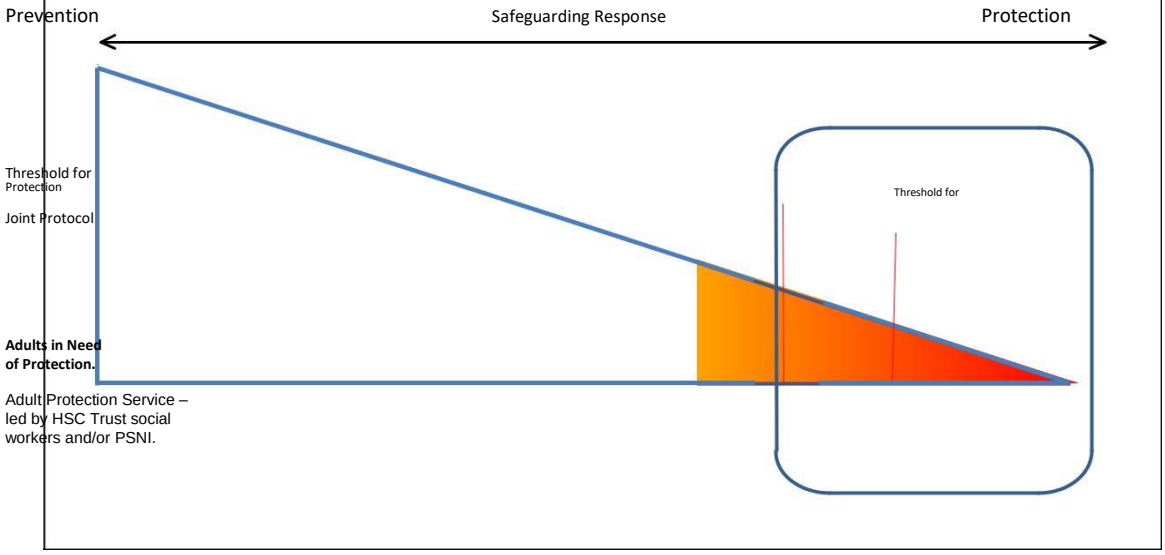


Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency 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.

Figure 10: THE ADULT SAFEGUARDING CONTINUUM – PROTECTION



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[17].

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

[17]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.

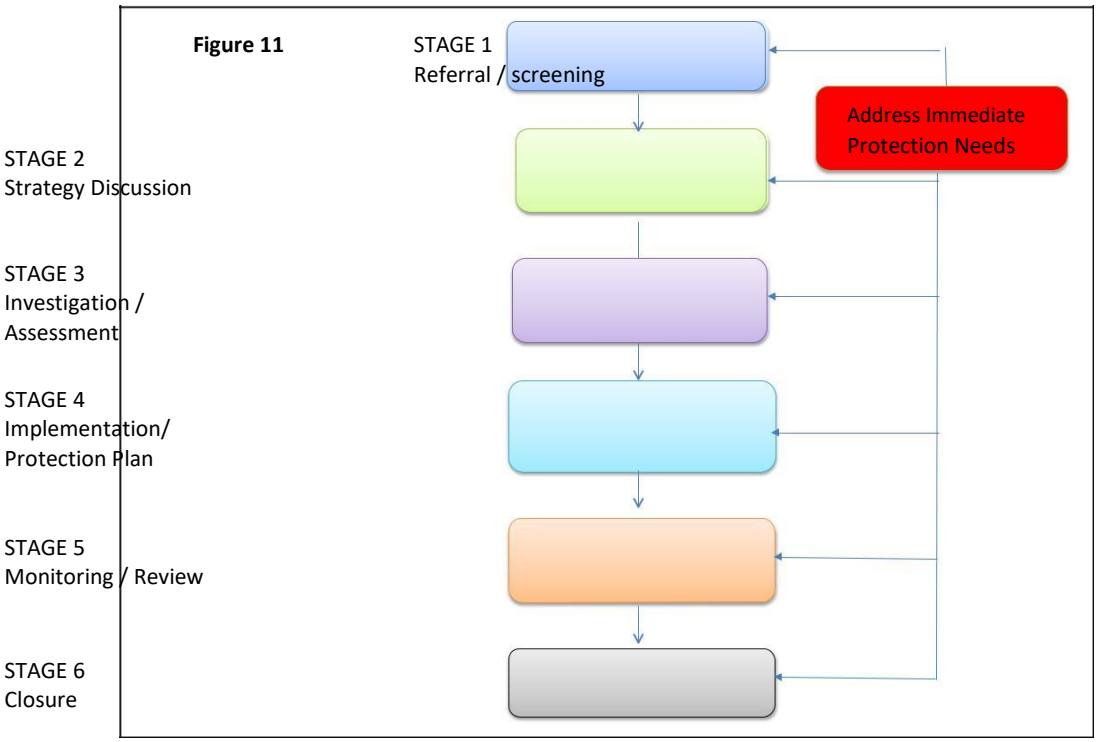
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

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:

o Multi Agency Risk Assessment Conference (MARAC) o Domestic and sexual violence services
o Public Protection Arrangements in Northern Ireland framework (PPANI)
o Human trafficking procedures
o Hate Crime Practical Action Scheme
o The Office of Care and Protection (or equivalent) o Child Protection Gateway Service
o 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 h ave a n o pportunity 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[18], 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;

18 A leaflet on special measures is available at 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[19] 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.

[19] Further information on Victim Support NI can be found at: 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' [20] 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'[21]. 'Good Management

20 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998: http://www.legislation.gov.uk/ukpga/1998/29/section/2

21 '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'[22] 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 [23] 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[24] 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.

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22 'Good Management Good Records' can be accessed at: http://www.dhsspsni.gov.uk/index/gmgr.htm

23 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

24 The 'Privacy Notices Code of Practice' can be accessed at: 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 **Adult Protection Gateway Service** 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 **Child Protection Gateway Service** 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 N orthern Ireland ap art f rom t he judiciary. It a lso 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: • be social work qualified; • be working in a minimum of a band seven; • have first line m anagement r esponsibilities, or in a senior practitioner role;

	• be suitably experienced; and • have undertaken the necessary training.
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: • The Belfast Trust • The South Eastern Trust • The Southern Trust • The Northern Trust • The Western Trust.
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 pr actice a nd em phasises the ne ed to involve a ll other relevant ag encies i n i nformation sharing, ear ly as sessment and t he planning pr ocess. 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	Personal data means data which relate to a living individual who can be identified – (a) from those data, or (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. 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”. The d efinition also s pecifically includes op inions ab out the individual, or what is intended for them.
PPANI	Public P rotection 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	Sensitive Personal Data means personal data consisting of information as to— (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or o ther b eliefs of a s imilar nature, (d) whether he is a member of a trade union (within the meaning of the M1Trade Union and La bour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any pr oceedings f or 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. 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.

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.

Document Title	Author
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

Health and Social Care Board

Appendix 2

Adult Safeguarding Operational Procedures – Adults at Risk of Harm and Adults in Need of Protection (NIASP) September 2016

NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP

Adult Safeguarding Operational Procedures

Adults at Risk of Harm and Adults in Need of Protection

September 2016

CONTENTS

SECTION A

INTRODUCTION

1. Introduction

1.1 Scope of the Operational Procedures

The responsibility for enacting the procedures to protect adults from harm caused by abuse, neglect or exploitation is principally the responsibility of Health and Social Care Trusts (HSC Trusts) and, where a crime is suspected or alleged, the Police Service of Northern Ireland (PSNI).

However, **safeguarding is everyone's business.**

These procedures are intended for use by all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. This includes paid staff and volunteers.

They describe what organisations need to do to provide a safe environment and how to respond appropriately to situations where an adult is at risk of being harmed or abused.

These procedures should be read in conjunction with all other relevant policies, such as:

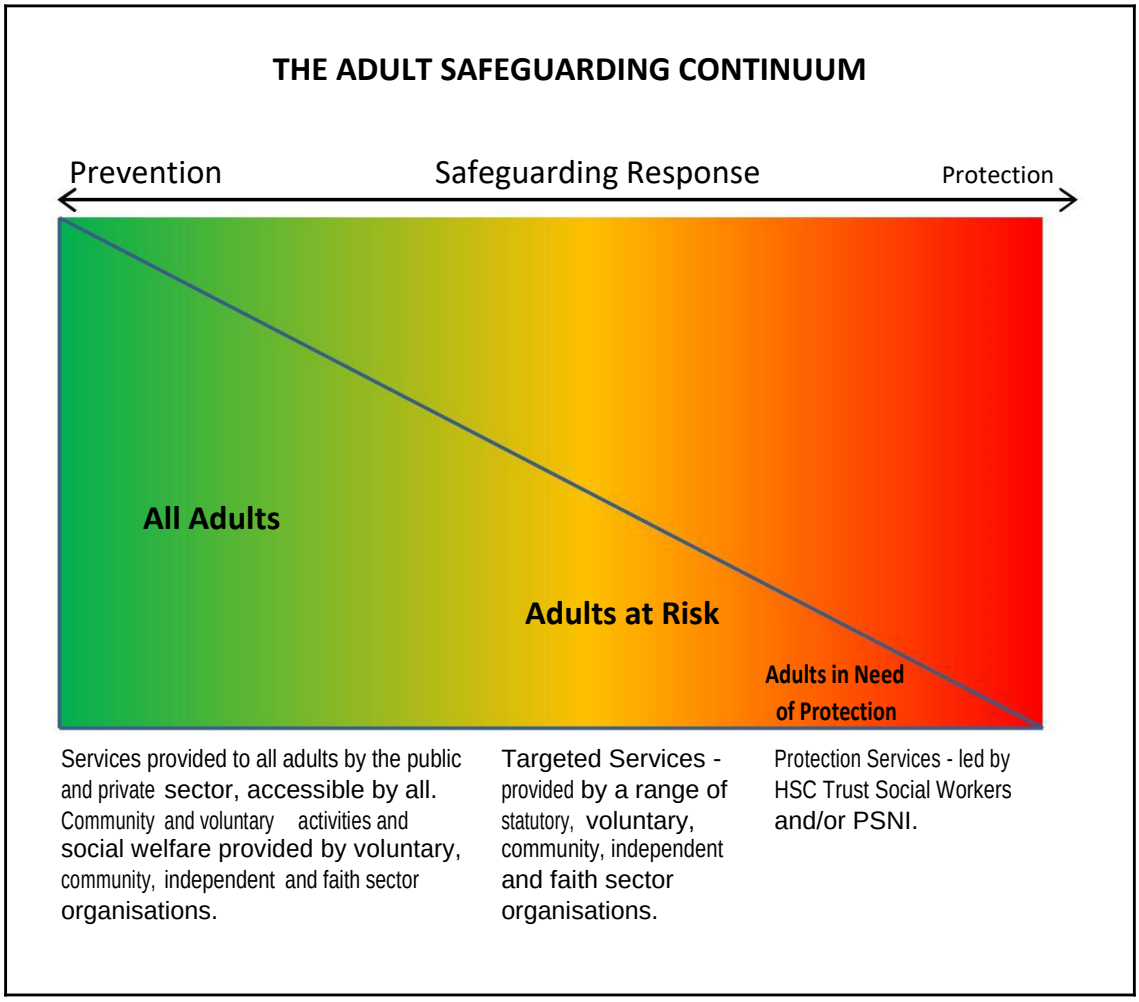
β) Adult Safeguarding: Prevention to Protection in Partnership Policy (DHSSPS 2015)

χ) Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)

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.

Safeguarding includes activity which **prevents** harm from occurring and activity which **protects** adults at risk where harm has occurred.

The diagram overleaf outlines this continuum



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. This is the first and crucial step to ensuring that services are high quality. 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.

These procedures outline the actions needed to respond to adults at risk of abuse or harm.

1.2 How to Use the Operational Procedures.

These procedures set out broad principles of good practice when responding to situations where adults are at risk or in need of protection. They place the adult at the centre of the safeguarding process and provide some practical guidance on how specific roles such as the Adult Safeguarding Champion should be implemented.

The procedures support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Each response should be tailored to meet the needs of that individual, working towards the achievement of their preferred outcome.

The procedures do not describe every potential safeguarding scenario and some, such as those involving Domestic Violence or Modern Slavery, require more specialist responses. Guidance on these responses is available elsewhere and practitioners should refer to such detailed advice as necessary.

2. Definitions

2.1 What is Abuse?

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'[1].

Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

The main forms of abuse are:

Physical abuse

[1] 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/

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. Female genital mutilation (FGM) is considered a form of physical **AND** sexual abuse.

Sexual violence and abuse

Sexual abuse is 'any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability). [2]

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,

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d) The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' are from "Stopping
Domestic and Sexual Violence and Abuse in Northern Ireland, A seven year strategy. March 2016.

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 Health and Social Care (HSC) provision. 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.

Neglect

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.

The Safeguarding Adults: Prevention and Protection in Partnership Policy does not include self-harm or self-neglect within the definition of an 'adult in need of protection'. Each individual set of circumstances will require a professional 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

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 neither 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.

2.2 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 or abuse is 'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member'. 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.

The response to any adult facing this situation will usually require a referral to specialist services such as Women's Aid or the Men's Advisory Project. In high risk cases a referral will also be made to the Multi- Agency Risk Assessment (MARAC) process. Specialist services will then decide if the case needs to be referred to a

HSC Trust for action under the safeguarding procedures. If in doubt, anyone with a concern can ring the Domestic and Sexual Violence helpline (0808 802 1414) to receive advice and guidance about how best to proceed.

Human Trafficking/Modern Slavery

Human trafficking/modern slavery 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/ modern slavery 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.

The response to adults at risk experiencing human trafficking/modern slavery will always be to report the incident to the Police Service.

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.

The response to adults at risk experiencing hate crime will usually be to report the incident to the Police Service.

2.3 Adult at Risk of Harm

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 personal characteristics and/or 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.

2.4 Adult in Need of Protection

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:

e) personal characteristics

and/or

f) life circumstances

AND

who is unable to protect their own well-being, property, assets, rights or other interests;

AND

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).

In most situations HSC Trusts will make decisions regarding the degree of risk and level of harm an adult may be facing and decide on the most appropriate action to take. 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.

If you think a crime has occurred where medical or forensic evidence might still be present consider the need for an urgent referral to the police service and be cautious not to touch or disturb possible evidential material.

SECTION B

ADULTS AT RISK OF HARM

3. The Adult Safeguarding Champion

3.1 Which Organisations Need an ASC?

Adult Safeguarding: Prevention and Protection in Partnership (2015) sets out the requirement for organisations to have an Adult Safeguarding Champion (ASC). If the organisation or group does not have staff or volunteers who require to be vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation.

Targeted services include organisations that have staff or volunteers who are subject to **any** level of vetting under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.
All providers of targeted services are required to have an ASC and an adult safeguarding policy which demonstrates a zero tolerance of harm to adults.

Members of the public, voluntary and community groups NOT required to have an Adult Safeguarding Champion (ASC) should report all adult at risk or in need of protection safeguarding concerns directly to the HSC Trust Adult Protection Gateway Service. They can do so by phoning the Trust's single point of contact telephone number (see Appendix 2).

3.2 The Role of ASC

The ASC should be within a senior position within the organisation and should have the necessary training, skills and experience to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy.

The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters. Each organisation should, therefore, ensure that arrangements are in place to provide appropriate cover in the ASCs absence.

The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

β) Recognising that adult harm is wrong and should not be tolerated

χ) Being aware of the signs of harm from abuse, exploitation and neglect

δ) Reducing opportunities for harm, abuse, exploitation and neglect to occur

ε) Knowing how and when to report adult safeguarding concerns to HSC Trusts and / or the PSNI

3.3 Key Responsibilities of the ASC

11) To provide information, support and advice for staff and/or volunteers on adult safeguarding within the organisation.

12) To ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation.

13) To advise the organisation regarding adult safeguarding training needs.

14) To provide advice to staff or volunteers who have concerns about the signs of harm and ensure a report is made to HSC Trusts where there is a safeguarding concern.

15) To support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about risks of serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision making.

16) To establish contact with the HSC Trust Designated Adult Protection Officer (DAPO), PSNI and other agencies as appropriate.

17) To ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken.

18) To compile and analyse records of reported concerns to determine whether a number of low level concerns are accumulating to become more significant. These records must be available on request for inspection or by way of service level agreements or contract review meetings.

In larger organisations the ASC may delegate the operational day to day responsibility for safeguarding to an appointed person(s) within their organisation. For example, a provider with a number of Nursing Homes throughout Northern Ireland may choose to delegate some of the tasks of an ASC to a member of staff in each facility. They will then report to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Organisations who delegate operational tasks to appointed person(s)

must have sufficient numbers to ensure they are accessible to all service areas in the organisation as a source of advice and guidance.

In smaller organisations the ASC may be responsible for all actions relating to adult safeguarding situations, including working with the adult at risk and making referrals to PSNI and/or HSC Trusts.

Contact details for the HSC Trust Adult Safeguarding Gateway Services are contained in Appendix 2.

3.4 Information to be Monitored by an ASC

Most ASCs will already have daily access to a great deal of information that will assist the organisation or group improve the services it provides to adults at risk or in need of protection.

To meet the governance requirements set out in the Policy, the ASC will compile an annual Adult Safeguarding Position Report using the following core data:

7 Number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;

8 Number of adult safeguarding discussions where the decision taken was to **not** refer to HSC Trust;

9 Any untoward event that triggered an adult protection investigation;

10 Adult safeguarding training opportunities provided and uptake across staff groups; and

11 Any action that your organisation plans to take to ensure it is compliant with Adult Safeguarding: Prevention and Protection in Partnership and to implement the organisation's own adult safeguarding policy.

3.5 The Adult Safeguarding Position Report

The Position Report is an important overview and governance tool for all organisations and groups supporting adults at risk or in need of protection. It will contain significant information for the organisation or group's Senior Management Team and/or Trustees. It should be scrutinised by them on an annual basis.

It would also be appropriate to provide core information from the Position Report in any organisational annual reports or updates.

The Position Reports should be made available for any external audit purposes, for example any audits undertaken by the Local Adult Safeguarding Partnership, and to demonstrate compliance with policies as specified within any contracts with HSC Trusts.

Services that are externally regulated, e.g. by RQIA or CJINI, may also be subject to inspection on adult safeguarding arrangements. The Position Report will be central in demonstrating that the organisation is complying with the requirements of the regional adult safeguarding policy.

If the service or group is contracted to provide services by the HSC normal contract monitoring processes should be used to provide confirmation to the relevant Trust(s) that the safeguarding Position Report is available for scrutiny.

4. Recognising and Responding to Adult Safeguarding Concerns

Staff or volunteers who are concerned about someone who may be experiencing harm or abuse must promptly report these to their line manager or person in charge.

There are a variety of ways that you could be alerted that an adult is suffering harm:

7. They may disclose to you;
8. Someone else may tell you of their concerns or something that causes you concern;
9. They may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
10. Their demeanour/behaviour may lead you to suspect abuse or neglect;
11. The behaviour of a person close to them makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
12. Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that adults are safeguarded and it is important that all concerns about possible abuse are taken seriously and appropriate action is taken.

4.1 When an Adult at Risk Discloses Abuse

In cases where an adult discloses abuse to a staff member or volunteer, it is vital that staff/volunteers know how to react appropriately.

All staff/volunteers should be made aware of to the following guidelines:

Do

9 Stay calm;

10 Listen attentively;

11 Express concern and acknowledge what is being said;

12 Reassure the person – tell the person that s/he did the right thing in telling you;

13 Let the person know that the information will be taken seriously and provide details about what will happen next, including the limits and boundaries of confidentiality (see leaflet);

14 If urgent medical/police help is required, call the emergency services;

15 Ensure the immediate safety of the person;

16 If you think a crime has occurred be aware that medical and forensic evidence might be needed. Consider the need for a timely referral to the police service and make sure nothing you do will contaminate it;

17 Let the person know that they will be kept involved at every stage;

18 Record in writing (date and sign your report) and report to the Line Manager/person in charge/Adult Safeguarding Champion at the earliest possible time;

19 Act without delay.

Do not

8. Stop someone disclosing to you;
9. Promise to keep secrets;
10. Press the person for more details or make them repeat the story;

9. Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
10. Contact the alleged person to have caused the harm;
11. Attempt to investigate yourself;
12. Leave details of your concerns on a voicemail or by email;
13. Delay.

The line manager or person in charge will take any immediate action required to ensure the adult at risk of harm is safe and make a decision as to when it is appropriate to speak with the adult at risk of harm about the concerns and any proposed actions. They must then report the concerns and any action taken to the services appointed person or Adult Safeguarding Champion.

• Responding to an Adult Safeguarding Concern – the Role of the ASC

When an alert is raised within an organisation in relation to an adult safeguarding concern or disclosure, the ASC or appropriate appointed person, where these tasks have been delegated, will ensure the following actions occur:

- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided whilst being careful not to stray into the realm of investigation.
- **Where immediate danger exists or the situation warrants immediate action** ensure any necessary medical assistance has been sought and refer to HSC Adult Protection Gateway or PSNI.
- Support staff to ensure any actions take account of the adult's wishes.
- Where it has been deemed that it is not a safeguarding issue, other alternative responses should be considered such as monitoring, support or advice to staff or volunteers.
- If it is decided that it is a safeguarding issue, the situation should be reported to the HSC Key Worker where known. If unaware of HSC Key Worker contact details, a referral will be made to HSC Trust Adult Protection Gateway service. The HSC Trust will then conduct a risk assessment and decide what response is appropriate.

- If a crime is suspected or alleged, contact the HSC Adult Protection Gateway Service directly.
- If the concern involves a regulated service, inform RQIA.
- Act as the liaison point for any investigative activity which is required and will ensure easy access to relevant case records or staff.
- Ensure accurate and timely records and any adult safeguarding forms required have been completed.

If an adult at risk does not want a referral made to the HSC Trust or PSNI, the ASC or appropriate person must consider the following:

13 Do they have capacity to make this decision?

14 Have they been given full and accurate information in a way which they understand?

15 Are they experiencing undue influence or coercion?

16 Is the person causing harm a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service?

17 Is anyone else at risk from the person causing harm?

18 Is a crime suspected or alleged?

These factors will influence whether or not a referral without consent needs to be made. If in doubt contact the HSCTrust Gateway service for advice and guidance.

If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and the reasons for not referring to HSC Trust.

The ASC will ensure that records of reported concerns are compiled and analysed to determine whether a number of low-level concerns are accumulating to become significant. If the organisation is regulated by RQIA or other bodies, then the ASC will make records available to them for inspection.

Where the ASC or appointed person 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.

In most circumstances there will be an emerging safeguarding concern which should be referred to the relevant HSC Trust for assessment. HSC professionals will determine whether the threshold for an adult protection intervention has been met, or whether alternative safeguarding responses are more appropriate.

6. Responding to an Adult Safeguarding Concern – the Role of the HSC Trust

6.1 Determining if an adult is at risk

On receipt of the adult at risk referral the HSC Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses.

The line manager must ensure that the adult's immediate needs are met, eg they are in no immediate danger and that any medical assistance required has been sought.

Line managers must refer all cases where there is a clear and immediate risk of harm to the adult or a crime is alleged or suspected, to the PSNI using the emergency police 999 number and the Designated Adult Protection Officer (DAPO) in the HSC Trust Adult Safeguarding Gateway Team. The appropriate documentation should be used (see Appendix 7).

Where the decision is that the adult is potentially at risk of harm the line manager and the keyworker will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm (See Appendix 7). The consent of the adult at risk will be sought (see Section 7:0 below for advice on capacity and consent) and the assessment will include the wishes and views of the adult at risk and where appropriate their family and carers. The keyworker will inform the referrer of the outcome of the assessment and care plan.

6.2 Determining if the Threshold for Referral to the Adult Protection Gateway Service is met

Where a risk assessment concludes that the adult is at risk of or has experienced serious harm, the next step is to consider whether the threshold for referral to the HSC Trust Adult Protection Gateway Service has been met.

Where the line manager determines that the threshold for an adult in need of protection is met, the keyworker refers the concern to the HSC Trust Adult Protection Gateway service (See Section C). The keyworker will advise the adult in need in protection of the decision to refer.

The following thresholds are intended as a guide only. It should be noted that 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.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

NB: In the majority of cases where serious harm has been identified, the threshold for referral to the HSCTrust Adult Protection Gateway Service will have been met. However, in a limited number of circumstances referral to this service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is a concern. In such circumstances, an alternative response may be more appropriate (see below)

6.3 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:

- escalation to the service manager to address any issues about the quality of service provision;
- 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;
- 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;
- action taken under complaints procedures;
- action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
- referral to an advocacy service;

- referral to another service;
- a risk management intervention in relation to self-neglect;
- a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
- no further action required;

or a combination of two or more of the above.

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 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.

7. Human Rights, Consent and Capacity

Adults at risk of harm should be central to decisions regarding any actions to prevent or protect them from harm. The adult's reasons for refusal to consent to a referral to the HSC Trust for assessment and support should be explored with them. Consent may be over-ridden in some cases, for example, where the individual lacks the capacity to appreciate the nature of the concerns and the potential consequences to them of not addressing those concerns; where there is a potential risk to others or in the public interest.

If you have any concerns that the adult at risk may not have capacity to consent or may be coming under pressure to refuse consent you should refer to the HSC Trust key worker or HSC Trust Adult Protection Gateway team.

Human Rights, Consent and Capacity, the European Convention for the Protection of Human Rights and Fundamental Freedoms (Human Rights Act 1998)

The Human Rights Act 1998 has been fully effective from 2nd 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 sets out the main Convention Rights enshrined in the 1998 Act.

Decisions taken not to comply with the wishes of the adult in need of protection/adult at risk may constitute a breach of Human Rights legislation. Where consideration is being given not to comply with the wishes of the adults in need of protection adult/adult at risk, the decision taken must be lawful, proportionate and in keeping with what is in the public interest.

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. Reporting a relevant offence, as defined in the Criminal Law Northern Ireland Order (1967), is not only lawful but a legal requirement on public authorities.

Proportionate means the proposed action is viewed by any reasonable person as fair, necessary and the least restrictive in order to benefit the individual.

Necessary in a democratic society means

Does it fulfil a pressing social need?

Does it pursue a legitimate aim? And

14 Is the proposed action in the public interest taking into consideration whether other Adults at risk or children may be at risk of harm?

7.1 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?

10. Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
11. 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).
12. Is the restriction required for legitimate purposes?
13. 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 human 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.

7.2 Consent

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse. Where a crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection.

The consent of the adult in need of protection for contact with the PSNI should be sought as a first step.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision regarding how they wish the situation to be handled. They should be fully advised by the Trust key worker and/or Designated Adult Protection Officer (DAPO) of the Protocol for Joint Working process and of their right to have a referral made to the PSNI. The adult in need of protection should also be informed if this is a referral to PSNI for action, or whether consultation on the need for a Joint Agency approach is required.

The adult in need of protection should be advised that agreeing to a Joint Agency consultation does not in itself constitute agreement to a full PSNI investigation. The benefits of a Joint Agency consultation in terms of information gathering should be explained. Their entitlement to full consultation and involvement at each stage in the

Joint Protocol process should also be emphasised. All staff involved must ensure that this person centred approach is strictly adhered to.

Details of all supports available to an adult in need of protection as outlined in 'Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy' (2012) should also be provided.

In the majority of cases where the adult in need of protection is deemed to have capacity, the PSNI will only proceed to a full investigation with the consent of the adult in need of protection. In practice this will mean that the adult in need of protection should be willing to make a complaint to the PSNI. However, there are some exceptions to this.

7.3 Dispensing with Consent

In exceptional circumstances, the DAPO may need to consider over riding the wishes of an adult in need of protection if they do not consent to a joint agency consultation with the PSNI. These include situations where:

- There is reasonable evidence or information to indicate that a possible relevant offence has been committed and the Trust have a legal obligation to report to the PSNI.
- There is a significant query regarding the individual's capacity to make an informed decision and therefore their ability to give or withhold consent is in question. Actions taken must be proportionate to the level of concern and the views of substitute decision makers.
- Information available clearly demonstrates that the individual is subject to substantial undue influence or coercion.
- There is a significant risk to other adults at risk and/or children.
- The likelihood of further harm is high and there is a substantial opportunity to prevent further crime.

The PSNI also have the authority to investigate alleged or suspected criminal abuse where this is agreed to be in the best interests of the adult in need of protection and or others.

The above list indicates possible situations where the DAPO may need to consider overriding the wishes of an adult in need of protection adult. The list is not exhaustive. Cases will need to be assessed on a case by case basis and requirements in relation to making decisions which are lawful, proportionate and necessary in the public interests are applicable.

7.4 Acting without Consent in Emergency Situation

In situations where the adult in need of protection is in imminent danger it may not be possible to discuss with them their wishes and obtaining a valid consent may not be achievable. Trust staff, under these circumstances, should take whatever action they feel is appropriate to protect the adult in need of protection, including seeking medical and/or PSNI intervention.

Where there is no information and/or clarity regarding the wishes of the adult in need of protection and it is safe to do so, consideration should be given to deferring a decision re a joint agency consultation until such time as the adult in need of protection's views and permission can be sought. The DAPO will need to consider this on a case by case basis, mindful that a number of factors will need to be taken into account. Where a decision is taken to consult with the PSNI and the adult in need of protection has not consented to this, a detailed rationale for this decision should be recorded.

7.5 Capacity

There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, the DAPO should ensure a capacity assessment is completed.

Capacity assessments/reassessment should determine:

- the extent to which the adults in need of protection/adult at risk is able to make informed decisions about their safety and protection.

16 whether the adults in need of protection adult/adult at risk is able to make a complaint to the PSNI and/or give legal instruction.

17 whether the adults in need of protection adult/adult at risk has the capacity to be interviewed by the PSNI.

Capacity assessments will also inform the assessment of the needs of the adult at risk or in need of protection.

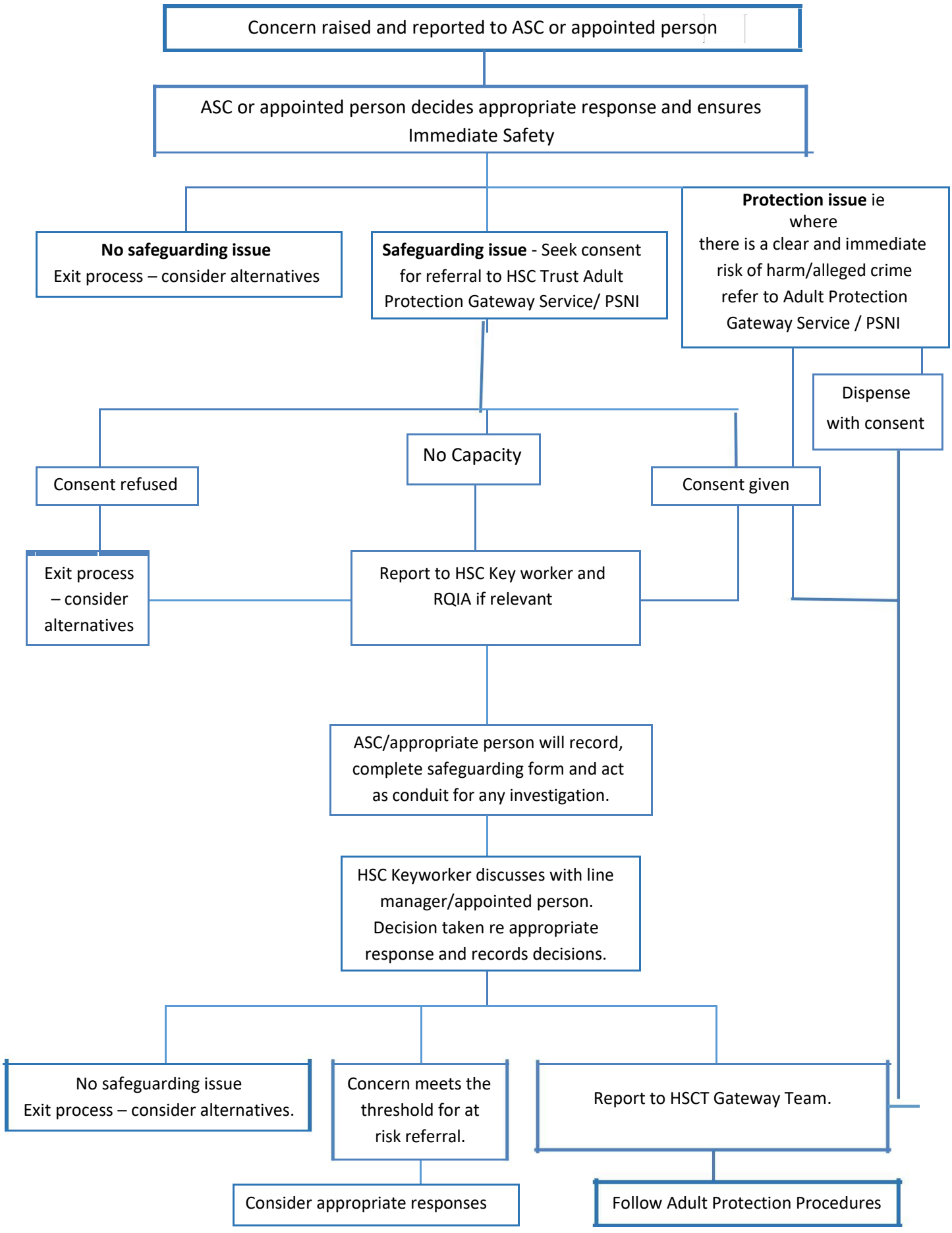
Formal capacity assessments should be carried out by an appropriately trained professional. In cases where the adult in need of protection is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

It is important to remember that an individual's capacity to consent to any course of action, decision or intervention may fluctuate. A capacity assessment should not, therefore, be considered as a one-off event. DAPOs should ensure that issues of capacity are constantly borne in mind throughout any safeguarding or protection interventions.

The onus is on professionals such as nurses and social workers to ensure that any intervention where the individual is considered to lack capacity is respectful of the person's human rights and that actions are both proportionate and lawful.

It is important to note that any and all information provided by an adult in need of protection is relevant and should be considered in a safeguarding context.

PATHWAY FOR DEALING WITH CONCERNS



SECTION C

SAFEGUARDING ADULTS IN NEED OF PROTECTION

Introduction:

These procedures set out the process to be followed in reporting and responding to concerns that an adult is at risk of harm and may be in need of protection (see Appendix 3, Six Stages of the Adult Protection Process).

8. Roles and Responsibilities

Safeguarding is everyone's business and includes the decision to make a referral when there is a concern relating to an adult in need of protection. There will however be more specific roles and responsibilities within the process and these will be discussed in more detail in the relevant section of the protection process (see below).

8.1 Designated Adult Protection Officer

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 service teams.

Every DAPO must:

- Be a qualified social worker at Band 7 seniority or above;
- Have first line management responsibilities, or in a senior practitioner role;
- Be suitably experienced; and
- Have undertaken the required training as outlined in the Northern Ireland Adult Safeguarding Partnership Training Framework (2016).

The role of the DAPO is to

- Complete an initial screening against the thresholds for serious harm. Where this threshold has not been met, the DAPO should consider all alternative safeguarding responses
- Manage and coordinate the adult protection intervention;
- Provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer;
- Analyse the adult safeguarding data within their service area and contribute to 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 and modern slavery 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;
- 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 and there is no need to conduct an investigation; 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 Regulation and Quality Improvement Authority (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.

Where there are multiple adults in need of protection the DAPO will also

- Liaise and agree with other potential DAPOs who will take lead responsibility.
- Agree joint working and feedback arrangements as necessary.

This is critical:

12. In cases where there is more than one programme of care involved in delivering a service.
13. If the adult in need of protection is in a care environment outside their home e.g. Acute Care.
14. Where there is more than one Trust involved in the provision of care (Ref Section 10 on Large Scale and Complex Investigations).

8.2 The HSC Investigating Officer

The Investigating Officer must be a HSC Trust professionally qualified practitioner (Band 6 and above). Investigating Officers **must** receive specific training as set out in the NIASP Training Framework prior to undertaking the role.

Their role is to carry out an assessment of risk, collate and analyse all available information, determine how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support.
The Investigating Officer, alongside relevant professionals, will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

While carrying out these duties, the Investigating Officer will be guided and supported by the DAPO. The Investigating Officer will:-


Meet with the adult in need of protection and carer/relative separately to establish the preliminary information.


Investigate allegations and concerns as directed by the DAPO. The investigation should take the form of an assessment of risk, needs and, where appropriate, a carer's assessment. This will inform the review and updating of the interim protection plan.


Inform the adult in need of protection of expressed concerns and the Adult Protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.


Inform the adult in need of protection of his/her rights to protection under law.


Support the adult in need of protection through the assessment process.

- Keep the adult in need of protection informed and updated throughout the investigation process to ensure informed decision making.
- Identify needs and supports which may be required by the person alleged to have caused the harm and, where appropriate, refer on for professional input and support.
- Commission medical or other specialist assessments, where appropriate.
- Inform and liaise with relevant professionals and significant others as appropriate.
- Make a clear record of the investigation process.
- Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- Provide an investigation report for a case conference/review. This report must include an analysis of the findings with a conclusion and, where appropriate, make recommendations.
- Ensure the implementation of any care and protection plan as agreed with the DAPO.

8.3 The HSC Achieving Best Evidence Interviewer

The specialist Achieving Best Evidence (ABE) Interviewer must be a professionally qualified Social Worker. Specialist Interviewers must have completed Investigating Officer training, Joint Protocol training and ABE training prior to undertaking the role.

The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in “Protocol for Joint Investigation of Adult Safeguarding Cases (2016)” and “Achieving Best Evidence in Criminal Proceedings” (2012).

The Pre Interview Assessment, where possible, will be conducted by the same person conducting the ABE Interview. (See also Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and Achieving Best Evidence in Criminal Proceedings (2012)).

8.4 Line Manager

On receiving an allegation or concern of abuse the line manager must ensure that the adult's immediate needs are being met; i.e. that they are in no immediate danger and that medical assistance if required is sought. The line manager must consider the need for emergency PSNI intervention. For example, where there remains immediate risk of harm to the adult in need of protection or others the line manager must contact the emergency PSNI number, 999.

Line managers must refer all cases where there is a clear and immediate risk of harm or a crime is alleged or suspected regarding an adult at risk to the PSNI or the DAPO in the HSC Trust Gateway Service using the relevant regional referral and recording systems, including where there are concerns that physical harm has occurred, a body map or diagram completed by an appropriately trained person.

In most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust for a professional assessment of risk. It will be a matter for the HSC professional to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate.

In circumstances where the care manager for the service user is from another HSC Trust, the referral should be made to the Adult Safeguarding Gateway Service in the placing HSC Trust. The line manager must also notify the host Trust for information purposes as this may be relevant to other current concerns (refer to section 15.2). In instances where the person who has allegedly caused the harm is also an adult at risk the line manager should ensure necessary arrangements are in place to support them.

In instances where the allegations are made against a member of staff, the line manager will be responsible for the instigation of appropriate protection measures which may involve staff such as redeployment, being placed on restricted duties or precautionary suspension and any subsequent disciplinary procedures. The line manager must consult with the responsible DAPO to ensure that Disciplinary Procedures run parallel to the adult protection investigation. It is essential in these circumstances that close communication and sharing of information is maintained

between the line manager, DAPO and Human Resources. (See section on Guidance on the Co-ordination of Adult Protection Investigations with Human Resource and/or PSNI Investigations)

8.5 HSC Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency social work service outside normal office hours including weekends and public holidays. These are 5pm to 9am Monday to Thursday and 5pm on Friday to 9am on Monday. There is 24 hour cover over public holidays.

The RESWS responds to a wide range of people in crisis and deals with situations which cannot be left until the next working day. People in crisis can include older people, people with mental health issues, learning disabilities, physical disabilities, potential victims of human trafficking and children and young people.

There are a number of situations in which the RESWS will become involved or work with other agencies to ensure the safety of an individual and others who may be at risk. Examples of emergency situations are where:

- There are immediate significant protection and welfare concerns in relation to an adult at risk and/or an adult in need of protection;
- There are immediate significant protection and welfare concerns in relation to children and young people;
- Urgent advice and/or support is required by families or carers;
- Older people are at risk;
- There is consideration that compulsory admission to hospital under the Mental Health Order (NI) 1986 is required.

Staff within RESWS will provide an adult safeguarding and adult protection service where required and Managers within the RESW will fulfil the role of Designated Adult Protection Officers (DAPOs) when required RESWS will respond to all elements of the role in emergency situations which require an urgent response.

8.6 Role of Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (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.

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[3].

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

9. Adult Protection Procedures

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.

10. Stage 1 Screening the Adult Protection Referral

On receipt of a referral the DAPO will take the following actions:

- Consider immediate safeguards for the adult and take appropriate action to meet identified safety needs.
- Ensure that a face to face contact with the adult in need of protection is completed without undue delay.
- Clarify basic facts and determine if the adult meets the definition of an adult in need of protection.

• RQIA publications are available on www.rqia.org.uk

- Determine whether the threshold for serious harm (Appendix4) and the threshold for referral to the HSC Trust Adult Protection Gateway Service are met. This 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 consider 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 in need of protection;

  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 adequately addressed.

- If referral does not meet the above protection thresholds, the DAPO will advise referrer and agree appropriate alternative safeguarding responses. At all times the least intrusive and most effective response should be made.

- Where the HSC Trust Adult Protection Gateway Service DAPO determines that an alternative course of action is appropriate, there must be mechanisms in place to ensure that the outcomes of this action is reported back to the DAPO;

- 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. If the person has no suitable family or friend who can be consulted with regarding their best interests, an advocate may be appointed.

- Where there is a query regarding the capacity of the adult to consent to the referral, the DAPO should screen the referral into the adult protection process pending the completion of a capacity assessment. The absence of a capacity assessment must not delay the protection of an adult in need. It is important that a capacity assessment is undertaken as soon as possible. It may be established that with the appropriate support, the adult in need of protection is able to make their own decisions.
- 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, the DAPO may decide to progress a case 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 relevant and reportable 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.

- The DAPO must ensure that the HSC staff member communicating with the adult in need of protection has sufficient knowledge of the Protocol for Joint Investigation of Adult Safeguarding Cases to provide relevant

information in order that the adult in need of protection can make an informed decision in relation to PSNI involvement.

- If the allegation is a potential crime there must be consideration of the application of the Protocol and immediate liaison with the PSNI to avoid contamination of evidence.
- Consider if there are other adults or children in need of protection.
- Consider any indicators of potential human trafficking or modern slavery and, if relevant, refer to regional guidance.
- Inform other relevant organisations of the nature of the allegation and the actions being taken.
- Complete the relevant electronic information system.
- Complete the relevant documentation advising the referrer of outcomes of the screening decision. The referrer, if appropriate, notifies service user / family with due regard to maintaining the safety of the service user in need of protection.
- Where appropriate, the Gateway DAPO will forward the screened referral to the most appropriate DAPO within core operational services to take the lead role in initiating, convening and chairing a strategy planning meeting/discussion. Feedback should be given to the person who made the referral, taking into account confidentiality and data protection issues.

10.1 Supporting an Adult at Risk Who Makes Repeated Allegations

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated without prejudice. Each allegation must be responded to and recorded under these procedures. A risk assessment must be undertaken respecting the rights of the individual and measures taken to protect staff and others and a case conference convened, where appropriate.

10.2 Responding to Family Members, Others Who Make Repeated Allegations

Allegations of abuse made by family members or others should be investigated without prejudice. However, where repeated allegations are made and there is no foundation to the allegations and further investigation is not in the best interests of the adult in need of protection, then the appropriate HSC Trust Director should make a determination in consultation with relevant others about an appropriate response.

10.3 If a Referral is Received after an Adult in need of protection has Died:

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required. If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

10.4 Outcome of Screening:

There is Insufficient Information to Determine if an Investigation is Required

Additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

The Threshold of Adult in Need of Protection IS NOT MET

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.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights 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.

A decision to close the Adult Protection process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

The Threshold for Referral to Adult Protection Gateway Service is Met: -

The DAPO will proceed with the management of the protection process.

11. Stage Two: Strategy Discussion

11.1 Purpose of the Strategy Discussion

Strategy meetings provide a forum for professionals and agencies to work together to ensure a coordinated investigation and protection response. They are an opportunity to address any potential conflicts between agencies at an early stage. They also provide the opportunity for clarification of roles and responsibilities in relation to HSC Trust, PSNI, RQIA and where applicable an employing organisation.

In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts. However, there may be occasions when a telephone discussion would be more appropriate and proportionate, eg emergency situations. There must be careful consideration about the most appropriate way to ensure the wishes of the adult in need of protection are at the centre of the decision making at a strategy discussion.

Every effort should be made prior to the meeting to explain its purpose to the adult in need of protection to find out their concerns, what they want to happen and how they want to be involved in what is decided. This can be done either by the keyworker or the Investigating Officer, or both if this is deemed most appropriate.

11.2 Supporting the Adult in Need of Protection:

The wishes of the adult in need of protection are central to the process and will, as far as possible, direct any decision-making. However, there may be circumstances in which the person concerned about the adult in need of protection may not be best placed to seek their consent to a referral being made, or the person clearly states 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 mean this may not be possible, for example, where there appears to be undue influence or

coercion or another person is suspected to have influenced the adult's decision or other people may be at risk or it constitutes a relevant offence.

The strategy meeting will consider the wishes of the adult in need of protection as to who will support them throughout the adult protection process if this is required. During this process those involved must:

- ο) Ensure that the adult in need of protection is given every opportunity to speak in private regarding their concerns, taking care not to place the adult in need of protection at greater risk.
- π) Inform the person of advice, support, assistance or services available.
- θ) Offer the use of an advocate if this would be beneficial.
- ρ) Decide what information legally can be shared with next of kin. This may vary in differing circumstances either due to consent and capacity issues or through the choices of the adult in need of protection. The principles of best interests and information sharing apply. Good practice will evidence the rationale for the decision to share such information.
- σ) Promote the human rights of the adult in need of protection.

11.3 Role of DAPO at the Strategy Discussion

The DAPO must ensure that an adult protection strategy discussion is convened and chaired, and minutes taken and circulated. The DAPO will invite those who will provide critical or relevant information that will inform decision making to attend and/or provide a written report. This may include, for example, the PSNI or RQIA. The DAPO will also invite those who will be required to implement the various elements of any protection plan. In respect of regulated services this will include the Regulator. If the allegation involves a member of staff or paid carer, the strategy discussion will be attended, where appropriate, by:

13. PSNI
14. RQIA
15. The authorised officer for contracts
16. The HSC Trust commissioning manager/Contracts Manager
17. The Human Resources officer
18. The line manager of the member of staff

12.2. A senior manager of the employing organisation

Where a formal strategy meeting is convened of any individual requested to attend should treat the request as a priority. In exceptional circumstances, iIf no one from the organisation is able to attend, they should provide written information as requested and ensure it is available at the meeting.

In most cases it would be deemed to be good practice for a strategy discussion to take place as soon as possible. It is important that each adult protection intervention is conducted without undue delay, and remains outcome focused, rather than process driven. 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. HSC Trusts must ensure that the timeliness of interventions will be monitored and reviewed at an appropriately senior level.

11.4 Role of Line Managers in Strategy Planning

Line Managers may be required to take part in a strategy discussion in relation to service delivery and /or in relation to a member of staff. The Line Manager will be asked to contribute information about potential risk to inform the protection plan.

Line managers will implement any actions agreed and, in conjunction with the DAPO, they will agree what information will be shared with the person raising the concern and the adult in need of protection. Line managers may also be responsible for taking protective actions in relation to the person who has allegedly caused the harm. They will record all conversations, meetings with the person who allegedly has caused the harm, feedback to the DAPO, refer to HR for advice and notify appropriate professional and regulatory bodies as required.

NB where a PSNI investigation has commenced, it will be necessary to seek PSNI permission prior to interviewing a member of staff under disciplinary procedures, in case this interferes with PSNI procedures.

11.5 Adult Protection Strategy Discussion

The strategy discussion must demonstrate the following actions have been undertaken.

- Review the screening decision, including any requirement to refer to PSNI
- Consider the wishes of the adult in need of protection
- Clarify the mental capacity of the adult in need of protection to make decisions about their own safety. Arrange for an assessment by the most appropriate person, if required
- If the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, and/or who is a suitable person to act in the person's best interests.
- Consider the use of advocacy if appropriate
- Identify any communication needs of the adult in need of protection
- Discuss the nature of the concerns and review preliminary risk assessment and interim protection plan
- Consideration should be given to the safety and wellbeing of other adults or children. Where appropriate, refer to children's Gateway Service and/or Adult Gateway service.
- Consider the human rights for both the adult in need of protection and the person alleged to have caused the harm who may also be an adult at risk.
- Review and record available, relevant information and determine any further information required. Discussions should include decisions about sharing of information.
- Agree the most appropriate way of responding to the concerns identified, e.g. Single agency PSNI investigation; Single agency HSC Trust investigation; Joint Protocol investigation; disciplinary investigation; family group conference; care planning; risk management meeting; or formal complaint in order to create and implement a protection plan. The detailed rationale for this decision must be recorded and will be subject to audit.

- Where a decision has been made that an investigation will take place, agree an investigation plan to include timescales for same and how it should be conducted and by whom.
- Agree a clear rationale for the actions to be undertaken and by whom.
- Agree a communication strategy including who should inform service user/carer/advocate of outcome of strategy discussion.
- Consider the need to inform other regulatory/professional bodies.
- Circulate minutes to all invitees within ten working days using the appropriate regional pro forma (Appendix 6).
- If the investigation is likely to be prolonged, other strategy meeting(s) must be held to ensure that actions are progressed and the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary).
- Full cooperation will be afforded to police investigations and in such cases the DAPO must ensure appropriate care and protection plans are in place to protect and safeguard the adult in need of protection. It will be necessary to consult with PSNI before proceeding with any internal organisational investigations such as disciplinary proceedings
- Regular contact should be maintained between the DAPO and the PSNI representative during the PSNI investigation process, and the position communicated to the staff member's manager and HR representative (particularly as the suspension/transfer decision must be reviewed every 4 weeks).

11.6 Coordination of Adult Protection and Disciplinary Investigations:

The focus of a Disciplinary Investigation is to determine if a staff member has breached disciplinary rules, which may require disciplinary action to be taken. The threshold for decision-making is whether there is a case to answer 'on the balance of probabilities'.

The different focus of protection and disciplinary investigations will require separate reports to be prepared. However, coordinating the process by which each investigation gathers information will make the best use of the Trust's skills and expertise, avoid duplication, and avoid undue delay.

11.7 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is Also an Adult at Risk

The primary focus of the strategy meeting or discussion is the adult in need of protection. However, it may be necessary to hold a separate multi-agency meeting to address the needs and behaviour of the person causing the harm. Decisions that will need to be taken at the strategy meeting in relation to the person causing the harm will include:

14. How to co-ordinate action in relation to the adult at risk causing the harm.
15. Identification and allocation, of a separate care manager/keyworker in order to ensure that the needs of the adult at risk causing the harm are met and that a care plan is devised to ensure that other adults at risk are not also put at further risk from that person's actions.
16. Whether there is likely to be a criminal prosecution (if known at this point).
17. What information needs to be shared and with whom.

The DAPO will maintain communication with those concerned with the care of the adult at risk who is also alleged to be the person causing harm.

In all situations, the care manager/key worker representing the adult at risk and the relevant staff working with the person causing the harm must be informed of any risk management issues immediately and be closely involved at all stages of the investigation

Where the person alleged to have caused the harm is under 18 years of age, a referral should be made to the relevant HSC Trust Children's Services

.

The strategy discussion should demonstrate how the needs of the person who has allegedly caused the harm have been supported during the adult protection investigation.

Throughout the Adult Protection process, people alleged to have caused harm must be treated and spoken to without prejudice.

The person allegedly causing harm has a right to information about any allegations made. However, their right to information must be balanced with the rights of the adult in need of protection and/or any other safety concerns.

Where a decision is taken not to inform the person alleged to have caused harm of an allegation there must be a clear rationale for this decision which must be recorded and kept under review. Where a crime is alleged or suspected, advice should be sought from PSNI before information is shared.

11.8 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Member of Staff/Volunteer

If the person alleged to have caused the harm is a member of staff or a volunteer and an immediate decision is needed, the line manager should notify those with responsibility for Human Resource functions in the relevant organisation of the concern and liaise with the relevant manager for a decision on whether precautionary suspension/transfer/restricted duties of the staff or volunteer is necessary and appropriate. The employer should inform the person in broad terms of the nature of the allegations in line with HR Procedures.

There is a requirement in these circumstances to ensure that the rights of the adult in need of protection and the rights of a member of staff/ volunteer are fully considered and all actions taken at this stage are without prejudice in order to facilitate the investigation/s taking place.

11.9 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Family Member, Friend or Carer.

Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, information may need to be given to the person alleged to have caused harm to ensure they understand how poor care practices can become abusive. A carer may also require a carer's assessment.

In cases where a crime is alleged or suspected, advice on what can or should be shared should be sought from the PSNI.

11.12 Outcomes of Strategy Discussion

The strategy meeting/discussion must decide who will inform the adult in need of protection of the decisions and outcomes reached at the meeting. There are a number of outcomes that may be determined at the strategy (see Appendix 5). The relevant outcome should be recorded in the minutes of the meeting.

i. Insufficient Information to Determine if an Investigation is Required

It is agreed that additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

- **Threshold of Adult in Need of Protection is not met**

Where the threshold of "an adult in need of protection" is not 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:


Escalation to the service manager to address any issues about the quality of service provision;


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;


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;


Action taken under complaints procedures;


Action taken under HR/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;


Referral to an advocacy service;


Referral to another service or agency;

A risk management intervention in relation to self -neglect;

A strategy to manage risks within a complex group living environment

and the management of challenging behaviour;

- No further action required; **or**

a combination of any of the above.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights 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.

A decision to discontinue the Adult Safeguarding process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

15. The Threshold for an Adult in Need of Protection is Met

If the threshold is met and it is determined that investigation is required then consideration should be given as to the most appropriate type of investigation. This may be either a single agency (HSC Trust or PSNI) or alternatively a Joint Protocol Investigation.

Where the threshold is met and the adult in need of protection has capacity to withhold consent for an adult protection investigation, the expressed wishes of the adult will be respected and the investigation will not proceed provided there are no other adults at risk or concerns which may constitute a relevant and reportable offence.

In such circumstances, practitioners must be confident that the adult at risk is making this decision without undue influence, threats and intimidation. If there are no other people at risk from the person causing the harm, there will be no further action under the procedures at this time. In this situation there should be a written record, confirming their decision not to proceed with an investigation.

The adult at risk should be given information about abuse and neglect, possible sources of help and support and who to contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.
If protection concerns persist the strategy meeting must consider other types of intervention to be offered, including a risk management plan, care plan or Family Group Conference or legal powers available to intervene with the person(s) causing the harm. This must be shared and agreed in writing with the adult in need of protection.

11.13 Single Agency PSNI Investigation

Where a single agency PSNI investigation is considered to be the appropriate response, PSNI officers should refer to Police Service Procedures. During a single agency PSNI investigation the HSC Trust will ensure, where appropriate, any adult safeguarding or protection issues are addressed.

HSC Trusts will give full co-operation to police investigations and in such cases the DAPO must ensure appropriate risk and protection plans are in place to protect and safeguard the adult in need of protection.

The PSNI and HSC Trust should continue to liaise throughout the investigation in relation to any protection issues. The HSC DAPO will continue to hold strategy discussions throughout the PSNI single agency investigation to ensure that the protection plan is reviewed and those involved are updated on the progress of the PSNI investigation.

11.14 Joint Agency Investigations

Refer to Protocol for Joint Investigation of Adult Safeguarding Cases (2016).

In cases where an investigation is proceeding under the Protocol, clarity should be sought at the strategy meeting as to whether any element of a Trust protection investigation can commence (to include review of documentary evidence; meeting with adult in need of protection; meetings with witnesses; meetings with the person alleged to have caused the harm) in parallel with the PSNI investigation. Criminal investigations by the PSNI will take priority over all other investigations. Any internal investigation should not proceed without the knowledge and agreement of the

PSNI. This will ensure that the criminal investigation is not jeopardised or prejudiced by internal enquiries.

11.15 HSC Trust Single Agency Investigation

Where the decision is taken to continue with a single agency HSC Trust investigation under the protection procedures, the DAPO will be responsible for the management of the protection investigation, including the following::

14.2. The appointment of a HSC Investigating Officer(s).

14.3. Ensure the adult in need of protection is aware of the allegation of abuse;

14.4. Ensure the wishes of the adult in need of protection are recorded;

14.5. Agree methodology and terms of reference for the investigation. This should reflect agreed management of other possible forms of harm which may become apparent during the investigation.

14.6. Is the response proportionate?

14.7. Agree documentation to be reviewed.

14.8. Consider needs of other adults at risk/children.

14.9. Consider HR/other investigatory processes. If there are going to be a number of investigations, running alongside adult protection, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place.

14.10. Identify an indicative timeframe in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion without undue delay.

14.11. Is there any medical evidence or record of the impact of the abuse?

14.12. Has there been a disclosure? Is it signed and dated?

14.13. Have the human rights of both the adult in need of protection and the person alleged to have caused the harm been considered?

14.14. Is there any documentary evidence available? E.g. bank statements, accident reports.

14.15. Has the adult in need of protection been contacted about the alleged abuse?

14.16. Have the holistic ‘best interests’ of the adult in need of protection remained paramount in the decision making process?

14.17. Have the wishes of the adult in need of protection been recorded?

- Has the adult in need of protection's capacity to consent been considered and is there any report regarding capacity where appropriate?
- Are there risks to other adult in need of protection or children? If so, agree a referral to the children's services and who will make the referral.
- Have appropriate regulatory and professional bodies been informed, e.g. RQIA, NISCC?
- Has consideration been given to notifying other relevant agencies, e.g. other departments, trusts, providers?
- If the alleged offender is an employee Human Resources should be consulted.
- Has consideration been given to ensuring appropriate supports are available for the adult in need of protection accounting for cognitive ability, comprehension and communication needs?
- Has consideration been given to appropriate supports for carers during the investigation?
- Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these.
- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- Agree how communication will be maintained during the investigation.
- Identify who will be the responsible person within each participating organisation for any agreed actions.
- If the situation indicates that the adult in need of protection is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the DASH risk assessment and make the referral (NB The MARAC process does not replace the Adult Protection process, but adds benefit to any risk assessment).
- If the alert was made by a service user or a member of the public about abuse or neglect within an organisation, the organisation's complaints procedure may form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the

complaints process is suspended pending the outcome of protection investigation.

Agree the need for further strategy reviews during the investigation and agree dates.

• Stage Three: Investigation/Assessment

12.0 Purpose of the Investigation

A single agency adult protection investigation is a professional assessment which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

The purpose of the investigation is to:

- Establish the facts and contributing factors leading to the referral.
- Determine and manage the level of risk to an adult in need of protection and or others and update the care and protection plan as required.

The investigation must:

- Be open to the possibility of the presence of other forms of harm.
- Reflect the wishes of the adult in need of protection
- Produce an investigation report.

12.1 The Investigating Officer Role

The Investigating Officer will:-

- Meet with the adult in need of protection and carer/relative separately where appropriate to establish the preliminary information.
- Investigate allegations and concerns when appointed by DAPO. The investigation should take the form of an assessment of risk and needs. This will inform the review and updating of the interim protection plan.
- Inform the adult in need of protection of expressed concerns and the adult protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.

- Inform the adult in need of protection of his/her rights to protection under law.
- Support the adult in need of protection through the assessment process.
- Keep the adult in need of protection, or their representative, informed and updated throughout the investigation process to ensure informed decision making.
- Consider whether there is a need to refer the person alleged to have caused the harm on for professional input and support.
- Commission medical or other specialist assessments, where appropriate.
- Inform and liaise with relevant professionals and significant others.
- Investigating officer may require other information, action and support from other disciplines, agencies and organisations to assist with and adult protection or criminal investigation.
- Make a clear record of the investigation process.
- Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- Provide an investigation report for a case conference/review. This report must include an analysis of the findings and a conclusion and recommendations.
- Keep personally identifiable information concerning the adult in need of protection, the person causing the harm and any third parties to a minimum.
- Ensure the implementation of any care and protection plan as agreed with the DAPO.

12.2 The Investigation Report

The investigation report must clearly set out the following:

- Context of the referral and detail of the alleged concerns;
- A pen picture of the adult in need of protection and his/her circumstances, including formal and informal networks of support.
- An assessment of the adult in need of protection's capacity to consent.
- Information about the person alleged to have caused the harm.
- A brief account of the methodology for the investigation.
- The investigation findings, including:

a professional assessment of the impact of the harm on the adult in need of protection **AND**

analysis of the evidence giving consideration of the impact of decisions on the person's rights and the need to balance competing rights as positively as possible


The report must reach conclusions on the balance of probability, determining whether harm occurred.


Make recommendations where appropriate.

12.3 Undertaking the Investigation

Timescales

The Investigating Officer will make contact with the adult in need of protection and begin the investigation immediately following receipt of the referral and an initial discussion with the DAPO. The investigation should be conducted without undue delay. The Investigating Officer must keep the DAPO informed of the progress of the investigation and any change to the investigation plan. If for any reason the investigation plan cannot be completed within the agreed timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached between the DAPO and other relevant organisations and clearly recorded.

The DAPO can take a professional decision to close the investigation process where additional information identified throughout the investigation demonstrates that there is no requirement to proceed with a protection investigation. The DAPO must communicate the rationale for closing the investigation in writing to the strategy planning group. Any disagreements should be recorded on the regional adult protection closure documentation.

12.4 If the Adult in Need of Protection Moves During the Adult Protection Process

The DAPO must:

17. Contact and reach agreement with a senior manager or DAPO in the new host Trust about future action, roles and responsibilities.
18. Send fully documented and relevant information and summaries as appropriate.

Other organisations that have been involved in the investigation must also be advised if the adult need of protection has moved to another area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently.

12.5 If the Person Alleged to Have Caused the Harm Moves During the Adult Protection Process

If the person allegedly causing the harm is an informal carer or member of the public, any information on a change of address or location should be shared with the PSNI. If the person allegedly causing the harm is a paid worker or a volunteer, the line manager should also follow appropriate Human Resources advice.

12.6 If a Referral or Complaint is Received After an Adult in Need of Protection Has Died

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required.

If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

12.7 Resolution of disagreements

Where there are disagreements at any stage in the process that cannot be resolved by discussions between those responsible for decision making, these should be escalated to senior managers within the HSC Trust and/or PSNI, who will make a determination. At all times participating agencies should avoid delay resulting from

inter-agency disagreement and ensure that the wellbeing of the person in need is prioritised.

13. Stage 4 Implementation / Protection planning

Following the completion of the final draft investigation report consideration must be given by the DAPO to the most appropriate method for sharing and agreeing the final outcomes of the investigation and the process for managing the next steps or recommendations with the adult in need of protection.
The forum for decision-making and managing any outstanding risks must be carefully considered and fully person-centred. It might involve, for example, a risk management meeting, a Family Group Conference, a family meeting held in the person's own home a case discussion or a case conference.

When the adult in need of protection lacks capacity, the DAPO must take the complexity of the case and interagency involvement into consideration when deciding on the most appropriate forum for sharing information and agreeing the protection plan.

13.1 Planning the Meeting

The case conference meeting should take place after the completion of the protection investigation. Some parallel investigations may not be completed, for example, a criminal prosecution or Human Resources process but this should not be considered grounds to delay the meeting. The DAPO should ensure that a suitable meeting is convened without undue delay. The DAPO will Chair and ensure arrangements are in place to have the meeting minuted. The Investigating Officer should submit their investigation report to the Chair of the case conference prior to the meeting. Copies will also be made available to all attendees. Representatives invited to and attending the meeting should have the delegated authority to agree to provide services to contribute to the reviewed protection plan if their organisation has a role to play.

13.2 Purpose of the Case Conference

The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability (see above).

The aim of this meeting is to:

- Consider the information contained in the investigating officer's report.
- Consider the evidence and, if the allegation of abuse/serious harm is substantiated, plan what action is indicated.
- Agree and plan further action(s) if required.
- Consider whether there are legal or statutory actions indicated.
- Make a decision about the levels of current risks to the adult in need of protection or others and a judgement about any likely future risks.
- Analyse and evaluate the findings of the investigation report and agree a consensus decision as to the conclusions reached; i.e. substantiated; unsubstantiated; partially substantiated; inconclusive. Record any disagreements/amendments within the minutes of the meeting.
- Agree an ongoing protection plan if required including how this will be reviewed and monitored.

These aims must be met irrespective of whether the meeting is a formal case conference or a meeting with the adult in need of protection within their family home.

13.3 Sharing the report

The content of the draft report and care and protection plan should be shared with the adult in need of protection and their family where appropriate prior to the case conference in order to ascertain their views on the findings and reflect these at the case conference.

A copy of the draft report should also be shared with the person who was alleged to have caused the harm and the relevant employer where the person is a member of staff. This provides an opportunity for a right to reply and the report may either be amended to reflect comments, correct inaccuracies, or to register disagreements. Any decision not to share this draft report must be recorded including the rationale for this decision.

When deciding to share the draft report, the DAPO should carefully consider any possibility of escalating risk to the adult in need of protection or others inclusive of

staff whistleblowing requirements. The rationale for all decisions must be recorded by the DAPO.

All parties, where appropriate, have a right to a copy of the **final** written investigation report except where to do so would place the adult in need of protection or others at greater risk of harm. The adult in need of protection and provider organisations should be advised of the confidential nature of the report.

13.4 Outcomes of the Case Conference

The meeting must reach a decision, based on the balance of probabilities, as to whether the harm occurred. The meeting must agree whether there is a need for an ongoing protection plan with associated roles and responsibilities for implementation t agree any recommendations that should be taken forward. The meeting must make a decision as to whether the case should be closed under Adult Protection Procedures.

The protection plan will focus on the adult in need of protection. Actions arising in relation to the person causing the harm should be taken forward by the keyworker under normal care planning arrangements.

Possible recommendations of the case conference may include the following:

- The case conference should consider requirements to refer to other regulatory or professional bodies.
- Consider any systemic, contractual or practice issues that must be referred to the relevant organisation for action.
- Consider the need for further or additional information to be shared with Human Resources.

13.5 Minutes

The minutes record the decisions of the meeting and evidence how these decisions were made. The minutes will be shared with those present and those contributing to the protection plan. The protection plan will be attached to the minutes of the meeting.

Where the adult in need of protection has not been in attendance at the meeting the outcome should be shared with them as soon as possible and the protection plan discussed and agreed. If the person does not have capacity, a decision should be made in their best interests and shared appropriately.

Where there is information that cannot be shared outside the case conference meeting, it should be redacted from versions of documents sent out. It is imperative that Data Protection Act 1998 principles are adhered to. Whether or not minutes of the meeting are shared with the adult in need of protection, the DAPO will decide the best person to feed back to them on the outcome of the meeting. This should take place as soon as possible afterwards. The adult in need of protection should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed/agreed.

13.6 Feedback to the Person Alleged to Have Caused the Harm

A decision must be made in the meeting about what feedback should be provided to the person alleged to have caused harm and the organisation that employs that person (if relevant), as well as who should provide it. Due consideration must be given to any potential risk this might pose to the adult in need of protection. The rationale for any decision not to feedback to the person alleged to have caused the harm must be clearly recorded and agreed by the case conference. If the person alleged to have caused the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

14. Stage Five: Monitoring/Review of the Protection plan

14.1 Purpose of the Review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed. Additional concerns of abuse or neglect would be considered as a new alert/referral.

The review should

- Review the risk assessment
- Decide about ongoing responsibility for the protection plan

- Decide, in consultation with the adult need of protection or their personal representative, what changes, if any, need to be made to the protection plan to decrease or manage the level of risk
- Decide whether there is need for a further review and, if so, set a date
- Decide whether to close the Adult Protection Plan.

14.2 Recording and Feedback

- Record any decisions, agreed actions and those responsible for contributing to the implementation of the protection plan.
- Ensure that all involved in the review of the protection plan have a copy of the review notes, including the adult in need of protection or their personal representative (with the permission of the adult in need of protection and where it is safe and appropriate to do so).
- Reach agreement about feedback arrangements, in accordance with the adult in need of protections best interests, if they do not have mental capacity and do not attend the review. This feedback should be provided as soon as possible after the review meeting.

15. Stage Six: Closing the Adult Protection Process

The Adult Protection process may be closed at any stage if it is agreed that further investigation is not needed or if the investigation has been completed and a protection plan is agreed and put in place. In most cases a decision to close the Adult Protection process is taken at the case conference or case conference review where the protection plan is reviewed.

The DAPO must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. Where there is disagreement this should be escalated to the senior managers within the relevant organisations for resolution. The closing process must be signed off by the DAPO and/or a Senior Manager in the case of a serious/complex Adult Protection situation.

15.1 Actions on Closing

The DAPO should ensure that, on conclusion of the process:

- All necessary and agreed actions are completed or are in progress.

- Case records contain all relevant information and forms are satisfactorily completed.
- The person in need of protection knows that the process is concluded and where/who to contact if they have any future concerns about abuse.
- Responsibility for the review of the protection plan transfers to the operational team.
- All those involved with the person are informed about the closure and know how to re-refer if there are renewed or additional concerns.
- Referral is made to appropriate professional and regulatory bodies and/or notifiable occupation schemes where necessary.
- The referrer is notified of completion.
- The necessary monitoring forms and all data monitoring systems are completed.

16. Investigation of Large Scale, Organised or Multiple Abuse Cases

A large-scale adult protection investigation is likely to involve a range of organisations and potentially a number of individual adult protection interventions. 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 person alleged to have caused the abuse 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 of abuse.

Such abuse occurs 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 or community 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 become involved; its investigation is time-consuming and demanding work which requires specialist skills from PSNI and HSC Trust staff.

Each investigation of organised or multiple abuse will be different, according to the

characteristics of each situation and the scale and complexity of the investigation. 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. However, every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) in need of protection and the adult(s) at risk involved.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Gateway Service DAPO must immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, **if it is considered necessary,** establish a Strategy Management Group (SMG) to oversee the process of investigation. Core members of an SMG are:

- PSNI;
- HSC Trust DAPO;
- a senior manager from the relevant HSC Trust 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.

16.1 Functions of the Strategic Management Group

The SMG will:

- Establish the principles and practice of the investigation and ensure regular review of progress against that plan;
- Prioritise and allocate expedient resources to establish an Investigative Team within their respective agencies;
- Ensure co-ordination between the key agencies and the Investigative Team within the HSC Trusts and PSNI. This includes resolving any interagency operational interface challenges between various established processes;
- Ensure decisions of the strategy planning group are actioned in a timely manner;

- Act in a consultative capacity to those professionals who are involved in the investigation;
- Draw up a media strategy to respond to public interest issues and agree who will take responsibility for responding to media enquiries;
- Have oversight of the agreed communication strategy/liaison with adults in need of protection/families and carers involved in the 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;
- The closing process must be signed off by the SMG in the case of a serious/complex Adult Protection situation.

16.2 Working Across Trust Boundaries

It should be recognised that there may be an increased risk to the adult in need of protection whose care arrangements are complicated by cross boundary considerations. These situations may arise in residential, nursing or hospital placements where funding or commissioning responsibility lies with one HSC Trust (Placing), but the concerns about potential harm or exploitation subsequently arise in another Trust area (Host).

The scenarios most likely to arise in cross boundary adult protection investigations are:

Scenario A: where allegations relate to one individual only, in which case the responsible Placing HSC Trust undertakes the investigation and informs the Host HSC Trust of the concerns and outcomes for information and any necessary relevant contractual actions.

Scenario B: If, during the course of the investigation, there are emerging concerns about systemic practice potentially leading to harm for other residents, the Placing Trust must notify the Host Trust. The Host Trust must assume responsibility by convening a strategy meeting with a view to extending the investigation.

Scenario C: If an incident arises within an acute hospital it is the responsibility of the DAPO within that acute setting to respond by taking any necessary immediate actions and referring to the Trust of residence as appropriate. If the disclosure

relates to an incident prior to admission, the DAPO will link with the resident Trust to respond as appropriate.

16.3 Responsibilities of the Host Trust

The Host Trust will always take the initial lead on responding to a referral. This will include taking any necessary immediate action to protect the adult/s in need of protection, and where appropriate, making initial contact with the PSNI. Where there are concerns regarding more than one adult in need of protection the HSC Trust where the harm occurs will have overall responsibility for co-ordinating the adult protection investigation.

In all cases, it is vital that, when a referral is received, there is open communication between Host and Placing Trusts to ensure that:-

- Any immediate risks are identified and acted upon;
- There is a single, timely response to the referrer;
- Strategy discussions to co-ordinate the investigation are commenced without delay; and
- The individual's on-going case management needs are addressed.

The Host Trust will also co-ordinate initial information gathering, including systems checks to determine services that have been or are involved and ensures prompt notification to any other relevant agencies.

It is the responsibility of the Host Trust to identify all adults at risk within a regulated facility or service who may have been victims of the person alleged to have caused the abuse and to notify the Placing Trusts, or where the adult at risk's usual place of residence is outside Northern Ireland, the relevant Local Authority in Great Britain or the Health Service Executive in the Republic of Ireland. This includes those adults at risk not known to any HSC Trust.

In those instances where Joint Protocol/ABE social work interviewers are required these will be provided by the Placing Trust or by agreement with the Host Trust.

16.4 Responsibilities of the Placing Trust

- Attend any Strategy Meeting(s).
- Identify the Investigating Officer who will be part of the wider investigation team.
- Provide any necessary support and information to the Host Trust in order for a prompt and thorough investigation to take place.
- Exercise a continuing duty of care to the adult at risk/in need of protection.
- Inform families of investigation and ensure ongoing communication as agreed throughout.
- Devise and implement an Individual Protection plan.
- Act on the case conference recommendations.

Appendices

Appendix 1

References

Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy. Department of Justice (2012)

Adult Safeguarding: Prevention and Protection in Partnership
Department of Health Social Services and Public Safety and Department of Justice (2015)

Northern Ireland Adult Safeguarding Partnership Training Framework
NIASP (2016)

Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy
Department of Health and Department of Justice (2016)

Protocol for Joint Investigation of Adult Safeguarding Cases
NIASP (2016)

Appendix 2

Glossary of Terms

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'. Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

ABE (Achieving Best Evidence) Interviewer – The Specialist Achieving Best Evidence Interviewer must be a professionally qualified Social Worker. The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding cases" and "Achieving Best Evidence in Criminal Proceedings."

Adult Protection Gateway Service – is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.

Adult Safeguarding - encompasses 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.

Adult at risk of harm – A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

i) **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*);

and/or

ii) **life circumstances** *(may include, but are not limited to, isolation, socio-economic factors and environmental living conditions).*

Adult in need of protection - An adult at risk of harm (above):

i) who is **unable to protect** their own well-being, property, assets, rights or other interests;

and

ii) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

ASC (Adult Safeguarding Champion) - The ASC should be within a senior position within the organisation and should be suitably skilled and experienced to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Case Conference - The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability.

CRU (Central Referral Unit) – The central point of referral to PSNI in relation to adult protection is based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland) - an independent legal 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.

Domestic 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.

Designated Adult Protection Officer (DAPO) – the person 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 service teams. The DAPO will provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer; 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.

DBS (Disclosure and Barring Service) - helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Exploitation - 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.

FGC (Family Group Conferencing) - A family group conference is a process led by family members to plan and make decisions for a person who is at risk. People are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

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.

Harm - 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.

Investigation Officer (IO) - is a HSC Trust professionally qualified practitioner. Their role is to establish matters of fact, how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer alongside relevant professionals will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

The Protocol – (Protocol for Joint Investigation of Adult Safeguarding Cases) - - 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 (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.

Modern Slavery - 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.

NIASP (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.

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

NMC (Nursing and Midwifery Council) – is the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. NMC sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

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.

Registered Intermediary - RIs have a range of responsibilities intended to help adult witnesses who are in need of protection, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

RQIA (Regulation 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.

SAI (Serious Adverse Incident) - an adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people.

Serious Harm – is a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome.

Single Agency Investigation – a single agency adult protection investigation is a **professional assessment** which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

Special Measures - the measures specified in the Criminal Evidence (NI) Order 1999, as amended, which may be ordered in respect of some or all categories of eligible witnesses by means of a special measures direction. The special measures are the use of screens; the giving of evidence by live link; the giving of evidence in private; the removal of wigs and gowns; the showing of video recorded evidence in chief, and aids to communication.

SMG (Strategic Management Group) – has responsibility to oversee the process of investigation. Core representatives of SMG are: PSNI; HSC Trust nominated Adult protection Gateway DAPO; a senior manager from the relevant adult programme of care; and RQIA (where the allegation relates to a regulated service).

Strategy Meeting - In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts.

Appendix 3

HSC Trust Adult Safeguarding Contact Details

HSC Trust	Adult Safeguarding Number
Belfast	028 9504 1744
Northern	028 2563 5512
Western	028 7161 1366
South Eastern	028 9250 1227
Southern	028 3741 2015/2354

Regional Emergency Social Work Service (RESWS)

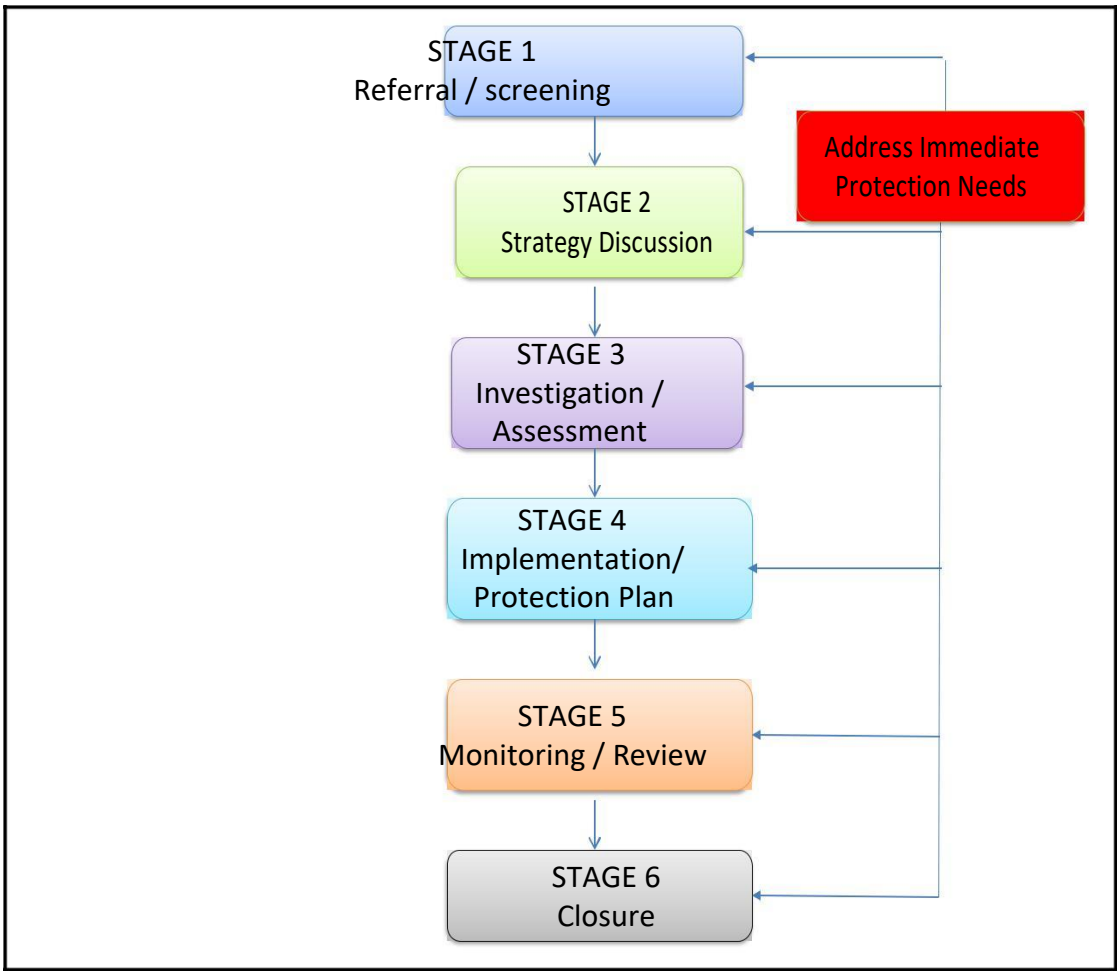
Tel: 028 9504 9999 (Mon-Fri 5pm-9am; Saturday & Sunday)

HSC Trust Child Protection Contact Details

HSC Trust	Child Protection Gateway Number
Belfast	028 9050 7000
Northern	0300 1234 333
Western	028 7131 4090
South Eastern	0300 1000 300
Southern	0800 7837 745

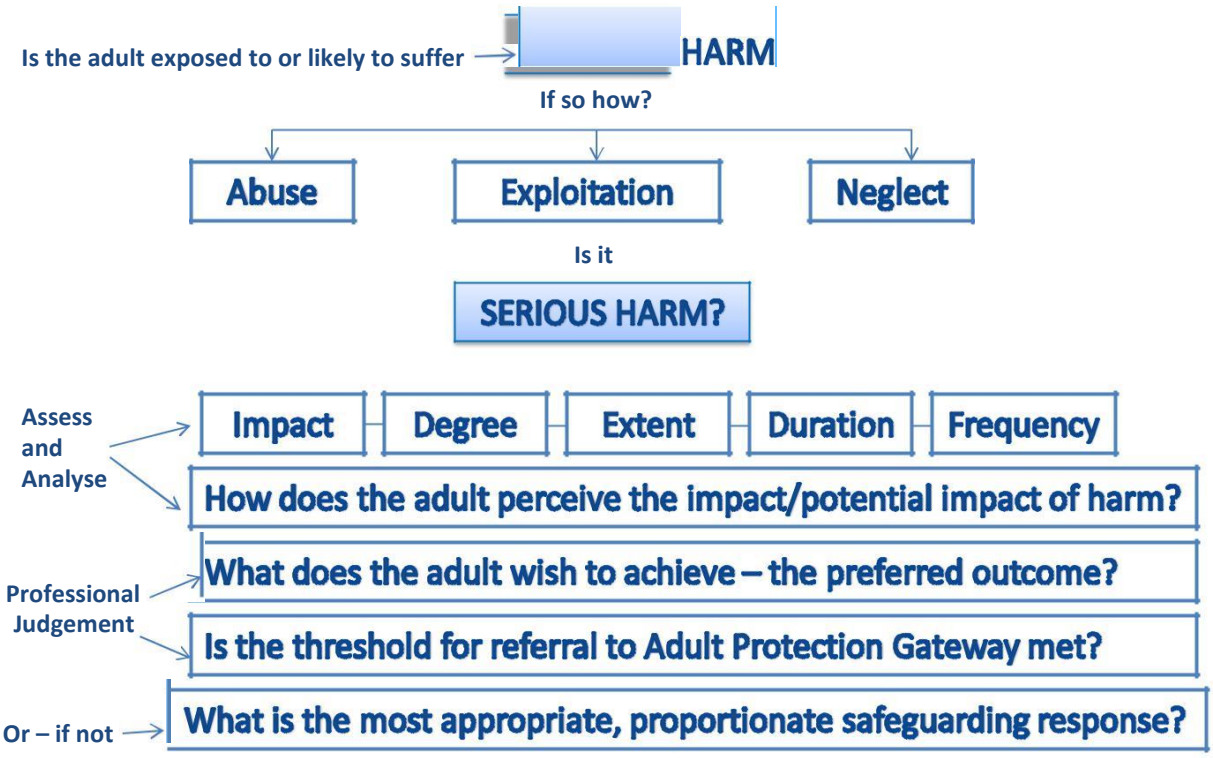
Appendix 4

Six Stages of Adult Protection Process



Appendix 5

Factors for Consideration in Determining whether Harm has become Serious Harm



Appendix 6

Possible Outcomes

Possible Outcomes for the adult in need of protection	
Protection Plan	**Actions**
Increased monitoring	Referral to advocacy service
Removal from property	Referral to counselling services
Application to the Office of Care and Protection	Assessment/support/advice/services
Application to change Appointee-ship	Referral to MARAC
Referral under the "Family Homes and Domestic Violence (Northern Ireland) Order 1998" re use of non-molestation or Occupancy Order	Seek legal advice regarding use of "The Mental Health (Northern Ireland) Order 1986" Guardianship; or application to the High Court for a Declaration of Best Interests
Review of Self-directed Support/Direct Payments	

Possible outcomes for the person alleged to have caused the harm	
Protection Plan	**Actions**
Referral under Joint Protocol Procedures	Assessment/support, advice, services
Removal from property	Continued monitoring
Management of access to adult in need of protection	Counselling/training
Action by RQIA	Disciplinary action
Action by contract compliance	Referral to a regulatory/Professional body/ISA
	Referral to court-mandated treatment
	Referral to PPANI
	Action under “The Mental Health (Northern Ireland) Order 1986”

Appendix 7

HSC Trust 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. The decision regarding the most appropriate professional to undertake the assessment will be determined by the nature of the need/risk identified, for example where the concern relates to pressure ulcers the most appropriate professional to assess and respond is likely to be from nursing and/or tissue viability.

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 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.

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 having carried out a professional assessment they should escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust.

Consideration must also be given to the vulnerability of the person who is alleged to have caused harm. It is possible that a risk assessment may also be required for the person who is alleged to have caused harm.

Appendix8

Adult Protection Regional Documentation

APP1 FORM

REGIONAL ADULT PROTECTION PROCEDURES

APP1(a) REFERRAL / SCREENING INFORMATION

For completion by HSC staff and contracted providers

PLEASE ENSURE SECTIONS 1 & 2 ARE FULLY COMPLETED BEFORE REFERRAL TO TRUST DAPO

Name:	Date of Birth: *(if not known, please give approximate age)*	Date of Referral:
Address: Postcode:	Gender: M ☐ F ☐	Service/Client Group:
Telephone No:	Is the person known to the Trust? Yes ☐ No ☐	Reference No:

SECTION ONE

Section 1 – completed by Referrer

Source Of Referral			
☐ Carer	☐ Other Trust	☐ RQIA	☐ Regulated Care Home
☐ GP	☐ Other Health Professional	☐ Adult Mental Health Unit	☐ Other Regulated Facility *Specify*
☐ Hospital Staff	☐ Anonymous	☐ Self	☐ Learning Disability Hospital
☐ PSNI	☐ Social Worker	☐ MARAC	☐ Other *Specify*
☐ DHSS	☐ Care Manager/Care or Homecare Worker	☐ Adult Safeguarding Champion	
☐ Vol. Organisation	☐ Housing Association	☐ Acute General Hospital	

Details Of Referrer (*the person who brings the concerns to the attention of your agency*)	
Name:	Relationship to adult at risk of harm:
Job title and agency:	Contact number:

Who Was The First Person To Note Concern		
Name:	Relationship to adult at risk of harm:	Contact number:

APP1 FORM

Key Contacts			
	Name	Address	Contact number:
Key Worker			
Care Manager			
G.P			
Family/Carer			
Significant other			
Other			

What Is The Main Form Of Suspected, Admitted Or Known Abuse?			
☐ Physical	☐ Sexual	☐ Institutional Abuse	☐ Human Trafficking
☐ Financial	☐ Neglect	☐ Psychological	☐ Domestic Violence
☐ Discrimination	☐ Exploitation		

Incident Report

Background Information: *(To include factors precipitating referral, home circumstances, support available, including issues of capacity)*

Incident Report – Location / Date / Time of Incident *(Please give exact details of what has been reported and if appropriate include names of any witnesses and note injuries on the attached body chart)*

Details Of Any Witnesses

Name: **Name:**

Address: **Address:**

Contact No: **Contact No:**

APP1 FORM 2 | Page

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Describe The Impact Of The Incident On the Adult At Risk of Harm

The Adult At Risk of Harm Usual Living Arrangements

Does the adult at risk of harm live alone? ☐ Yes ☐ No

Does the person who is suspected to have caused harm live with the adult at risk of harm? ☐ Yes ☐ No

Is the adult at risk of harm present location different from home address? ☐ Yes ☐ No *If Yes give present location*

Have You Taken Any Action Due To Emergency Situation To Avoid Immediate Serious Risk?

Was immediate protection needed for adult at risk of harm? ☐ Yes ☐ No

If Yes give details:

Are there any children or other adults at risk? ☐ Yes ☐ No

If Yes give details:

Was immediate protection required? ☐ Yes ☐ No

If Yes give details:

Adult At Risk of Harm's Knowledge Of Referral

Does the adult at risk of harm know that a referral may be made? ☐ Yes ☐ No

Is the adult at risk of harm able to give informed consent? ☐ Yes ☐ No ☐ N/K

Has the adult at risk of harm consented to a referral? ☐ Yes ☐ No

APP1 FORM

Details of Person/Persons Suspected of Causing Harm		
Name:	Date of Birth:	☐M ☐F
Address:		

Does the person/persons suspected of causing harm know that an allegation has been made against them? ☐ Yes ☐No ☐ N/K

Is the person/persons suspected of causing harm known to the adult at risk of harm? ☐Yes ☐ No ☐ N/K

If yes please specify below:

☐ Family member ☐ Another service user ☐ Paid carer ☐ Trust employee

☐ Other *(specify)*

Any Additional Information Relevant To The Referral
(Please note the views of others you have consulted and note any difference of opinion)

Signature:	Date:

SECTION TWO

Completed by Appointed Person

Have 'Alerts' been checked to establish if previous APP1s are recorded? ☐ Yes ☐ No ☐ N/K

Have previous APP1 alerts been recorded? ☐ Yes ☐ No ☐ N/K

If yes give summary of previous APP1s

Actions Agreed By Appointed Other

Further information required prior to a decision being made and If yes, What information is required and who will action ☐ Yes ☐ No

Answer EITHER

(a. HSC Trust Line managers)

Consultation with core team DAPO re adult at risk of harm ☐ Yes ☐ No

OR

(a. Adult Safeguarding Champion managers)

Consultation with key worker if known / or Adult Protection Gateway service re adult at risk of harm ☐ Yes ☐ No

Referral of Adult in need of protection to Trust Adult Protection Gateway Services ☐ Yes ☐ No

No further action under Adult Protection Procedures ☐ Yes ☐ No

Is there a need to refer to or notify?

☐ Professional Community Assessment ☐ Quality Assurance Team ☐ Care Management

☐ Contracts ☐ Human Resources ☐ Adverse incident reporting ☐ RQIA ☐ PSNI

Is there a need to consider any immediate Human Rights issues? ☐ Yes ☐ No

(Please refer to drop down of Convention Human Rights or manual form)

Details of Decision Making

This should prioritise issues of Risk/ Harm/ Possible Criminal Offence

Signature:	**Date:**

APP1(b) - Initial Screening by Trust Adult Protection Service

SECTION THREE

- *Section 3 – completed by Trust DAPO*

Outcome of Initial Screening and Actions Agreed by DAPO under Adult Protection Procedures	Date:
Details of Decision Making	

☐ Referral does not meet criteria for Trust Adult Protection Procedures
☐ Decision pending further information
☐ Referral forwarded to Trust core team for investigation as Adult at Risk of Harm
☐ Referral accepted for Investigation under Adult Protection Procedures
☐ Referral being considered under Joint Protocol

Are there any considerations for allocation of referral?

Has the adult in need of protection any preferences relating to who should carry out the investigation? *(e.g. gender)* ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Has the adult in need of protection any special requirements? ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Are there issues of safety for the worker? ☐ Yes ☐ No ☐ N/K
If Yes, state what safeguards are in place

Will the service user (adult in need of protection) be visited on the same day as referral received? ☐ Yes ☐ No
If no, state reasons

APP1 FORM

Details of Decision Making

Is immediate action required to protect the adult in need of protection?

Urgent medical attention required?	☐ Yes	☐ No
Additional care resources or staff required?	☐ Yes	☐ No
Protection or respite admission required?	☐ Yes	☐ No
Any other action required	☐ Yes	☐ No

Details of decision making:

Is there a possible criminal offence? ☐ Yes ☐ No ☐ N/K

Is there a need to preserve possible forensic evidence? ☐ Yes ☐ No

Is there a need for immediate report to the PSNI? ☐ Yes ☐ No

Is Joint Agency Consultation required? ☐ Yes ☐ No ☐ Pending more information
If Yes, please complete AJP1

Outcome of Report to PSNI / Joint Agency Consultation: *(Lead agency to record all decisions on AJP documentation)*

PSNI lead Investigation	☐ Yes	☐ No	
Trust Lead Investigation	☐ Yes	☐ No	
Joint Protocol Investigation	☐ Yes	☐ No	
PIA required	☐ Yes	☐ No	
ABE interview required	☐ Yes	☐ No	☐ N/K

Are the criteria met for Not-Reporting to PSNI? ☐ Yes ☐ No

If criteria are met for Not-Reporting complete section below:

In making the decision NOT to report to the PSNI please ensure that all criteria have been met. (ALL boxes must be ticked):

☐ The victim has capacity to make an informed decision and does not want to make a complaint to PSNI / or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf
(Refer to Joint Protocol Appendix 7 Consent/Capacity/Human Rights)

and

☐ The Trust is not required by law to make a referral to PSNI
If the incident does not meet the threshold of relevant offence under section 5 of the Criminal Law Act (NI) 1967
(Refer to Joint Protocol Appendix 2 Definition of Relevant Offence)

and

☐ It is a minor incident
A comprehensive assessment of all the factors must be taken into consideration
(Refer to Joint Protocol Appendix 8 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm)

and

☐ The situation is being managed through an Adult Protection process and/or there are other protective measures in place

Are there any Human Rights issues? ☐ Yes ☐ No
(Please refer to drop down of Convention Human Rights or manual form)

Do the RQIA need to be informed? ☐ Yes ☐ No ☐ N/K
If yes:-

Name of Inspector: **Date:**

Does the Trust need legal advice? ☐ Yes ☐ No ☐ N/K

Date of Contact:

Are there any other potential DAPOs to be consulted? ☐ Yes ☐ No ☐ N/K
If Yes give details:

Details Of DAPOS:

Name:	**Name:**	**Name:**
Trust:	**Trust**	**Trust:**
Service Area:	**Service Area :**	**Service Area:**
Contact No:	**Contact No:**	**Contact No:**

Has a discussion taken place? ☐ Yes ☐ No

If Yes record any joint working and feedback arrangements agreed between Managers/DAPOs (NB: This is critical when there is more than one Service area or one Trust involved).
Details of discussion:

Signature of DAPO:	**Date:**

HSC

APP1 FORM

Trust Adult Protection Investigation Commenced	Date:

Referral allocated to:

DAPO: Contact No:

Investigating Officer: Contact No:

Allocated By: Date:

SOSCARE ADMIN BOX: SCREENING DECISION	DO DECISION AS PER CODES
MULTIPLE INCIDENT	
NO OF CLIENTS INVOLVED	
ALLEGED ABUSE	
STAFF INVOLVED	
ADULT PROTECTION PLAN INITIATED	
DATE AP PLAN INITIATED	
LEGAL STATUS OF CLIENT	
DATE OF JOINT AGENCY CONSULTATION	
OUTCOME OF JA CONSULTATION	
DATE SCREENING COMPLETED	
REASON SCREENING COMPLETED	

APP1 BODY MAP

ADULT PROTECTION PROCEDURES

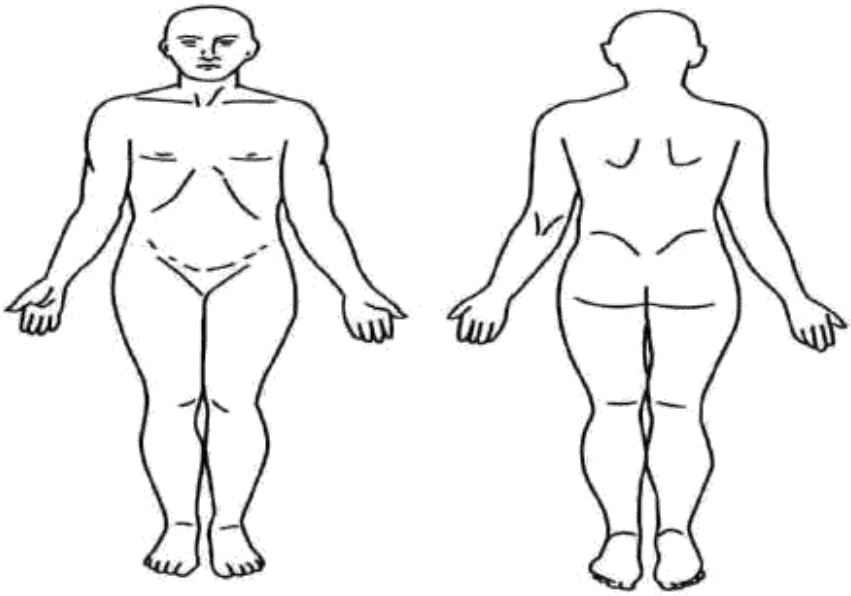
REFERRAL FORM – BODY MAP

Name: **Date of birth:**

Health & Social Care Number *(if known)*

APP1(a) Body Map is to be used in conjunction with the APP1Referral form by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care. Where used, the completed APP1(a) Body Map should be submitted with the APP1 Referral form.

Please mark with numbers drawn on the body map in black ink to indicate the different injuries, and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows (a ruler is provided to assist with measurement):



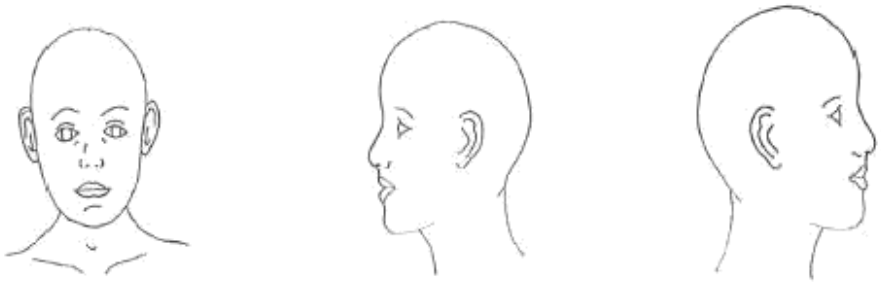
No	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments
1					
2					
3					
4					
5					
6					

APP1 BODY MAP

Body Map notes:

Note any other details, such as anything the vulnerable adult discloses on examination (verbatim), or information received from any other source regarding injuries.

Front & Side Views – Head



Number	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments

Timing of Injury:	
Date when the Injury happened *(if Known)*	
Date Injuries above were first observed *(if this is different to the original date)*	

Completed By:	
Printed Name/designation of person completing Body Map form	
Signature of personal completing Body Map form	
Contact details of person completing Body Map Form	
Date/time of completion	
(NB. When used, completed APP1 Body Map form should be attached to completed APP1 Referral form)	

APP2

REGIONAL ADULT PROTECTION PROCEDURES

ACKNOWLEDGEMENT OF REFERRAL

To be completed by the DAPO and returned to Referrer within 2 days

NAME:	ADDRESS:	DATE OF BIRTH:
		DATE OF REFERRAL:
	TELEPHONE NO:	

OUTCOME OF REFERRAL RECEIVED

Referral not appropriate for Adult Protection Investigation ☐

Adult Protection Investigation commenced ☐

Name of Designated Adult Protection Officer

Contact telephone number

Contact email address

Name of Investigating Officer (if appointed at this stage)

Address

Contact telephone number

SIGNATURE OF DAPO

DATE ☐

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

Introduction

This risk assessment and management tool should be used when a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances **AND** who is unable to protect their own wellbeing, property, assets, rights or other interest **AND** where the action or inaction of another person or persons is causing or is likely to cause him/her to be harmed. The assessment should be used to inform and support but not replace professional decision making.

Risk assessment and management planning should include key individuals that can contribute to the assessment of risk and/or the management response. This may necessitate the investigating officer commissioning specific risk assessments from relevant others which will be included in the overall risk assessment. Wherever possible this should always include the person who is at risk and in need of protection. If they decline to be involved or it is not appropriate for them to contribute, their views, as far as possible, should be included and feedback provided. If for reasons of mental capacity the person is unable to make decisions about their safety and welfare, it may be necessary to consider opinions from others who can represent them such as family, friends or an independent advocate.

List all risks that require to be considered. These are the risks that are or may leave the person open to harm through abuse, exploitation or neglect. There may be other risks that are managed effectively and therefore do not need to be included in this assessment. Sometimes the concerns emerge because of the persons at risk not accepting or engaging about the risks they are facing. If this is the case, seek to understand the reasons for this and how support can be offered in a manner acceptable to them.

The nature and degree of risk may change, over time, for a variety of reasons. It should not be assumed that the risk management plan will always remain necessary but it should at all times be proportionate, tailored and mindful of the Human rights of the person at risk and others as appropriate.

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

(To be completed by INVESTIGATING OFFICER)

SECTION 1

NAME:	**ADDRESS:** **POSTCODE:**	**DATE OF BIRTH:**
REFERENCE NUMBER:	**TEL NO.**	**GENDER:** M☐ F☐

NAME OF WORKER (S) AND JOB TITLE COMPLETING THE RISK TOOL & THOSE CONTRIBUTING TO THE ASSESSMENT

Background: *(are there factors that may mean the person is more at risk of harm from others due to personal characteristics and / or life circumstances and is unable to protect themselves. Include existing strengths and protection factors precipitating referral, home circumstances, support available, high levels of carer stress or summary / outcome of previous investigations)*

Wishes of adult in need of protection: *(is the person aware of alleged abuse? If so what is their perception of the impact/potential impact of harm? Do they understand the risks around the situation they are in? What do they see as the benefits for them in taking the risk? What protective steps do they wish to consider? Do they want to remain in their current environment? Do they wish to involve police?)*

Capacity / consent to issues under investigation: *(Please include statement as to consent of adult in need of protection for information about risks to be shared; relevant reports / opinions and bear in mind how client's capacity might be enhanced, are the views of others required?)*

APP3

Section 2. Please complete separately for each risk identified	
Current Risk of abuse / harm identified.	**Specific evidence of risk of abuse / harm**
What has been the impact of the harm on the adult's independence, health, general wellbeing?	**Specific evidence demonstrating impact**
Assess evidence demonstrating Pattern / frequency of risk of abuse / harm for each identified risk. ***(consider repeated acts of omission / neglect that compromise safety)***	**Outcome** Isolated ☐ Occasional occurrence ☐ Repeated occurrence ☐ Established pattern ☐
Evidence demonstrating probability of reoccurrence or escalation for each identified risk	**Outcome** Unlikely ☐ Likely ☐ Highly probably ☐ Certainty ☐
Assess the Severity of degree, extent and duration of risk of abuse / harm for each identified risk	**Outcome** Serious ☐ Moderately Serious ☐ Very Serious ☐ Extremely serious / Death ☐
Detail evidence which suggests the risk may constitute a potential criminal offence?(include relevant reference to coercion; threatening behaviour; abuse of trust / position)	Specific evidence demonstrating risk
Has there been an impact on other adults at risk / in need of protection or children?	☐ Yes ☐ No (If yes record what appropriate action has been taken to protect?)
Positive factors that minimise each identified risk of abuse / harm	

APP3

Section 3

Human Rights Considerations:

Identify which Human Rights have been considered:
(see attached European Convention guidance and please give details)

Risk analysis summary:

View of Professional

View of adult in need of protection / carer

Explain reasons for any disagreements to the risk assessment and by whom

Completed by: Date:

Adult in need of protection signature Date:

Carer signature Date:

Review Date:

APP4

REGIONAL ADULT PROTECTION PROCEDURES

PROTECTION PLAN

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should
Be notified to the Chairperson within 7 days: otherwise it
Will be assumed that the reports are agreed.

NAME:	DATE CREATED:	DATE OF COMMENCEMENT:	DATE OF REVIEW:

RISK	ASSESSED NEED	INTERVENTION	BY WHOM	REASON FOR NOT TAKING ANY ACTION
1.				
2.				
3.				
4.				
5.				
6.				

APP4

UNMET NEED AND UNRESOLVED ISSUES: *(If there are unmet needs or unresolved issues, identify the alternative services that have been provided)*

ARE ANY OF THE FOLLOWING ACTIONS REQUIRED (tick all appropriate boxes)

☐ *REFERRAL TO THE OFFICE OF CARE AND PROTECTION*	☐ *APPLICATION FOR GUARDIANSHIP M.H.O.*
☐ *ADMISSION TO A CARE FACILITY*	☐ *ADMISSION FOR ASSESSMENT M.H.O.*
☐ *NON-MOLESTATION ORDER*	☐ *REFERRAL TO MARAC*
☐ *DASH FORM*	☐ *CARER'S ASSESSMENT*

ADULT IN NEED OF PROTECTION / CARER COMMENTS:

WILL THIS CASE BE MONITORED UNDER THE ADULT PROTECTION PROCEDURES ☐ **YES** ☐ **NO**

IF YES, BY WHOM:

WHAT IS THE FREQUENCY OF MONITORING:

WILL THE MONITORING BE MANAGED VIA:

☐ **PROFESSIONAL SUPERVISION** **DATE**

☐ **CASE DISCUSSION/CONFERENCE DATE**

IF NO,

☐ **THE INVESTIGATING OFFICER WILL CONTINUE IN A KEY WORKER ROLE**

☐ **CASE TRANSFERRED TO OTHER KEY WORKER / SERVICE**

(please specify)

☐ **CLOSE CASE UNDER ADULT PROTECTION**

☐ **OTHER (please specify)**

ADULT IN NEED OF PROTECTION'S SIGNATURE:	**AND/OR CARER / ADVOCATE / REPRESENTATIVE'S SIGNATURE:**
DATE:	**DATE:**
KEY WORKER SIGNATURE:	**DESIGNATED ADULT PROTECTION OFFICER SIGNATURE:**
DATE:	**DATE:**

APP5

REGIONAL ADULT PROTECTION PROCEDURES

STRATEGY / CASE DISCUSSION MINUTES

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
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Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

This provides a template to record who attended the meeting, reports submitted and future review arrangements. The DAPO will also include a minute of the essential facts, discussion and decisions taken at the meeting.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:	**POSTCODE:**	**GENDER:** M ☐ F ☐
VENUE:	**DATE**	
DAPO CHAIR:		

WAS THE SERVICE USER INVITED? YES ☐ NO ☐
WAS THE SERVICE USER IN ATTENDANCE? YES ☐ NO ☐
(if not give details)

OTHERS INVITED (ADVOCATE OR CARER)

NAME IN ATTENDANCE YES ☐ NO ☐
NAME IN ATTENDANCE YES ☐ NO ☐

IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON

APP5

NAME OF THOSE PRESENT	TITLE

LIST OF APOLOGIES RECEIVED

WRITTEN REPORTS SUBMITTED BY:

Free-text Minutes

Prompt: *please evidence due consideration of Human Rights issues through completion of risk assessment.*

INTRODUCTIONS / PURPOSE OF MEETING

- *Synopsis of referral and immediate actions taken to safeguard the individual(s)*

PROFESSIONAL REPORTS

- *Key worker*
- *PSNI*
- *RQIA*
- *Human Resources(if applicable)*
- *Professional*
- *Other reports*

DISCUSSION – *Record of concerns raised and consideration given to the following as appropriate in making multiagency decisions: -*

- *Consent / capacity*
- *Undue influence / coercion*
- *Crime prevention*
- *Human Rights Considerations*
- *Best interests Concept*
- *Proportionate Response*
- *Wishes of the Adult in Need of Protection*
- *Safeguarding of other adults at risk of harm and children*
- *Supports for adult in need of protection and family through investigation process*
- *Employee Relations issues / Contracts Dept. External Providers*

APP5

INVESTIGATION STRATEGY

- *Process of Investigation – single/joint*
  (include detail of methodology – Medical / structured meetings / documentary evidence to be reviewed / Joint Interview)
- *Appointment of Investigating Officer*
- *Who will conduct interviews / structured meetings / when / with whom*
- *Requirement for ABE Joint Protocol interview*
- *Arrangements for special needs, race, culture, gender, language, communication etc.*

REVISED CARE PLAN *including Actions to be taken / when / by whom*

- *Services, treatment or therapy to be accessed*
- *Modifications in services*

REVIEW OF PROTECTION PLAN (record on ***APP4)***

- *Steps to be taken to ensure future safety, incl. When and by whom.*
- *Support services through the legal process*
- *Updated risk assessment and management including actions to be taken*

OTHER ACTIONS

- *Reporting to other bodies. I.e. RQIA, Professional Regulators, DBS*
- *Reporting back arrangements and communication strategy.*
- *Record of reasons for not proceeding where there is no significant indicator of risk or insufficient evidence to substantiate concern(s)*
- *Decision to terminate protection plan and close involvement on SOSCARE module.*
- *Date for next meeting following completion of the investigation or earlier if required.*

SOSCARE ADMIN BOX: UPDATE VA STRATEGY PLANNING		
1	Date of Meet/Discussion	
2	Type of Contact (Select from coded list)	
3	Location of incident	
4	Alleged Abuse (Select from coded List)	
5	DAPO	
6	Method of Discussion (Select from coded list)	
7	Location of Meeting	
8	Other Staff involved (Soscare number)	
9	Other Agencies (select from coded list)	
10	Initiate/Review APP	(Y ☐ or N ☐)
11	Outcome	
12	Date Next meet/Discussion	
13	Clarification Meeting	
14	Date	
15	Date of Investigation	

APP5

SOSCARE ADMIN BOX: VA CASE DISCUSSION STAGE (Complete for every Discussion/Review)

4	Other agencies involved (select from coded list)	
5	Category of abuse	
6	Outcome of case discussion (select from coded list)	
7	Has APP been updated?	
8	Date of Next Discussion/Review	
9	Termination date	
10	Reason for termination	

Signed:

Dated:

APP6

ADULT PROTECTION PROCEDURES

SIGNIFICANT SAFEGUARDING MEETING / EVENT REPORT

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
The contents of these reports are not to be reproduced, copied or divulged.

Information obtained at a case discussion is not to be discussed with or revealed to others without first obtaining written permission from the source of the information.

Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

NAME OF ATTENDEE:	ADDRESS:
(IF APPLICABLE) NAME AND POSITION OF PERSON ACCOMPANYING:	TEL. NO:
ALLEGED VICTIM REFERNCE NO:	
NAMES OF INVESTIGATION STAFF:	
DATE:	TIME: / VENUE:

PURPOSE OF THE MEETING:

(Include Boundaries of Confidentiality; whistleblowing policy & potential use of safeguarding report and information for HR processes as appropriate.)

GENERAL BACKGROUND QUESTIONS:

APP6

SPECIFIC QUESTIONS PERTAINING TO INDIVIDUAL CONTEXT:
(Open ended questions should be relevant to the aspect of care / support being provided and investigated in order to gather the individual's knowledge of the circumstances)

REPORT OF ALLEGED INCIDENT AND COMMENTS FROM THOSE PRESENT:

Summary of Action required:

- To safeguard adults; children or others:
- Is dash form required?
- To forward information to identified and agreed persons.

Signature of investigators **Date**

APP7

ADULT PROTECTION REPORT ON THE INVESTIGATION IN RESPECT OF

DATE:

Designated Adult Protection Officer:

Designation:

Report Authors:

Date report signed off:

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
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Any important omissions or inaccuracies in these reports should
Be notified to the Chairperson within 7 days: otherwise it
Will be assumed that the reports are agreed.

APP7

EXECUTIVE SUMMARY

LIST THE MEMBERSHIP OF THE INVESTIGATION TEAM. *(IO (s) and DAPO)*

INVESTIGATION TERMS OF REFERENCE (*What have you been asked to do?)*

INVESTIGATION METHODOLOGY *(How were the concerns investigated. Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.)*

PROVIDE A DESCRIPTION OF INCIDENT/CASE. *(Outline the details of the adult safeguarding concerns including any previous concerns. Include a pen picture of the adult/s in need of protection.)*

APP7

FINDINGS (*This section must include the detail and analysis of the factual evidence identified in the investigation including the source and dates of any meetings where information came to light. Detail must include the weight attributed by the IO to the seriousness of the harm /abuse and the rationale for same. Attach a copy of the risk assessment completed by the IO.*)

CONCLUSIONS (*Were the adult safeguarding allegations substantiated on the balance of probability/not substantiated etc. Include the views of the Adult in Need of Protection and/or their representative.*)

LESSONS LEARNED

RECOMMENDATIONS AND ACTION PLANNING

APP7

DISTRIBUTION LIST

APP8

REGIONAL ADULT PROTECTION PROCEDURES

CLOSURE / TRANSFER SUMMARY MEETING

PRIVATE AND STRICTLY CONFIDENTIAL

NOTE:
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Any important omissions or inaccuracies in these reports should Be notified to the Chairperson within 7 days: otherwise it Will be assumed that the reports are agreed.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:		**GENDER: M☐ F☐**
DATE OF REFERRAL:	**POSTCODE:**	

Adult Safeguarding investigation completed ☐Yes ☐No

Summary of Investigation outcomes discussed at case discussion:

AGREED ACTION

Case to be transferred ☐Yes ☐No
(if yes complete Sections One and Two)

Case closed ☐Yes *(if yes complete Section One)* ☐No

SECTION ONE (CASE TO BE CLOSED TO ADULT PROTECTION SERVICE)

Reason for Closure?	Investigation complete ☐	Client unwilling to proceed ☐
	Refer other agency ☐	Refer other process ☐

Has anyone expressed a contrary view to transfer/closure? ☐Yes ☐No

(if yes specify)

Has the service user been informed in writing? ☐Yes ☐No

Has the referrer been notified of outcome? ☐Yes ☐No

Have relevant others been informed in writing? ☐Yes ☐No

(if yes specify) (include contracts; HR; RQIA; other professionals)

APP8

SECTION TWO (ONGOING SAFEGUARDING ACTIVITY WITH ADULT AT RISK)

☐ Investigating officer will continue with a key worker role in core team

☐ Transfer to other services
(specify) _____ Date of Transfer _____

☐ Transfer to Investigating Officer in different team
(specify) _____ Date of Transfer _____

☐ Transfer to other Trust
(specify) _____ Date of Transfer _____

☐ Other
(specify) _____ Date of Transfer _____

☐ Date SOSCARE completed _____

SIGNED INVESTIGATING OFFICER	**DATE**
SIGNED DAPO	**DATE**

Form forwarded to: Care Manager ☐ GP ☐ PSNI ☐ Care Provider ☐
RQIA ☐ Client/Carer ☐ Relevant other ☐

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:
Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

Appendix 3

BHSCT Reporting Template

BHSCT REPORTING TEMPLATE

The Belfast Trust Adult Safeguarding Champion (ASC) provides strategic and operational leadership and oversight in relation to adult safeguarding for the Trust and is responsible for implementing its Adult Safeguarding Policy. The Adult Safeguarding Champion complies with the responsibilities as laid out in the Regional Adult Safeguarding Operational Procedures but has delegated the day-to-day responsibility for safeguarding to operational managers who are the appointed person(s) within the organisation. The appointed person(s) will report through to existing management structures to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Belfast Trust have adopted this approach to ensure that there are sufficient numbers of appointed persons in order that all services have easy access to appropriate advice and guidance in relation to safeguarding concerns. The following structure outlines the reporting arrangements and the process for escalation of issues of concern. Staff identifying a safeguarding concern should in the first instance report to the Facility Manager / Appointed Person.

Adult Safeguarding Champion (ASC) Structure *Reporting Structure to include escalation of concerns*

Name of Facility: _____

Name of Facility Manager/Appointed Person:

Contact Number

Name of Assistant Service Manager/Appointed Person:

Contact Number

Name of Service Manager/Appointed Person:

Contact Number

Name of Trust Adult Safeguarding Champion: **Marie Heaney**

Contact Number: 028 9504 8626

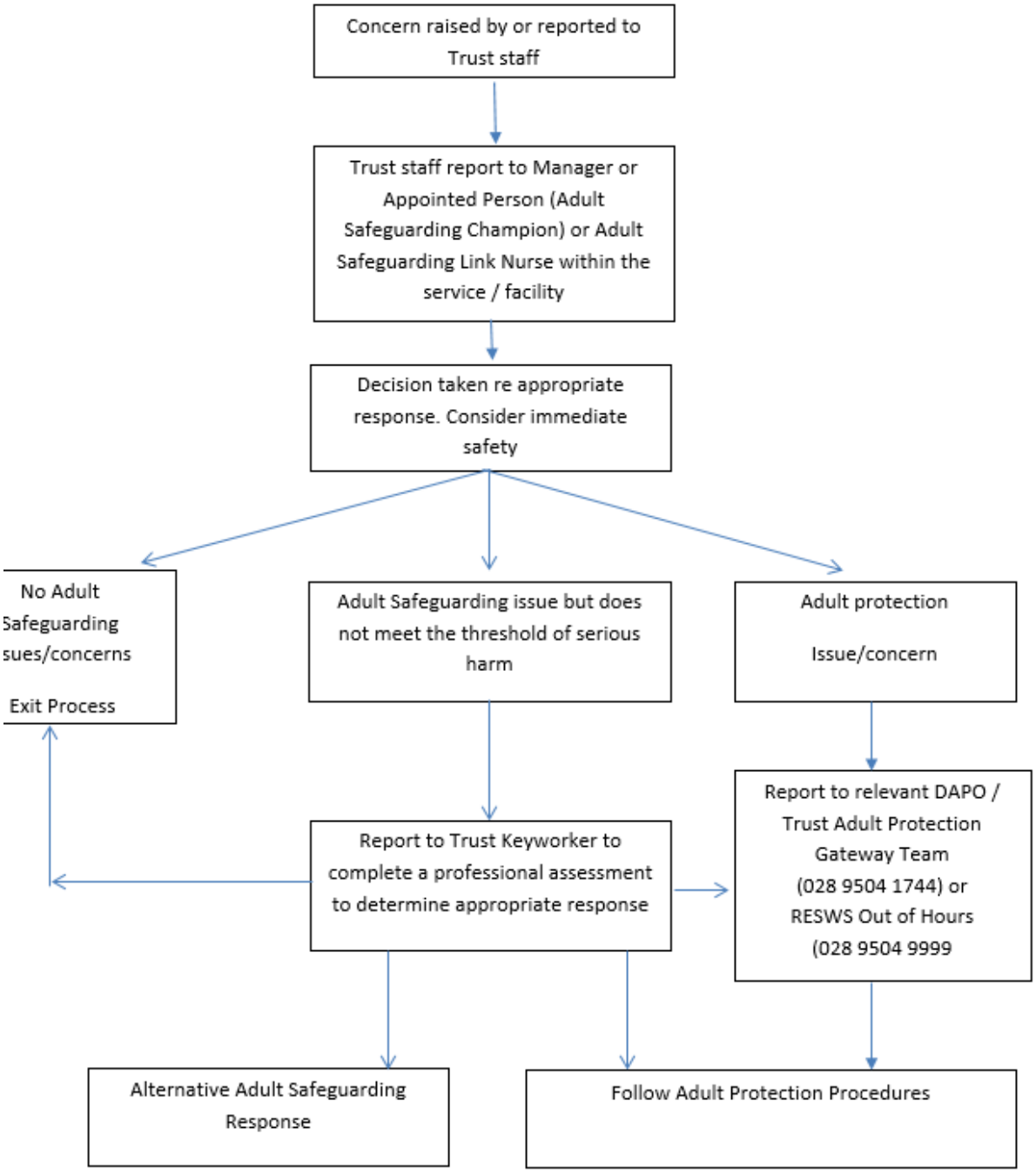
In the absence of the line manager / facility manager / appointed person, escalation should be to the next nominated senior manager. The TASS can also provide advice and guidance in the absence of the Adult Safeguarding Champion – Contact: Yvonne McKnight - 028 9504 6896

Referral pathway should be used by appointed person(s) and or Adult Safeguarding Champion.

Appendix 4

BHSCT Adult Safeguarding and Adult Protection Referral Pathway

(Sample - Information should be used to inform local service-specific Referral Pathways)



PROCEDURE FOR RESPONDING TO ADULT SAFEGUARDING / ADULT PROTECTION CONCERNS

ACTION TO BE TAKEN
• Where staff identify a concern in relation to an adult at risk of harm, they must ensure this is reported to senior staff and that service users' immediate safety is considered. This will include seeking medical attention if required. • It is important that service users' Human Rights are considered and they are informed appropriately about the need to communicate with other professionals. There will be some circumstances when it will be necessary to override the wishes of an individual to prevent significant risk, death or serious harm to the adult at risk of harm.
• In urgent cases, in the absence of the Manager/ASC, the line manager providing cover should be contacted to discuss details of the concern. Where there are immediate safety issues there should be no delay in reporting to the relevant Designated Adult Protection Officer (DAPO), Adult Protection Gateway Team (APGT) or Out of Hours Regional Social Work Team. • The DAPO, APGT or Out of Hours Regional Social Work Team will instruct on what actions need to be taken. This will include an initial judgement based on referral information regarding whether further investigation is appropriate.
Contact the Adult Protection Gateway Team on: **028 9504 1744** or Out Of Hours Duty Social Work on **028 9056 5565** to report the safeguarding concern / incident with a DAPO. This contact can be made by telephone in first instance.
• In all cases the staff member who receives the report, witnesses or suspects harm caused by abuse, exploitation or neglect of an adult at risk, should complete the first section of the ASP1 electronically on Paris. The ASP1 must then be forwarded to the named Manager/ASC. • In most instances, the line Manager/ASC will assess the information to determine whether a safeguarding response is required. If a safeguarding response IS required, the line Manager/ASC will determine whether the threshold for serious harm has been met. If so, they should then forward completed ASP1 to the relevant DAPO/APGT. In all other situations, safeguarding concerns should be referred to the relevant key worker.
Senior staff should also follow normal reporting procedures and where applicable complete a Datix Incident form and RQIA Notification of Events form.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 45/09

Title:	**Management And Prevention Of Adult Inpatient Falls In A Hospital Setting**		
Author(s)	Kirsty Beattie, Fall Safe Co-Ordinator (first point of contact for nursing) [redacted] Lynn Wightman, Nurse Development Lead, Older People's Inpatient Services [redacted] Dr Mark Cross, Consultant, General Medicine [redacted] Karen Devenney, Senior Manager Nursing, Safety and Quality. [redacted]		
Ownership:	Brenda Creaney, Nursing and User Experience Director		
Approval by:	Trust Falls Forum Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting	**Approval date:**	08/08/2019 08/10/2019 06/02/2020 12/02/2020
Operational Date:	February 2020	**Next Review:**	February 2025
Version No.	3	**Supersedes**	V2 - October 2009 – March 2014
Key words:	Falls, Trips, Slips		
Links to other policies	BHSCT Policy and Procedural Arrangement for the Prevention and Management of Slips, Trips and Falls 2018 (TP 069/11) BHSCT Manual Handling Policy and Procedural Arrangements 2018 (TP 34/08) BHSCT Management of Bariatric Patient / Client Policy 2018 (TP 034/08) BHSCT Safe Use of Bedrails Policy 2011 (SG 09/08) BHSCT Adverse Incident Reporting and Management Policy 2018 (TP 94/14) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Policy 2018 (TP 42/08) Policy for the Early Recognition and Management of a Suspected Head Injury 2018 (SG 03/09)		

Date	Version	Author	Comments
February 2008	0.1	Mary McElroy	First draft
March 2009	0.2	Mary McElroy	Second draft
June 2009	0.3	Mary McElroy	Third draft – changes to tool in light of incident. Sent to service groups and users for comment.
October 2009	1	Mary McElroy	Final version
March 2011	2	Olive MacLeod	Review of policy – change of date only
June 2019	2.1	K Devenney L Wightman Dr M Cross	Policy revised
October 2021	3.1	Kirsty Beattie	Amendment made Section 4.1

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

A 'fall' is defined by, WHO (2018) as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

Patient falls have both a human and financial impact. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and in some incidents, death. Patients, relatives and Trust staff can feel anxious and guilty which can adversely affect caring relationships.

The cost for the Trust includes the provision of additional treatment, increased lengths of stay/care, complaints and in some cases, litigation.

No single intervention when implemented on its own has been shown to reduce falls. However research has demonstrated when a multifactorial assessment and interventions are implemented by the multidisciplinary team, this can reduce the rate of falls by 20-30%, Royal College of Physicians (2012)

1.2 Definitions

Fall: An unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Slip: To slide accidently causing the person to lose their balance. This is either corrected or causes the person to fall.

Trip: To stumble accidently, often over an obstacle causing the person to lose their balance. This either is corrected or causes the person to fall.

Controlled/assisted fall: For example when a staff member attempts to minimize the impact of the fall by easing the patient's descent to the floor or by breaking the patient's fall.

Fall from height: Any level above floor level must be considered a 'height', which should the patient fall from, could result in serious injury. Examples would include, a patient falling out of bed/from a trolley, climbing out of a window, falling over a barrier.

1.3 Purpose

This policy seeks to raise and improve awareness, provide guidance and support regarding in-patient falls to **all** staff who work within the Trust (including those contracted through an agency).

Falls includes not just the actual incident of falling but includes the following:

- Assessment of all patients' to identify those at risk of falls

- To identify risks and reduce these. Risk mitigation can occur by a variety of strategies including but not restricted to; creating safer environments, patient centred components etc.
- Manage a fall when it occurs
- Monitor and learn from incidents of patients falling and subsequent service improvements.

1.4 Aims and Objectives

The aim of this policy is to ensure the safety of patients, improve awareness of falls and promote a culture of falls prevention and management being **all** staff's responsibility. The document aims to work alongside existing policies and strategies within the organisation.

The aim of the policy is to:

- Inform staff of their responsibilities in relation to the prevention and management of patient falls
- Minimise the risk of falls and harm to patients
- Set out the Trust's responsibilities for monitoring and acting on Trust wide learning from patient falls.

The policy objectives include:

- Reduce the incidents of patient falls and falls related injuries in Trust facilities.
- To identify those patients who may be at risk of falling.
- Support clinical staff so they can assess, develop and implement appropriate interventions for individual patients at risk of falls.
- Provide guidance on actions to take immediately after a fall and perform risk mitigation for the fall recurrences.
- Ensure reporting and investigation of patient falls is performed appropriately and correctly.
- Monitor and act on learning from patient falls within the Trust.

2.0 SCOPE OF THE POLICY

This policy will apply to **all** staff who work within the Trust (including those contracted through an agency).

3.0 ROLES AND RESPONSIBILITIES

Trust Board and Executive Team: are responsible for ensuring the appropriate Health, Safety, and Risk management arrangements are in place throughout the Trust.

Directors, Co-Directors, Chairs of Division / Divisional Nurses: are responsible for adherence to this policy. Ensure that all staff have the

appropriate knowledge and skills to deliver care in accordance with the policy. Provide assurance to the Trust board and Executive team that adherence to the policy is being met.

Clinical Directors, **Service Managers, Assistant Service Managers, Patient Safety & Clinical Governance Leads, Ward Manager and Nurse in Charge:** are responsible for ensuring compliance with the policy, the completion of individual patient risk assessments and the implementation of identified falls prevention measures. They must ensure that all staff have the appropriate knowledge and skills to deliver care in accordance with the policy. They are responsible for ensuring the local environment under their responsibility is managed in respect to clutter, wet conditions and maintenance risks.

All Staff: including those contracted through an agency are responsible to be aware and familiarise themselves with this policy. All staff who provide direct care to patients must adhere to this policy and ensure all patients have a risk assessment completed and falls prevention measures implemented. All staff must take a proactive approach to preventing falls.

4.0 KEY POLICY STATEMENT(S)

4.1 Policy Principles

- All patients admitted to a ward must be orientated to the layout and facilities within it. Both patient and next of kin should be given verbal/ written information (in leaflet format) and education regarding falls prevention while in hospital. This should be documented in the patient's clinical notes.

- All patients admitted to a ward must have an evidenced based falls assessment completed within 6 hours (Appendix 1).

- When risks are identified a plan of multi-professional care should be completed for the individual patient at risk of falls.

- Patients identified at risk of falls should be highlighted at ward safety briefing, multi-disciplinary meetings and at every ward handover. The use of a falls sign can be used as a visible aid to all staff to identify patients who are at high risk of a fall or those who have fallen whilst in hospital.

Please click on link below to access falls signage.
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Fallsafe%20Toollkit%202018/Forms/Fallsafe%20View.aspx

- All medicines which potentially increase the risk of falling, should be reviewed on admission. As part of the routine daily medical review the medicine Kardex should be reviewed in relationship to a patient who is at risk of falling and also those that have fallen.

- The bed height must be kept at the most appropriate height for the patient. During direct patient care bed height can be adjusted but it must be returned to the appropriate height after care is provided. For those patients who are at particular risk of a fall a low entry bed may be considered and is available from the Trust's bed suppliers.

- All Trust staff should be vigilant to any potential slips, spills or trip hazards. All Trust staff are responsible to ensure any hazards are dealt with promptly or removed. All Trust staff have a duty to ensure the patient's environment should be clutter free at all times.

- A patient, at risk of a fall or who has fallen, must have this information shared when they are internally transferring within the Trust or attending another hospital.

When a falls happens

- When a fall happens, the first person on the scene must summon appropriate help. Healthcare staff must carry out an initial assessment to detect any signs and symptoms of injuries sustained during the fall, before the patient is moved (Appendix 2, immediate post falls response chart). **This must be in line with the Trust's moving and handling policy and procedures.**

- When a fall happens within the clinical area medical staff and the nurse in charge must be informed.

- Head injury should be suspected in any unwitnessed fall. When a head injury is suspected or has occurred the patient must be managed in accordance with the early recognition and management of a suspected head injury policy. Please also see (Appendix 3).

- C-Spine injury should be suspected in any patient sustaining a head injury with GCS less than 13.

- When a patient falls and there is a suspicion of spinal injury please see and follow (Appendix 4).

- When a patient falls and there is a suspicion of a fracture please see and follow (Appendix 5).

- When a patient falls, the next of kin must be informed as soon as practical with consent from the patient if they are cognitively aware

- When a patient falls**,** the following risk assessments must be reviewed and up-dated:
  - **Falls**
  - **Bed rails**
  - **Moving & handling**

- When a patient's condition deteriorates, the following risk assessments must be reviewed and up-dated:
  - **Falls**
  - **Bed rails**
  - **Moving & handling**

- When a patient is transferred between hospital sites or wards/departments, the following risk assessments must be reviewed and up-dated:
  - **Falls**
  - **Bed rails**
  - **Moving & handling**

Post fall

- After a patient has fallen this incident must be documented in both the nursing and medical notes. An adverse incident form must also be fully completed on the Datixweb system ideally within **24** hours of the incident. **This is in line with the Trust's procedure for reporting and managing adverse incidents.**

- After a patient has fallen a post falls assessment of the patient must be performed and documented. This can be done using the Immediate Medical Assessment (Appendix 6) or documented in the medical notes.

- The incident may be RIDDOR (Reporting of injuries, diseases and dangerous occurrences regulations) reportable if the following risk assessments are incomplete or not completed within the set timeframe specified:
  - **Falls**
  - **Bed rails**
  - **Moving & handling**

- If there has been an injury sustained that results in the incident being coded with a severity of moderate or above the ward sister/nurse in charge must ensure that the following staff will be informed:
  - **FallSafe Coordinator**
  - **Patient's Consultant**
  - **Assistant Service Manager/ Service Manager**
  - **Health and Safety Team**
  - **Divisional Nurse**
  - **Co-Director**
  - **Governance & Quality Manager**
  - **Patient Safety & Clinical Governance Lead**

- When a fall is coded with a severity of moderate or above, a post falls incident review and investigation will be initiated. An internal investigation will be completed and this will help promote shared learning.

- Once completed, the Minimum Data Set for Post Fall Incident Review (IR), falls resulting in moderate or more severe harm must be attached onto section 7 of the BHSCT Incident Approval Form.

Please click on link below to access post falls review documentation to help with this process

Link:
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Fallsafe%20Toollkit%202018/Forms/Fallsafe%20View.aspx

- When a patient falls in hospital, this may have relevance for discharge planning and must be communicated to all relevant disciplines both within and outside of the hospital setting prior to discharge.

- If a visiting service user falls outside of a clinical area and sustains a moderate or severe injury, please follow (Appendix 8) to ensure appropriate actions take place.

- All falls MUST be reported and recorded on the Trust Datixweb.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy is relevant to all staff who work within the Trust (including those contracted through an agency).

The policy will be made available on the Trust intranet and distributed accordingly.

Directorates are responsible for the dissemination of this policy to ensure all staff are aware of their roles, responsibilities and actions to take.

5.2 Resources

This policy will be uploaded onto the Trust's Hub for all Trust staff to view.
A member of the Trust's Falls Forum Group will raise awareness of this policy at the monthly Safety Improvement Team (SIT) meeting and this will be cascaded to all staff via the Divisional Nurses, Co-Directors and Directors.

5.3 Exceptions

There are no exceptions to this policy

6.0 MONITORING

Safety Improvement Team
FallSafe Co-ordinator
Health and Safety Team
Governance and Quality Managers

7.0 EVIDENCE BASE / REFERENCES

World Health Organisation WHO – January 2018
Royal College of Physicians – Implementing FallSafe: Care Bundles to Reduce Inpatient Falls, March (2012).

8.0 CONSULTATION PROCESS

Divisional Nurses
Trust Falls Forum Group
Allied Health Professionals
Colin Williamson, Head Injury Liaison Nurse
Lisa McCullough, Sister, Staff and Clinical Development

9.0 APPENDICES / ATTACHMENTS

Appendix 1 The Multi-factorial assessment and interventions in a care bundle approach to reduce a fall
Appendix 2 Immediate Post Falls Response Chart
Appendix 3 Is Head Injury Suspected?
Appendix 4 Is Spinal Injury Suspected?
Appendix 5 Is Fracture suspected?
Appendix 6 Immediate Medical Assessment Post Inpatient Fall (Patients 16 years+)
Appendix 7 Appropriate actions to take if a visiting service user falls outside of the clinical area and sustains an injury graded Moderate or Severe.

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. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to

consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link:**

The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

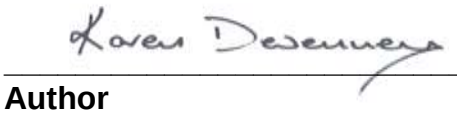
From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



12/02/2020

Author **Date:** _____

12/02/2020

Director **Date:** _____

Appendix 1

The multi-factorial assessment and interventions in a care bundle approach to reduce a fall

Bundle A is for All patients

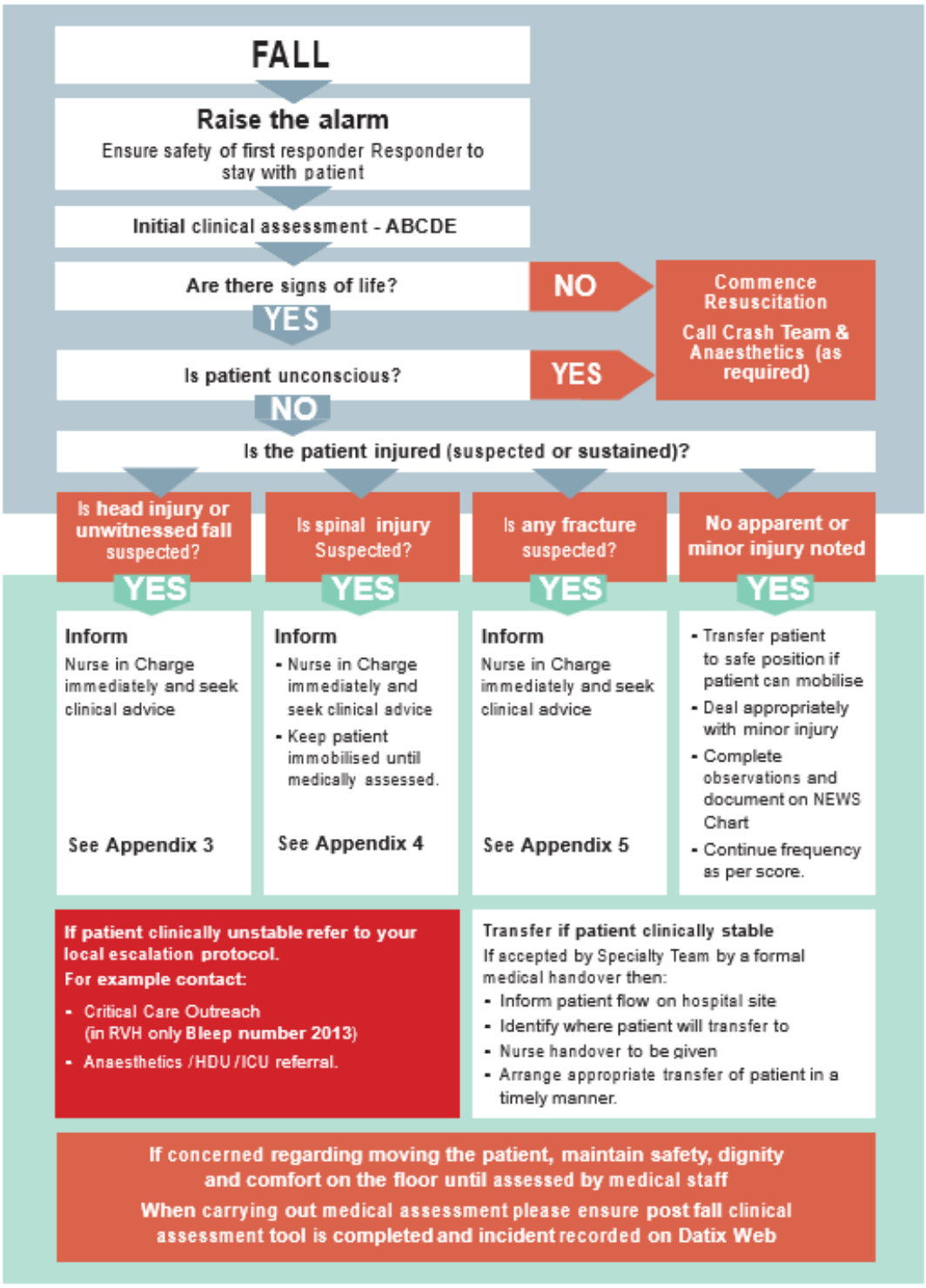
- Ask about history of falls within the last 12 months
- Ask about the fear of falling
- Urinalysis performed (At least once during this inpatient stay)
- Avoidance of prescription of night sedation
- Call bell is in sight and in reach
- Patient has safe footwear on feet
- Immediate assessment and provision of walking aids
- Clear communication regarding mobility status is recorded
- Personal items are within reach
- No slips or trips or hazards observed within patient's environment

Bundle B for All patients 65 years and over (Also patients aged 50-64 years who are judged by a clinician to be at a higher risk of falling because of an underlying condition)

- Cognitive screening performed
- A lying and standing blood pressure recorded
- Full medication review
- Bedrails risk assessment complete

Appendix 2

Immediate Post Falls Response Chart



Appendix 3

Is Head Injury Suspected?

Evidence of Head Injury, suspect C-spine injury (See Appendix 4)

Suspected head injury. Remember to suspect head injury in all *unwitnessed* falls
(Adults aged 16+)

YES

Actions: Record CNS Observations

- ½ hourly CNS observations until GCS is 15 or at baseline, then;
- ½ hourly CNS observations for 2 hours, then;
- 1 hourly CNS observations for 4 hours, then;
- 2 hourly CNS observations until reviewed by senior clinician.

THEN

Any sustained drop off *(that is for at least 30 minutes* 1 point less in GCS) requires **urgent** medical review
Note if GCS not returned to 15 by 2 hours **Inform Doctor immediately** (*See Foot Note)
(*go to last bullet point in red box on pg. 14

THEN

Assessment required if the following symptoms and/or signs are apparent:

1. GCS is less than 15 on initial assessment (unless at baseline)
2. A sustained (that is for at least 30 minutes) drop of 1 point in GCS
3. Open head wound / penetrating injury
4. Any of the following are noted or new onset neurological signs: unequal pupils, limb weakness, facial weakness
5. Visible trauma to head / face
6. Dangerous mechanism of injury (patient has fallen down more than 5 steps or more than 1 meter in height)
7. Loss of consciousness (LOC)
8. Dazed at time of injury
9. New or worsening headache
10. Vomiting post fall
11. Seizure post fall
12. New or worsening agitation or development of abnormal behaviour / confusion
13. Haematoma or bruising noted to head / face
14. Peri-orbital bruising or bruising behind ears
15. Any evidence of fluid leak from the ears or nose

YES

See page overleaf

NO

***If there is no medical or appropriate clinical team on site contact 999 ASAP and transfer patient to nearest ED**

Appendix 3 continued

Await urgent medical / other appropriate clinical review
Continue CNS observations

CT Brain should be performed within 1 hour

- If patient has a vomiting episode
- Seizure activity post fall
- GCS less than 13 on initial assessment
- Anticoagulation & GCS less than 15 or LOC or amnesia
- GCS falling or not improving
- Evidence of basal, depressed or penetrating skull fracture
- Focal neurological deficit
- Impaired coagulation
- Increased risk of bleed and or clotting disorder
- Failure to improve GCS to 15 (within 2 hours)

Discuss with Senior Clinician and CT Brain within 8 hours if GCS 15 with any of the following indicators

- Fall from height greater than 1 meter
- Fall down 5 steps or more
- Age 65 years or older with either LOC or pre / post amnesia
- Severe, persisting headache
- Pre traumatic amnesia / post traumatic amnesia greater than 30 minutes
- Antiplatelet Therapy

If GCS falls, urgent medical review from medical team must be sought and perform CT head within 1 hour

Patient not requiring imaging

- CNS observations may only stop in consultation with a Senior Clinician
- Inform patient and next of kin of head injury with appropriate consent
- Document that head injury advice has been given to the patient and or next of kin

Results discussion
Liaise with appropriate specialty after discussion with Senior Medical Team

Please consider:

- **That INR and coagulation is measured in all patients who have fallen with a head injury**
- **If patient is anticoagulated, immediate reversal after urgent discussion with Senior Clinician**
- **Following head injury, patients with congenital bleeding disorders require immediate discussion with Haematology**

Appendix 4

Is Spinal Injury Suspected?

A spinal injury should be suspected in patients with a head injury when GCS is less than 13/15 or clinical C-spine tenderness is evident (Adults aged 16+)

YES

Assessment required if the following spinal injury symptoms and/or signs are apparent

New or worsening....

- Spinal or neck pain / tenderness
- Sensation pins and needles
- Limb weakness / Numbness
- New or worsening movement of fingers, toes.

YES

In Muckamore and Knockbracken contact 999 ASAP and transfer patient to nearest ED.

- Do not move patient / commence spinal precautions.
- **Inform Clinical Team within your site.**

THEN

In the following sites: BCH, MIH, MPH and RVH, implement the following spinal precautions:

1. Locate rigid neck collar and apply.
2. Locate trauma mattress.
3. Use Scoop board to transfer patient to safe position on trauma mattress.
4. Use Hoverjack (if available / necessary).
5. Use adjuvant stabilising equipment i.e. neck blocks / tape etc.

THEN

BCH, MIH, MPH & RVH Sites:

- Arrange urgent CT Scan. Discuss with appropriate Specialty following CT results
- Follow recommended management plan.

THEN

For non RVH sites follow 1 of the 3 Pathways

Pathway 1

- Patient accepted by Specialty team, with a formal medical handover
- Inform patient flow on Hospital site
- Identify where patient will go to either:
  - Direct to specialty inpatient bed
  - If specialty inpatient bed not available contact RVH ED doctor in charge to discuss **before transfer**
- Nursing handover to be given
- Arrange 999 ambulance for patient transfer.

Pathway 2

- Abnormality of spine reported
- Conservative management recommended by Specialty
- Patient to remain on site
- Inform nursing staff of any follow up plans as per Specialty.

Pathway 3

- No spinal injury detected radiologically
- Medical team to document after Senior discussion. Remove spinal precautions and inform nursing staff of result and management plan.

Appendix 5

Is Fracture Suspected?

YES

Assessment required if the following fracture injury symptoms and/or signs are apparent:

- Any obvious broken bone including chest wall. Shortening, rotation or deformity of limb
- New or worsening pain in any limb or joint
- Inability to move any limb, joint or weight bear.

NO

- Is there a minor injury suspected eg. fractured toes or fingers
- Complete observations and document on NEWS chart
- Continue frequency as per score and assess patient for any signs of pain
- Assist patient to a safe position if patient can mobilise
- Reassess patient if any changes in condition
- Inform medical team.

YES

In Muckamore and Knockbracken contact 999 ASAP and transfer patient to nearest ED.

- Do not move patient / commence fracture precautions
- Inform Clinical Team within your site.

THEN

In the following sites: BCH, MIH, MPH & RVH, utilise the following equipment as necessary:

1. Use Emergency Handling Pack/Slide Sheets.
2. Use Hoverjack (if available/necessary). 3. Use Scoop board (if available/necessary).
4. Transfer patient to safe position. 5. Continue to monitor for signs of bleeding.

THEN

BCH, MIH, MPH and RVH Sites:

- Arrange appropriate radiological investigations
- Discuss results with Fracture doctor on Bleep number 2557
- Follow recommended management plan.

THEN

For non RVH sites follow 1 of 3 Pathways

Pathway 1

- Patient accepted by fracture team with a formal medical handover
- Inform Patient Flow in hospital site
- Identify where patient will go to, either:
  - Direct to Specialty bed
  - If bed not available speak with fracture clinic
- Nursing handover to be given
- Arrange transfer of patient.

Pathway 2

- Abnormality detected
- Conservative management recommended by Fractures
- Patient to remain on site
- Inform nursing staff of any follow up with Fracture Clinic appointments.

Pathway 3

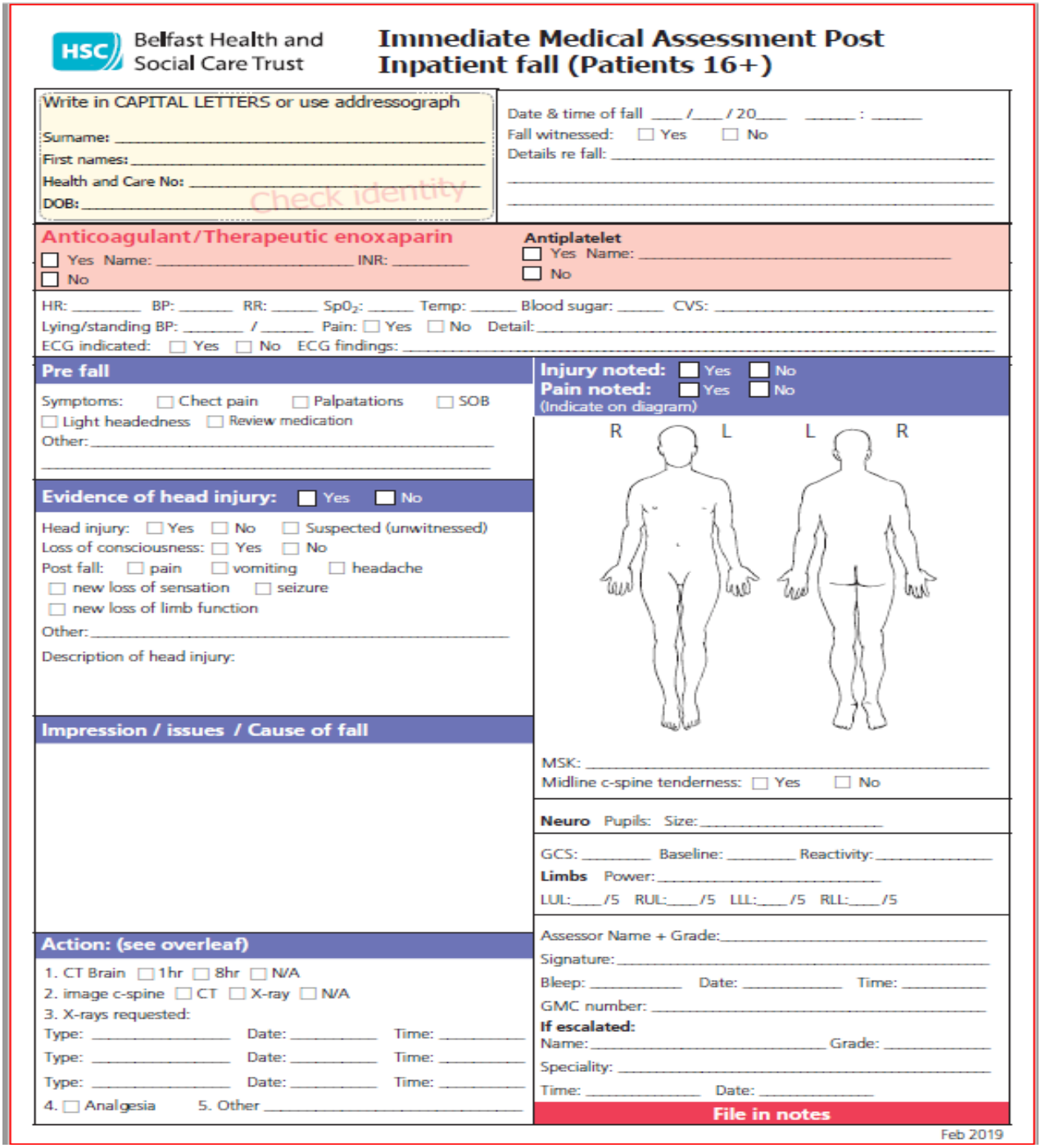
- No fracture detected radiologically
- If patient's mobility is not improving, re-discuss with Fractures regarding further management and requirement of further imaging.

With fracture injuries, patients may have complications such as bleeding.

Please be aware and monitor vital signs for evidence of blood loss.

Appendix 6

Minimum Data Set for Post Falls Incident Review (IR)



Belfast Health and Social Care Trust

Immediate Medical Assessment Post Inpatient fall (Patients 16+)

Write in CAPITAL LETTERS or use addressograph

Surname: _____

First names: _____

Health and Care No: _____

DOB: _____ Check identity

Date & time of fall ___/___/20___ ____:____

Fall witnessed: ☐ Yes ☐ No

Details re fall: _____

Anticoagulant/Therapeutic enoxaparin

☐ Yes Name: _____ INR: _____

☐ No

Antiplatelet

☐ Yes Name: _____

☐ No

HR: _____ BP: _____ RR: _____ SpO_2: _____ Temp: _____ Blood sugar: _____ CVS: _____

Lying/standing BP: _____ / _____ Pain: ☐ Yes ☐ No Detail: _____

ECG indicated: ☐ Yes ☐ No ECG findings: _____

Pre fall

Symptoms: ☐ Chect pain ☐ Palpatations ☐ SOB

☐ Light headedness ☐ Review medication

Other: _____

Evidence of head injury: ☐ Yes ☐ No

Head injury: ☐ Yes ☐ No ☐ Suspected (unwitnessed)

Loss of consciousness: ☐ Yes ☐ No

Post fall: ☐ pain ☐ vomiting ☐ headache

☐ new loss of sensation ☐ seizure

☐ new loss of limb function

Other: _____

Description of head injury:

Impression / issues / Cause of fall

Action: (see overleaf)

1. CT Brain ☐ 1hr ☐ 8hr ☐ N/A
2. image c-spine ☐ CT ☐ X-ray ☐ N/A
3. X-rays requested:

Type: _____ Date: _____ Time: _____

Type: _____ Date: _____ Time: _____

Type: _____ Date: _____ Time: _____

4. ☐ Analgesia 5. Other _____

Injury noted: ☐ Yes ☐ No

Pain noted: ☐ Yes ☐ No

(Indicate on diagram)

R L L R

MSK: _____

Midline c-spine tenderness: ☐ Yes ☐ No

Neuro Pupils: Size: _____

GCS: _____ Baseline: _____ Reactivity: _____

Limbs Power: _____

LUL: ___/5 RUL: ___/5 LLL: ___/5 RLL: ___/5

Assessor Name + Grade: _____

Signature: _____

Bleep: _____ Date: _____ Time: _____

GMC number: _____

If escalated:

Name: _____ Grade: _____

Speciality: _____

Time: _____ Date: _____

File in notes

Feb 2019

Link: To access Immediate Medical Assessment Inpatient Fall document
http://intranet.belfasttrust.local/directorates/medical/riskgovernance/Fallsafe%20Toolkit%202018/Forms/Fallsafe%20View.aspx

Appendix 6 Continued

Guidance

Please refer to policy for full information and algorythms

Head injury should be suspected in any unwitnessed fall

CT Brain should be performed within 1 hour

- If patient has a vomiting episode
- Seizure activity post fall
- GCS less than 13 on initial assessment
- Anticoagulation & GCS less than 15 or LOC or amnesia
- GCS falling or not improving
- Evidence of basal, depressed or penetrating skull fracture
- Focal neurological deficit
- Impaired coagulation
- Increased risk of bleed and or clotting disorder
- Failure to improve GCS to 15 (within 2 hours)

Discuss with Senior Clinician and CT Brain within 8 hours if GCS 15 with any of the following indicators

- Fall from height greater than 1 meter
- Fall down 5 steps or more
- Age 65 years or older with either LOC or pre/post amnesia
- Severe, persisting headache
- Pre traumatic amnesia/post traumatic amnesia greater than 30 minutes
- Antiplatelet Therapy

If GCS falls, urgent medical review from medical team must be sought and perform CT head within 1 hour

Suspect spinal injury in all patients with a head injury when GCS is less than 13/15 or clinical C-Spine tenderness is evident

Assessment required if the following spinal injury symptoms and or signs are apparent

New or worsening:

- Spinal or neck pain/tenderness
- Do not move patient/commence spinal precautions
- Arrange urgent CT scan

Patient cannot actively rotate their neck to 45 degrees to the left and right on safe assessment of neck movements

Spinal precautions

- Locate rigid neck collar and apply
- Locate trauma mattress
- Arrange urgent CT scan

Post fall consider/review

- Review footwear
- Full medication review
- Consider PT/OT review
- Assess cognition, vision & continence
- Review of bone health
- Consider referral to falls clinic if recurrent falls.

Glascow Coma Scale *Please see back page

Eyes ___/4		Verbal ___/5		Motor ___/6	
Spontanoeusly	4	Orientated	5	Obeys commands	6
To speech	3	Confused	4	Localises pain	5
To pain	2	Innapropriate words	3	Flexion withdrawal	4
Never open	1	Incomprehensible sounds	2	Abnormal flexion	3
		Silent	1	Abnormal extension	2
				No response	1

Please refer to the Trust Falls policy for further information

Appendix 7

Appropriate actions to take if a visiting service user falls outside of the clinical area and sustains an injury graded Moderate or Severe

- Incident took place on BCH site – call **999** for emergency transfer to nearest Emergency Department (ED)
- Incident took place on Knockbracken site – call **999** for emergency transfer to nearest ED
- Incident took place on Muckamore site – call 999 for emergency transfer to nearest ED
- Incident took place on MPH site – call **999** for emergency transfer to nearest ED
- Incident took place on MIH site – patient attends ED on this site
- Incident took place on RVH site – patient attends ED on this site
- **An adverse incident form must be fully completed on datixweb following this incident.**

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 52/10

Title:	**Protocol for the Recruitment and Employment of staff in Relation to Safeguarding Vulnerable Groups**		
Policy Author(s)	Alison Kerr, Senior Human Resources Manager/ Business Partner Tel: [redacted] Samantha Whann, Senior Human Resources Manager Tel: [redacted]		
Responsible Director:	Jacqui Kennedy, Director of Human Resources and Organisational Development		
Policy Type: (tick as appropriate)	*Directorate Specific ☐	Clinical Trust Wide ☐	Non Clinical Trust Wide ☒
If policy type is confirmed as ***Directorate Specific** please list the name and date of the local Committee/Group that policy was **approved**			
Date:			

Approval process:	Trust Policy Committee Executive Team Meeting	**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020	**Review Date:**	June 2025

Version No.	4	**Supercedes**	V3 – September 2015 – September 2018
Key Words:	Recruitment, Employment, Safeguarding Vulnerable Groups		
Links to other policies	BHSCT Volunteer Recruitment and Selection policy (2019) SG 72/11 BHSCT Work Experience Placement policy (2019) TP 80/12 BHSCT Safer Recruitment and Employment Alert Notice System (2020) TP 20/08 Fraud Response Plan TP 62/10 (2010) HSC Recruitment and Selection Framework 2018		

Date	Version	Policy Author	Comments
23/03/2010	0.1	L Beckett	Initial draft
09/06/2010	0.2	L Beckett	Final draft
09/06/2010	1.0	L Beckett	Final version
10/09/2012	1.1	A Kerr L Beckett	Revised version
13/05/2015	2.0	A Kerr L Beckett	Revised version
22/03/2017	2.1	A Kerr L Beckett	Revised version
13/05/2015	3.0	A Kerr L Beckett	Revised version
June 2020	4	Kerr S Whann	Revised version

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1. Background

Following the Bichard Inquiry on child protection procedures in Humberside Police and Cambridgeshire Constabulary, particularly the effectiveness of relevant intelligence based record keeping, vetting practices and information sharing with other agencies, the Bichard Inquiry Report, published in 2004, 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. This provided for the establishment of the Vetting and Barring Scheme. After full consultation, the Bichard Inquiry led to the Safeguarding Vulnerable Groups Act (SVGA) 2006 and the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012). This Legislation and Scheme replaced the former Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA).

In 2010, the new Government reviewed the safeguarding provisions and the Vetting and Barring Scheme was replaced by the Disclosure and Barring Service (DBS) enabled by the Protection of Freedoms Act 2012.

1.2 Purpose

This Protocol outlines the key responsibilities of the Belfast Health and Social Care Trust (the Trust) in relation to the implementation arrangements for the Safeguarding of Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) and the Disclosure and Barring Service as it relates to the recruitment and employment of staff.

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 wide range of responsibilities emanating from its statutory remit in respect of Social Services.

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.

The Protocol summarises the key details of the legislation and the Disclosure and Barring Service and outlines the procedural arrangements, which have been put in place to implement these.

1.3 Objectives

To provide guidance to managers on the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms

Act 2012) and the Disclosure and Barring Service in relation to the recruitment and employment of staff.

2.0 SCOPE OF THE POLICY

The Protocol covers the responsibilities of the Trust, Line Managers, Human Resources Staff and Recruitment Shared Services Centre and applies to all permanent, temporary, locum and agency staff, volunteers, students on placement and those staff engaged under external contract as Sub-contractors.

3.0 ROLES AND RESPONSIBILITIES

The specific responsibilities of the Trust, its Managers and Human Resources and Organisational Development staff are outlined.

4.0 CONSULTATION

The Protocol was fully consulted on with the Trusts Safer Recruitment & Employment Group at which Directorates, Trade Unions and Human Resources are represented.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Key Policy Statement(s)

The Protocol outlines the legislative context and responsibilities under Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) and the Disclosure and Barring Service in relation to the recruitment and employment of staff.

It sets out the main provisions of the Disclosure and Barring Service as it relates to conducting checks for new and current employees and the referral arrangements for existing employees.

It provides advice and clarification on the key elements of the Disclosure and Barring Service and a number of services for further information and documentation.

5.2 Dissemination

This Protocol should be disseminated throughout the Trust as it applies to all permanent, temporary, locum and agency staff, volunteers, students on placement and those staff engaged under external contract as sub-contractors

5.3 Resources
None

5.4 Exceptions
None

6.0 MONITORING AND REVIEW

The Protocol will be kept under review to ensure compliance with any future legislative requirements. The Protocol will be formally reviewed on a five yearly basis in accordance with Section 6 Governance Arrangements as set out in this Protocol.

7.0 EVIDENCE BASE/REFERENCES

The Protocol adheres to legislative requirements of the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012), Disclosure and Barring Service.

References: Department of Health Generic Guidance, Sector Specific Guidance, DBS Referral Guidance, Access NI Guidance and DAO (DOF) 04/18 - Fraud Proofing Guidance.

8.0 APPENDICES

Appendix 1 Access NI Policy Statement

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in **Protocol for the Recruitment and Employment of staff in Relation to Safeguarding Vulnerable Groups** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

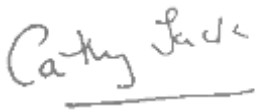
Wording within this section must not be removed.

SIGNATORIES

04/06/2020

_____ **Date:** _____

Name Jacqui Kennedy
Title Director of Human Resources/ Organisational Development



10/06/2020

_____ **Date:** _____

Name Dr Cathy Jack
Title Chief Executive

Belfast Health and Social Care Trust

PROTOCOL FOR:

RECRUITMENT AND EMPLOYMENT OF STAFF IN RELATION TO SAFEGUARDING VULNERABLE GROUPS.

Contents

Protocol for the Recruitment and Employment of Staff in Relation to Safeguarding Vulnerable Groups.

1.0. INTRODUCTION / PURPOSE 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 Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) and Disclosure and Barring Service as it relates to all permanent, temporary, locum and agency staff, volunteers, students on placement and those staff engaged under external contract as sub-contractors.

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 wide range of responsibilities emanating from its statutory remit in respect of Social Services.

The Protocol summarises the key details of the legislation and the Disclosure and Barring Service and outlines the procedural arrangements, which have been put in place to implement these.

2.0. LEGISLATIVE CONTEXT

The Bichard Inquiry 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. (Please refer to Section 3 for definitions of Regulated Activity in relation to Children and Vulnerable Adults). After full consultation, the Bichard Inquiry led to the Safeguarding Vulnerable Groups Act (SVGA) 2006 and the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) 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). In 2012 the Vetting and Barring Scheme was replaced by the Disclosure and Barring Service (DBS) enabled by the Protection of Freedoms Act 2012.

Access NI enables organisations to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work with children and vulnerable adults. Access NI offers two levels of disclosure, Standard and Enhanced – each of which represents a different level of check.

Disclosure and Barring Service (DBS) maintain a list of individuals deemed not suitable to work with children and vulnerable adults.

A Standard Disclosure Certificate shows details of spent and unspent convictions and cautions – not cases pending.

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.

An Enhanced Disclosure Certificate contains all the information in a Standard Disclosure and any further relevant information held in Police records e.g. information about attempted prosecutions that were unsuccessful or behaviour that might be indicative of criminal activity.

The Trust is a registered body with Access NI and can access the services of Access NI 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 HSC Recruitment and Selection Framework October 2018 ensures compliance with the requirements of the Disclosure and Barring Service as it relates to prospective employees. 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 Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) are undertaken in line with this Protocol.

Access NI process:

Detailed information about Access NI is available by accessing its website: 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 (www.accessni.gov.uk).

The Recruiting Manager will determine if the job meets the definition whereby an Access NI check is required i.e. is it regulated activity; the individual will be required to complete the necessary documentation. HR or Recruitment Shared Service Centre (RSSC) can clarify any queries re this matter.

The Trust will request an Access NI Disclosure only where it is regulated activity and where it is considered proportionate and relevant to the particular position. This will be based on a thorough risk assessment of that position and having considered the relevant legislation, which determines whether a Standard or Enhanced Disclosure is required for the position in question.

Where an Access NI Disclosure is deemed necessary for a post or position, all applicants will be made aware at the conditional employment offer stage that the position will be subject to a Disclosure and that the Belfast Trust will request the individual being offered the position to undergo an appropriate Access NI Disclosure check.

In line with the Rehabilitation of Offenders (Exceptions) (Northern Ireland) Order 1979 (as amended in 2014), Belfast Trust will only ask about convictions which are defined as "not protected" for the purposes of obtaining a Standard or Enhanced disclosure. (Please refer to BHSCT Recruitment and Selection Policy for Guidance on the Recruitment of Ex-Offenders).

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 based on a specific role or position.

- All staff newly appointed to the Belfast HSC Trust will require an access NI check as appropriate for the role.

- If staff are currently employed in a position within the BHSCT and have been Access NI checked, further checks are not required unless moving from one vulnerable group to another i.e. Children to Adults or vice versa.

- Access NI no longer provide a copy of certificates for standard and enhanced checks to the employer.

- The Trust will only be able to see any information disclosed if the applicant wishes to continue with the recruitment process and shows their certificate to the employer.

- Where police information, other than criminal record information, is disclosed on the certificate, an individual can appeal to an Independent Monitor to review the information.

- The applicant may seek a review if they believe the information is not relevant to the job they hope to do, or should not have been disclosed.

- With effect from 2 November 2015 via the Justice Act (2015 Act) statutory test applied by the police for releasing information changed from "might be relevant" to "reasonably believes to be relevant".

For further information or special guidance on a case-by-case basis, please contact Recruitment Shared Service Centre (recruitment.ssc@hscni.net).

3.0. MAIN PROVISIONS OF THE DISCLOSURE AND BARRING SERVICE.

The Trust is a Regulated Activity Provider and is responsible for the management or control of regulated activity, paid or unpaid, and arranges for people to work in that activity. The Trust is required to fully implement all the requirements of the Safeguarding Vulnerable Groups (Northern Ireland) (SVGO) 2007 (as amended by the Protection of Freedoms Act 2012) legislation and Disclosure and Barring Service.

Definitions of Regulated Activity

Regulated Activity relating to **Children** comprises:

- Unsupervised activities: teaching, training, instructing, caring for or supervising children, or providing advice/ guidance on well-being, or driving a vehicle only for children;

- 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 the above is regulated activity only if done regularly, or if done overnight.

- Relevant personal care, e.g. washing or dressing; or health care by, or supervised by, a professional;

- Registered child-minding and foster care.

Regulated activity still excludes family arrangements, and personal non-commercial arrangements.

- *Regulated Activity relating to Adults comprises:*

- Health Care provision including 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; and first aid.

- *Personal Care Provision*

- 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.

- **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.

- *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.

- *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.

- *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.

For further guidance, please refer to Access NI Website:
www.nidirect.gov.uk/campaigns/accessni-criminal-record-checks

An organisation, which knowingly allows a barred person to work in regulated activity, will be breaking the law.

The Trust's Disciplinary Policy ensures that the necessary referral requirements set out under the Disclosure and Barring Service are adhered to.

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 Disclosure & Barring Service. 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 Disclosure and Barring Service can be found on their website: http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/.

Please contact the HR Employment Law Team, who will be able to advise on a specific query or concern.

4.0. RESPONSIBILITIES OF THE BELFAST HEALTH AND SOCIAL CARE TRUST

As a Registered Body with Access NI the Trust:

- Must 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 (Appendix 1).
- 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 Disclosure and Barring Service any employee, 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.

4.1. Line Managers Responsibilities: -

- 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 consider if an Enhanced or Standard Disclosure is required (see Section 2.0 and Section 3.0 for guidance).

- 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 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 as appropriate is conducted for any staff member returning from an employment break/unpaid leave.

- Must liaise with Human Resources and Organisational Development staff in relation to any student's/training positions/other individuals to ensure that vetting is conducted as appropriate.

- Must alert Senior Management and Employment Law Team within Human Resources & OD Directorate to any incident, which gives rise to concern or where allegations are made about an individual working with children/vulnerable adults. The Employment Law Team will provide advice and guidance on issues, which may give rise to the referral of information to the Disclosure and Barring Service.

4.2. Human Resources Responsibilities: -

- 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 Disclosure & Barring Service.

- Must provide guidance and support to Line Managers in the implementation of this Protocol.

- Must ensure that associated Policies – Disciplinary, Recruitment and Selection, Placement Activity Policy, 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 that the Governance Arrangements set out in Section 6 of this protocol are satisfied.

4.3. Outcome of Checks

On receipt of a Disclosure Certificate, the Trust/RSSC 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. Access NI 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. 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.

Advice must be sought from the HR Employment Law Team.

4.4. Disputes and Disagreements

If an individual believes information disclosed about them is inaccurate, they should raise a dispute with Access NI at www.accessnichecks.co.uk.

4.5. 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 1). It adheres to the Access NI Code of Practice and guidance, its responsibilities under the Data Protection Act, General Data Protection Regulation 2018 and Good Management Good Records (GMGR).

4.6. Applicants from outside the United Kingdom/Overseas

Access NI 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.

5.0. REFERRALS TO DISCLOSURE AND BARRING SERVICE (DBS)

As a Regulated Activity Provider, the Trust has a legal duty to refer information to the Disclosure & Barring Service in certain circumstances and to notify the Disclosure & Barring Service of relevant information so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups. Disclosure & Barring Service Referral Guidance sets out the key elements of the 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 HR Employment Law Team when dealing with a referral issue.

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.

6.0. GOVERNANCE ARRANGEMENTS

This protocol will be kept under review to ensure compliance with any future legislative requirements. It will be reviewed formally on a five yearly basis and at appropriate periods where legislative changes occur.

The Trust will ensure compliance with this protocol by:

- Seeking evidence from the relevant HR Co Director/RSSC that the Recruitment & Selection and Disciplinary Policies have been reviewed in light of any legislative or Departmental guidance developments.

- Seeking evidence from the relevant HR Co Director/RSSC that the requirements for the vetting of prospective staff are being conducted in line with this Protocol and associated guidance.

- Seeking evidence from the relevant HR Co Director that the process for referring any staff to the Disclosure & Barring Service has been conducted in line with this Protocol and associated guidance.

- Seeking evidence from the relevant HR Co Director that any Contracts with Employment Agencies are compliant with the legislation and that monitoring arrangements are in place to ensure same.

- Seeking evidence from the relevant Service Co-Director that any Contracts with Private Contractors are registered with Access NI, compliant with and that monitoring arrangements are in place to ensure same.
- Seeking evidence from the relevant HR Co Director that all arrangements for Placement Activity are compliant with this protocol and associated guidance and that monitoring arrangements are in place to ensure same.

- The relevant HR Co Director will ensure that the audit arrangements set out in the Safer Recruitment and Employment Framework are implemented and any recommendations are taken forward.

APPENDIX 1

Belfast Health and Social Care Trust

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 Access NI'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 General Data Protection Regulation 2018 and other relevant legislation pertaining with 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

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, the Trust 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 Access NI unique reference number of the Disclosure Certificate and the details of the recruitment decision taken.

Independent Whole Systems Review

into Safeguarding and Care at Dunmurry Manor Care Home

EVIDENCE PAPER: 1

Adult Safeguarding within a Human Rights Based Framework in Northern Ireland

September 2020

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

cpea Adult Social Care and Health Management Associates

Contents

Section A: Introduction

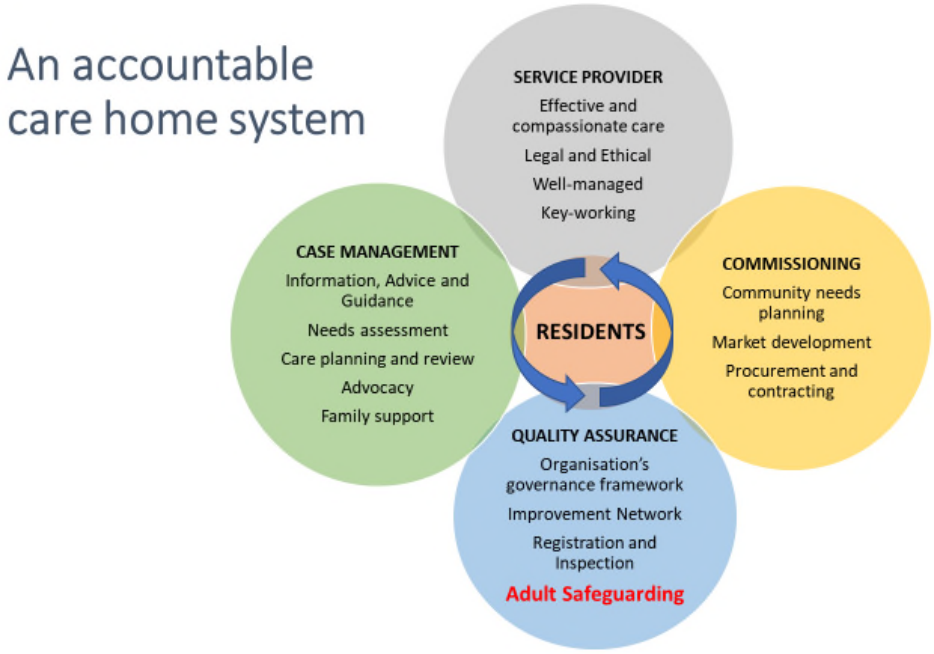
1. The Department of Health ("DH") of the Northern Ireland government commissioned CPEA Ltd ("CPEA") to undertake a *whole systems* review following the safeguarding and care issues identified by the Commissioner for Older People for Northern Ireland's ("COPNI") investigation into Dunmurry Manor Care Home ("DMCH")[1] which is run by Runwood Homes Limited ("Runwood").
2. Families had approached COPNI to express significant misgivings about the standards of care at the home. They reported that the care provider, the Regulation and Quality Improvement Authority ("RQIA"), the Health and Social Care Trusts ("HSCTs") and the Patient and Client Council ("PCC") had not addressed their complaints and they had nowhere else to go. In response, the COPNI used his investigation powers for the first time, requiring the DH, the HSCTs, RQIA and Runwood to submit information for his consideration. He engaged an expert panel of three[2] to advise him.
3. *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* ["Home Truths"] was published in June 2018. It is critical of the practice of adult safeguarding[3] and asserts the case for safeguarding legislation.[4]
4. The purpose of the whole systems review is to learn and change. An Evidence Paper is a way of soliciting comment to inform and advise those who are responsible for formulating and implementing change. The sources of adult safeguarding data and information are documented in Appendix A. This Evidence Paper addresses the question of what adult safeguarding achieved for the residents of DMCH and considers the broader impact of safeguarding initiatives on adults in residential and nursing settings in Northern Ireland. It draws on the experiences of the families of older people and professionals across health and social care; re-visits the information shared with the COPNI in the light of NI's safeguarding policy, procedures and associated processes such as contract monitoring; and it references peer-reviewed articles concerning the harms experienced by older people in residential settings and the ways in which the likelihood of such harms occurring may be reduced. Finally, its "proposed actions" arise from discussions among the Review Team, versions of which have been explored with families and professionals. It is brought forward in advance of the full report of the whole systems review as part of the DH commitment to make change and enhance the safety of people known to services.
5. The position of adult safeguarding in the context of the whole systems review is shown in the graphic below.

[1] It has been renamed Oak Tree Manor by Runwood Homes Ltd. For the purposes of the *whole systems review,* the name DMCH has been retained

[2] Eleanor Hayes, with expertise in nursing and care; Professor John Williams and Dr Robert Peat with expertise in safeguarding and human rights; regulation, inspection and commissioning respectively.

[3] This paper concerns adult safeguarding, *Home Truths* was critical of the standards of care at DMCH and of the whole system around care homes.

[4] Claire Keatinge, the first COPNI, published a Briefing Note in June 2014, *Protecting Our Older People: A Call for Adult Safeguarding Legislation.*



6. The Structure of the Evidence Paper reflects the endeavours of the Review Team to find meaning in the different configurations of adult safeguarding information. Counting referrals about different types of abuse – psychological, sexual, physical for example - reveals little about the volume entered into the safeguarding system or the inconsistencies in recording and practice within and across HSCTs. Of more use is information about the setting in which an individual is harmed – most particularly if the nature of the relationship between the person who is harmed and the person alleged to be responsible is known. Qualitative information is typically required to understand the context so it was engagement with professionals and the relatives of the people living in care homes that helped shape this Evidence Paper's structure. It begins by setting out the background to the review and the factors shaping a "good life" in care homes and leads to an exploration of the term "adult safeguarding" and Northern Ireland's policy and procedures.
7. In this and following sections, illustrative quotations from interviews and discussions during adult safeguarding workshop/events as well as meetings with individuals, families and groups are presented. The contributions of professionals delivering care and support to older people have been invaluable in analysing the challenges inherent in adult safeguarding practice and exploring with the Review Team what actions may be taken to improve practice. The main body of the Evidence Paper considers how adult safeguarding and associated activities work. Starting with the findings of *Home Truths,* it presents adult safeguarding information from the HSCTs for the purposes of the investigation and from the DH's audit of adult safeguarding.[5] The methods used gave assurance that as the experience of individuals was shared, their

[5] An audit of safeguarding investigations in relation to care homes operated by the independent sector was ordered by the Permanent Secretary on 27th June 2018. See: https://www.health-ni.gov.uk/news/department-health-details-series-measures-care-home-standards (accessed 1st July 2018)

identities and those of their families would be protected. In upholding those assurances, steps have been taken to convey relevant matters without personal, identifiable information.

8. Since residents' families have a compelling track record in specifying what needs to change in terms of fulfilling the support needs of their relatives, an overview of the themes they identified is presented. The realities faced by the HSCTs in invoking procedures are reported, followed by a consideration of "quality" and relevant notifications[6] to the RQIA. The penultimate section concerns partnerships in adult safeguarding and the remits of different organisations. The final section is a reality check because it does not appear that people are being made consistently safer by adult safeguarding practices in Northern Ireland.
9. Throughout the Evidence Paper, sections are concluded with "POINTS TO CONSIDER." These reflect the Review Team's discussions about emergent learning and possibilities for change as well as discussions with contributors – both professional and non-professional. They reflect the "no surprises" approach of the Review Team. The process of identifying them has helped to clarify our thinking and has shaped the specific advice and proposals within the final section of this paper.
10. There are several actions that ought to be taken and can be initiated without waiting for the perfect solution or the right time. The events at DMCH confirm the critical need for decisive action in protecting residents from actual and possible harm and neglect. This should not be separate from the tasks of seeking to understand the factors which led to harm. Actions should be concurrent, focussed on the resident(s) concerned and attentive to the importance of residents controlling those aspects of their lives that remain within their gift. Actions must be do-able and demonstrably add benefit to people's lives. They must be proportionate, risk-benefit based and credible.

[6] Regulation 30, among other things, requires notification to RQIA of 'any event in the home which adversely affects the care, health, welfare or safety of any resident/ any event in the nursing home which adversely affects the wellbeing or safety of any patient'.

Section B: Context

Strategic Background

11. During 2010, the strategic responsibility for adult safeguarding was delegated to the Health and Social Care Board ("HSCB") by the DH. The operational responsibilities for adult safeguarding are held by five HSCTs – Belfast HSCT, South Eastern HSCT, Western HSCT, Southern HSCT and Northern HSCT. Each manage and administer hospitals, health centres, residential homes and day centres and provide a range of health and social care services to the community. (A sixth HSCT is the Northern Ireland Ambulance Service ("NIAS") which operates a single, region-wide service). The "Northern Ireland Adult Safeguarding Partnership ("NIASP") and five Local Adult Safeguarding Partnerships ("LASPs") were established under *Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements* (Northern Ireland Office and DHSSPS 2010). The LASPs report to the NIASP which reports to the HSCB (via the Chair who is a senior officer), which reports to the DH.
12. DMCH is in South Eastern HSCT ("SEHSCT") area which acts as 'host' HSCT. At the time of the COPNI investigation there were residents at DMCH from all HSCTs except for Western HSCT.

Residents and Families

13. Discussions with the relatives of people who had lived at DMCH and at other homes in NI were occasions to reminisce about the lives of the people they loved. They affirmed that the lives of their relatives mattered a great deal before and after the decision was made to leave their own homes and move into a care home. They shared the distress and difficulties experienced in making these decisions. Some families have experienced relationship breakdowns with continuing impacts on their lives.
14. Although the background to people's transitions into care homes was diverse, the shared themes included decisions made by acute hospital clinicians and GPs; families acknowledging suspicions that their relatives' behaviours were becoming atypical and/or their memory loss more noticeable; a diagnosis of dementia, falls at home, and/or compromised health status; the death of spouses whose day to day support had disguised the extent of support required by their partners; and, reluctant acknowledgement that the support of relatives and friends could not keep pace with a person's accelerating need for help.
15. Typically, families had no previous experience of the care home system, struggled to make sense of the terminology of care and regulation and reported that the lack of clear, easily accessible information made "the system" even harder to understand. The relocation of their relatives was stressful, most particularly if it was associated with feelings of guilt and distress. Involvement in the post-placement lives of older people included investing in continuing relationships with spouses, siblings, children and grandchildren. However, not everyone recalled welcoming admission processes or even engaging communication with families. When DMCH families became attuned to evidence that their relatives were unprotected, that their care needs were overlooked and their appearance deteriorated, they questioned the adequacy, competence, empathy and continuity of care staff and their managers.

Living in a Care Home within a Human Rights Based Framework

> After all, "…What good is it making someone safer if it merely makes them miserable?" [7]
>
> "Human rights principles emphasise the importance of achieving a balance between ensuring residents' safety and promoting independence" [8]

16. Care homes are a critical and conspicuous part of the UK's care infrastructure and are likely to remain so. As Kennedy[9] noted:

    > "Care homes can be good places. They can be safe, secure and stimulating places to live and work, capable of fostering good relationships between people living and working in them and wider communities…Around 400,000 older people in the UK live in care homes, cared for by over a million care workers, 24 hours a day, seven days a week. With an ever-increasing population of older people, getting care homes 'right' is crucial to ensure a 'good life' for ALL of us – our parents and grandparents, aunties and uncles, friends and neighbours and, not least, ourselves!" (p10-11)

17. For people who are moving into care homes on a permanent basis, factors which shape a "good life" include sustaining relationships with families and friends and developing positive relationships with support staff. As well as recognising the significance of people's relationships inside and outside the care home, understanding what matters to individuals and helping them to maintain their independence and sense of self in their daily lives are critical. The potential for families to play a significant part in caregiving should be understood and welcomed.

18. Care homes are synonymous with group living. New residents and their families may not appreciate that the person-to-person care and support provided to individual residents is time-limited. Furthermore, maintaining mobility and being able to negotiate ways around care homes are important skills. They entail acceptance that the possible consequences of being mobile may be beneficial *or* harmful. This means that care homes typically support older people to take risks. The 'risk management approach' of care and support in a care home

[7] "A great judge once said, "all life is an experiment," adding that "every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge" (see Holmes J in Abrams v United States (1919) 250 US 616 at pages 624, 630). The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?" Munby J (as he then was) in Local Authority X v MM & Anor (No. 1) (2007)

[8] Page 66 of Northern Ireland Human Rights Commission (2012) *In Defence of Dignity - the Human Rights of Older People Living in Nursing Homes* Belfast: NIHRC, March

[9] Kennedy J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

involves identifying what needs to be in place to make it more likely that the benefits will be enhanced and harms reduced. However, there can be no guarantees of absolute safety.

19. The Registered Manager of a care home provides the leadership and management within a context of regulation and minimum standards as set by DH. (Many family members expressed dismay at the concept of minimum standards that did not reflect their expectations of care.) Registered Managers undertake this through values-based and relationship-based approaches to "caring well," that is, without detriment to individuals. This includes encouraging and supporting older people to maintain some control around their personal routines and activities, in making choices and in exercising their rights.
20. Just as with the general population, keeping care home residents safe requires environments and systems that seek to prevent harm as well as to respond to it in the most beneficial way. These tasks accept that taking reasonable risks can lead to accidents and mistakes, albeit permitted, for positive, documented reasons.
21. It is against this backdrop that when difficulties emerge in the life of a care home – such as those at DMCH - providers and managers must be accountable. Their powers and duties within legal and regulatory frameworks are centre stage in terms of accountability. The latter concerns trust, that is, trusting that all employees, managers and the regulator will hold people to account for the problems for which they are responsible, take improvement actions and contribute to learning. At best, accountability is not solely backward-looking, it is also forward-looking.[10]
22. *The Senses Framework: Improving Care for Older People through a Relationship-Centred Approach* [11] - identifies one of the six Senses within the framework as *Security - feeling safe. That is, ensuring that the person you care for: is safe and free from threat, harm, pain or discomfort…receives competent, sensitive and consistent care…is able to make choices about what they do.* The other Senses concern continuity, belonging, purpose, achievement and significance.
23. The *My Home Life*[12] initiative draws from the *Senses Framework* and underlines the rights of older people to retain their personal agency, dignity and control regardless of their age and health status. It identifies eight "Best Practice Themes," one of which is *Sharing Decision-making: Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life*. Other themes concern maintaining identity; creating community; managing transitions; improving health and healthcare; supporting good end of life; keeping the workforce fit for purpose; [and] promoting a positive

[10] Dekker, S. (2012) *Just Culture: Balancing Safety and Accountability* 2nd Edition, London: CRC Press, An Ashgate Book

[11] *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice* (GRiP) Report No 2. Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/280/; (accessed 4th September 2019)
Nolan, M. Lundh, U., Grant, G. and Keady, J. (Eds.) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press McGraw-Hill Education, 2003

[12] See https://www.myhomelifeni.co.uk/ (accessed 16th July 2019)

culture. During a discussion, the Responsible Individual[13] at Runwood advised the Review Team that the company's Registered Managers in Northern Ireland who had completed the *My Home Life* Leadership Programme included those at Weaver's House, Orchard Lodge Care Home and Kintullagh Care Home, for example. [14]

24. The events that precede an older person's admission to a care home are likely to be characterised by distress, most particularly if this major life event is triggered by a crisis. For many families it may be the first time that they encounter social care services, care homes, HSCTs and Care Managers. They are unlikely to have the information, knowledge or understanding about what to expect, what to do or who to ask questions with regard to attention to their relatives' support needs, for example. Many older people want and need their families to act on their behalf and to maintain a relationship with them, albeit in the face of uncertainties. People's families are more than visitors. Being part of a family and amongst staff and communities are critical to people's emotional well-being and their "sense of continuity." There is little evidence to suggest that families experienced such an approach at DMCH.
25. Care homes are subject to considerable scrutiny, most particularly when accidents happen and mistakes are made. Sometimes accidents and mistakes cause harm and sometimes they do not. Judgement and balance are important features of leadership across the care home system so that the danger of becoming "risk averse" is challenged and remedied wherever it occurs. Safeguarding systems may not be the best means of tackling every harmful caregiving scenario in all settings. Adult safeguarding applies methods which are most suited to addressing an individual's circumstances rather than those of group living/communal settings. The risks may result from people living together, some of whom may not be compatible with others and/or placed in circumstances or in areas within homes that become unsafe.
26. Necessarily people must be safe in care settings but it is unlikely that every accident, mistake or evidence of inattentive care reaches the point at which adult safeguarding is or should be invoked. What is the case for bringing the full weight of multi-agency, multi-professional activity to bear on a home – typically in an uncoordinated manner – when many situations require action by the manager, that is, complaints' investigations, adherence to contracts and regulations or referring to the Police Service of Northern Ireland ("PSNI") for investigation?
27. Most families believe that if their complaints concerning DMCH had been promptly addressed within a reasonable timeframe, the volume of safeguarding referrals could have been avoided and there would have been no need for the COPNI investigation.
28. The Human Rights Commission's investigation of nursing homes considered residents' quality of life, personal care, eating and drinking, medication and health care and the use of restraint. It stated that, *the same human rights apply to all regardless, even if the application of those*

[13] Responsible Individuals are in charge of overseeing the management of services regulated by RQIA and are ultimately accountable for safeguarding and promoting the welfare of vulnerable people in their care. They should have knowledge of and commitment to good care practices and possess the competencies necessary for the management of the service. Honesty, integrity and trustworthiness are essential requirements in determining the suitability of an applicant for registration.

[14] It is understood that a Regional Quality Manager became a mentor/ facilitator for *My Home Life*

standards requires different actions from the duty bearers (p10).[15] The report focused on how the quality of life of older people with complex health needs may be advanced. It proposed that the failure to place human rights standards at the core of nursing homes' legal and regulatory framework undermined residents' human rights. The report is silent about an adult safeguarding response to breaches of residents' human rights.

29. The report recommended clarity concerning human rights' standards and proposed that they should be applied by:
    - recognising the individual in a personalised way and supporting them;
    - encouraging and enabling older people to spend their days as they wish;
    - being involved in how personal care is provided;
    - being involved in when medication and treatment are provided; and
    - affording dignity and human rights protection.
30. The significant contextual background to DMCH and care homes generally was (i) the Human Rights Commission's primary focus: the right to life, to security, to respect and to "procedural protection in the event of a need for restraint" and (ii) the COPNI's advice to the Minister for Health, Social Services and Public Safety about changing the culture of care provision in Northern Ireland.[16]

POINTS TO CONSIDER – Learning and Change

- ✓ The assessment and support of risk decisions is not conspicuous in the safeguarding documentation concerning DMCH. A regional approach to risk management is required.
- ✓ Registered Managers' knowledge of the law and regulations is taken for granted rather than being the subject of planned training.
- ✓ The experience of residents and families when accidents happen, mistakes occur or when someone is harmed reveals a great deal about a home's leadership and readiness to improve practice. Responses to complaints must demonstrate timely remedy.
- ✓ The *My Home Life* leadership programme is experienced in seeking to promote a positive culture in care homes.
- ✓ Since some DMCH residents experienced safeguarding incidents soon after their admission, steps to encourage and promote a *sense of security* and *continuity* are needed at the outset.
- ✓ There is a case for setting out the specific contribution of adult safeguarding to features of communal living.
- ✓ Northern Ireland's care homes are expected to adopt a values-based approach. How this is advancing residents' human rights should be made explicit.

[15] Northern Ireland Human Rights Commission (2012) *In Defence of Dignity - the Human Rights of Older People Living in Nursing Homes* Belfast: NIHRC

[16] Commissioner for Older People for Northern Ireland (2014) *Changing the culture of care provision in Northern Ireland* Belfast: COPNI https://www.copni.org/media/1122/changing_the_culture_of_care_provision_in_northern_ireland_pdf.pdf (accessed 1st June 2019)

What is meant by Adult Safeguarding?

> "Families and service users need to understand us/the language we use and the processes" – contributor to the Adult Safeguarding Workshop - 12 March 2019

31. Confusion existed among families with relatives at DMCH about what adult safeguarding means.[17] Its language is bewildering. Families reported feeling anxious and concerned, perhaps interpreting "safeguarding" as being about the risk of violence and "just didn't know how to respond to do the right thing." The language of safeguarding typically matches that which is set out in policies and procedures and it explains as well as obscures. "Safeguarding" is not readily understood. In contrast, families understand terms such as "keeping people safe" and "adult protection."
32. The Introduction to *Adult Safeguarding: Prevention and Protection in Partnership* (DH and DoJ, 2015) states:
    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 (p4).
    The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult' …This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood…Preventive 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 (p5).
    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 (p6).
33. The safeguarding lexicon is too remote from everyday language. For example, some of the following terms merit space in a glossary: *threshold of assessment of need/risk… Adult Protection Gateway Service… protection plan… Threshold for Protection/screening… harm… serious harm… Multi Agency Risk Assessment Conference… Strategy Discussion… Monitoring/review… alternative safeguarding responses… investigation… untoward/adverse incidents... Designated Adult Protection Officer* ("DAPO").
34. Similarly the following statement which features in Appendix 10 of the *Protocol for Joint Investigation of Adult Safeguarding Cases,*[18] requires explanation. *The criteria for NOT reporting to PSNI are met and Apply Regional Adult Safeguarding Policy and Procedures for single Agency – manage under HSC Trust Procedures.*
35. The terms "concerns" and "complaints" feature in the safeguarding vocabulary of the HSCTs. There is an unclear interface between them. "Concerns" are non-specific and barely capture the harms endured by some residents. Families were clear that they initially raised 'concerns' about the physical condition of their relatives and their rooms. For example, they alerted the

[17] This confusion was not unique to families with relatives at DMCH
[18] NIASP August 2016

home to residents' deteriorating/ unkempt appearance and to food trays being left untouched in their rooms. When no changes occurred they made complaints. Because DMCH was unresponsive to families' complaints, the Review Team learned that the circumstances of their relatives and those of other residents continued to deteriorate.

36. The increasingly abstract entity of safeguarding requires attention because of its lack of clarity. For example, restating and refining definitions and operational policies within the HSCTs concerning, *physical abuse…sexual violence and abuse…psychological/emotional abuse financial abuse…institutional abuse...neglect…exploitation…domestic violence and abuse…human trafficking…*and *hate crime* (p13-15), do not provide practitioners with the means to deal with complex scenarios. As professionals noted in relation to DMCH, "You have to report any incident. Everything gets reported or you get blamed and all our time is spent just reporting things that don't need to be, just so we can cover our backs. // It's asking [the practitioner] to establish whether the threshold of harm has been met in which case you go down the adult safeguarding route and if it is serious harm, then it's the adult protection route."

POINTS TO CONSIDER – Learning and Change

- ✓ The model of safeguarding as set out in NI's policy and procedures is far-reaching and without decisive limits.
- ✓ The terms "roles" and "responsibilities" were used in all meetings. Arguably information concerning the remit and legal powers of professionals and the resources of their organisations is more useful than lengthy lists of their roles and responsibilities. Since the remit and legal powers of the HSCB, the HSCTs, NIASP, LASPs, the RQIA, the Northern Ireland Public Services Ombudsman ("NIPSO"), the PSNI, the Coroners Service which is part of the Northern Ireland Courts and Tribunal Service ("NICTS") and the Health and Safety Executive Northern Ireland ("HSENI") are not set out in this policy, there is uncertainty among practitioners about which professionals should assume lead responsibility within and across all sectors.
- ✓ There is confusion about what to report and how the reporting requirements, including escalation, to the host HSCT, the funding HSCT and the RQIA, work together.
- ✓ The culture within which safeguarding is operating has resulted in the "risk averse" practice of reporting everything.

Policy and Procedures

> "When they said that Mum was now in safeguarding, I was frightened, didn't understand it and thought she had been attacked" – relative of a DMCH resident
>
> "Safeguarding is put before caring for people"- relative of a DMCH resident

37. The adult safeguarding policy framework for Northern Ireland was set out by the DH[19] and DoJ in 2006. The *Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance* defined 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; 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.
38. This policy was revised, updated and published during July 2015. On publication, the Health Minister stated: *The policy provides the framework within which social workers, social care providers, health care providers, PSNI officers and those involved in the community, can work to prevent harm to adults at risk, recognise it and respond to it when it happens, and help those affected obtain the justice they deserve*.[20]
39. The aims of the policy *Adult Safeguarding: Prevention and Protection in Partnership* are 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 interagency 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* (p7).
40. In the 2015 policy,
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.

[19] Until 9 May 2016, the DH was known as the Department of Health, Social Services and Public Safety.
[20] DH Press Release *Adult safeguarding policy for Northern Ireland* was published on 10 July 2015

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 (p10).

41. The 2015 policy ceases to focus on vulnerability. It depicts adult safeguarding as a continuum from prevention to protection. That is, the 'safeguarding response' to adults at risk is twofold:
    - 'targeted services' (including statutory, voluntary, community, independent and faith organisations) and
    - 'protection services' which are led by HSCTs' social workers and/or the PSNI.
42. However, the continuum depicts two thresholds. One for the "assessment of need/risk" to distinguish "a person aged 18 or over" and an "adult at risk of harm." The "threshold for protection screening" distinguishes an "adult at risk of harm" and an "adult in need of protection." In addition, there is *harm…the impact on the victim of abuse, exploitation or neglect" and "serious harm…a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals…there are no absolute criteria for judging when 'harm' has become 'serious harm'* (p11-12).
43. The principles underpinning the 2015 policy are fivefold: *a rights-based approach… an empowering approach… a person-centred approach… a consent-driven approach… a collaborative approach* (p8-9).
44. The policy omits to reference the relevant legislation and Orders which influence safeguarding in NI. (See Appendix B: The legislative architecture.)
45. The policy states that: *Robust governance arrangements are key to an organisation's ability to keep adults safe from harm… 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* (p23). Examples of "internal governance" include *robust selection and recruitment procedures… effective management… procedures for responding to… safeguarding concerns… procedures for cooperating within the organisation and with others as required to address safeguarding concerns… procedures for managing… complaints… records… the sharing of information* (p24-25).
46. "External governance" is a free-standing section of the policy and it notes that *Services for adults at risk may be commissioned or subcontracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors…*e.g. *the NIHE* [Northern Ireland Housing Executive], *local councils, PSNI and other justice organisations or the HSC sector…The HSCB, HSC Trusts and the PHA* ("Public Health Agency") (p27). The section advises that in relation to the management and monitoring of contracts, all commissioning

organisations, should be knowledgeable about adult safeguarding, meet the requirements as set out in the policy, *monitor the performance of service providers and identify any deterioration in standards of care and risks this may present; regularly audit the third party service provider…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* (p27).

47. The following observations were made by senior HSCT managers at an event during July 2019: "If you trace back to 2015, the policy was flawed. // It was a flabby policy. // Adult safeguarding has corrupted social work. // The intention of the policy was not translated into practice. //There's no clarity at a system level. // We refer matters to the RQIA and they put responsibility back to the Trusts. // There's confusion across the system. // It's timely to review the processes in layman's terms. // There are massive inconsistencies between the regional policy and the procedures. // Quality of care matters have different processes to safeguarding. // It's "everyone's business" but no one adds, it's about needs assessments and risk assessments. // Adult safeguarding covers everything and it shouldn't. It hasn't got the thresholds right in relation to protection. // The policy has driven confusion – it's out of date. // It's not fit for purpose. It needs more work. // Our work should be about helping people to live in a safe way. // It was as though when we heard "abuse" we jumped. // The policy isn't geared towards people in permanent care. // Policy development should be organic but there was little listening and no account taken of feedback. // There were opportunities to be involved in developing it. // The policy isn't right and neither is the way it is implemented – the policy and procedures are chalk and cheese with no synergy. // There were different authors."
48. With reference to all professionals with responsibility for carrying out the care management process and function, the policy states that they *must* focus on individuals, for example,
    - *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…*
    - *Ensure the care plan is being implemented…reviewed regularly…* [and that] *they are informed of any incidents, accidents or near misses in respect of the individuals for whom they have commissioned care* (p28).
49. The policy also requires Care Managers to take on a wider brief of ensuring, for example:
    - *That a safe and high-quality service is provided, noting any patterns emerging and which suggest there may be a cause for concern and acting upon any concerns*
    - *That they are informed of any complaints made and action taken to address them*
    - [an analysis of] *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*
    - [That they] *escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk* (p28).
50. The policy describes: "The Role of Regulation and Quality Improvement Authority" as having:

…a key preventative role in adult safeguarding practice…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…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…care governance elements…the number, nature and outcome of complaints made; safeguarding concerns raised with the Adult Safeguarding Champions; notifiable incidents or accidents which occurred…any disciplinary procedures conducted (p30).

51. RQIA's information sources include care homes' complaints records, notifiable incidents and accidents which, *should be triangulated* with a view to setting out trends for example. It *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 to contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service* (p31).
52. RQIA wrote a briefing paper for the DH on 15 June 2018. This noted:
"The 2015 Safeguarding Policy clearly establishes the HSCTs as the primary investigators of safeguarding incidents. It is correct that there is a crossover between safeguarding and care failures. Allegations of institutional abuse, neglect and failures to maintain human rights are all clear safeguarding issues. The [COPNI] *report cites numerous examples where HSCT staff have found care failings in the home. It is not clear what action the HSCT staff then took. These professional staff all operate under codes of conduct which include duties of care and candour…"*
53. The CE of RQIA referred to paragraph 14.3 of the policy in correspondence of 9 February 2018 to the HSCTs:
"I believe the RQIA and Trusts could and should be working more effectively to share information on trends identified in individual homes or groups of homes and would like to discuss with you how best to formalise this. RQIA cannot analyse every incident…but intelligence on trends would be very useful in planning inspections. I am aware that Trusts report at a strategic level to the HSCB as part of the Delegated Statutory Functions return and whilst there is some value in this for RQIA, it is not detailed enough for our purposes. I am aware of the responsibility noted in the safeguarding policy on those who monitor and manage contracts "to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract" (9.1) …these audits would be a valuable source of intelligence to RQIA. As a first step, I would be grateful if you could provide copies of audits and quality monitoring reports[21] undertaken in respect of all Runwood homes since October 2016…time constraints mean that inspectors are unable to attend all such [safeguarding] *meetings, I am keen that they understand and take the opportunity to learn*

[21] The Health and Personal Social Services (NI) Order 2003 states [34(1)] Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of – (a) the health and personal social services **which it provides to individuals** [emphasis added] (b) the environment in which it provides them.

from and share knowledge with Trust colleagues when there is a sense that issues are escalating within a home…"

54. The policy ends with a high-level overview of the topics of "Consent and Capacity," "Access to Justice," "Information Management/Sharing," safeguarding training and learning.
55. The September 2016, *Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection* were written by NIASP. As the 2015 policy noted: *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* (p42).
56. The Introduction of the Operational Procedures advised, "they should be read in conjunction with" the 2015 policy and the August 2016 *Protocol for Joint Investigation of Adult Safeguarding Cases* – also written by the NIASP. These restate and expand the definitions, e.g. to "physical abuse" is added "Female Genital Mutilation (FGM) a form of physical AND sexual abuse" (p8); the definition of "Domestic violence and abuse" is expanded and references specialist services and a helpline (p11); the title of "Human trafficking" is amended with the addition of "Modern Slavery" and advice that this form of abuse "will always be reported to the police service" (p11); similarly, the definition of "Hate Crime" notes that "the response…will usually be to report the incident to the police service" (p11).
57. The Procedures describe the role of "Adult Safeguarding Champions" - which the policy stated, "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[22] and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018" (p25). The Operational Procedures are less specific proposing that "the Champions should be within a senior position within the organisation (p14). They are expected to be a resource to their own organisations, compile "an Annual Safeguarding Position Report," "consider whether the concern is a safeguarding issue or not" (p19), and "refer to HSC Adult Protection Gateway or PSNI" (p19). *If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and reasons for not referring to the HSC Trust* (p20) … *In the majority of cases where serious harm has been identified, the threshold for referral to the HSC Trust Adult Protection Gateway Service will have been met…referral to this service may not be the most appropriate response…for example, a peer on peer incident where capacity is a concern [may merit] an alternative response* (p23). The latter includes referral to the RQIA for action… *in respect of quality of care concerns… reassessment and review of service user/carer's needs… mental capacity assessment… action taken under complaints procedures… referral to: an advocacy service; another service… [and] a strategy to manage risks within a complex group living environment* (p23-24).
58. The Operational Procedures advance the Human Rights Act 1998, cite the Criminal Law (Northern Ireland) Act 1967 and the role of consent in determining a professional response.

[22] Dated 2010. Its subtitle is *Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults.* It is a 136-page document

The procedures state that capacity assessments should establish, *whether the adult in need of protection/ adult at risk is able to make a complaint to the PSNI and/or give legal instruction… has the capacity to be interviewed by the PSNI* (p29).

59. The Procedures set out the "Roles and Responsibilities" of the DAPO, the *HSC Investigating Officer*, the *HSC Achieving Best Evidence Interviewer*, the Line Manager, the HSC Regional Emergency Social Work Service ("RESWS") and the RQIA. This reproduces most of the text contained in the 2015 Policy.
60. The six-stage procedures are detailed. The stages are *screening the referral, strategy discussion meeting, investigation/assessment, implementation of the protection plan, monitoring and review and closure*. The appendices are principally made up of sets of forms (p84-116) to be completed when an allegation is made, through to a "Closure/ transfer summary meeting."
61. With reference to planning, the 2015 adult safeguarding policy defines two types:
    - *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* (p56).
    - *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* (p59).

    The definition of the protection plan is repeated in the 2016 operational procedures (p75) and the joint protocol (p55).
62. The 2016, *Joint Protocol* identifies a specific protection planning role for the RQIA.
    - *With regard to the Joint Protocol RQIA are a key partner in relation to investigations and protection planning in all regulated services* (p12).
63. Subsequent references to an *interim protection plan* (p24, 34, 97), and *single agency protection planning* (p35) give way to an *initial assessment and/or implementation of an Interim Protection Plan* (p36). On page 37 it is proposed that *when the investigation and/or protection plan have the potential to infringe on the human rights of others, focused consideration needs to be given to this issue.*
64. The NIASP's Annual Report April 2017 – March 2018 conflates the plans:
    - *Care and Protection Plans are the actions taken by HSC Trusts to protect an adult from further harm, where it has been alleged that they may have been subjected to some form of abuse, neglect or exploitation* (p16).
65. The Report notes
    - *…that some investigations will refer to group living situations where one investigative process may include two or more adults, whereas a Care and Protection Plan is associated with an individual adult in need of protection. Consequently, it is not unusual for the number of investigations and the number of Care and Protection Plans initiated to be slightly different* (p15).
    - *The downward trend in the number of Care and Protection Plans initiated is slightly less marked than the trend in relation to investigations commenced. Again, this may be an*

indication that new thresholds are being applied and that high-risk situations are being identified and managed appropriately (p17).

POINTS TO CONSIDER – Learning and Change

- ✓ Legislation impacts on safeguarding practice across health, social care, regulation and policing. It requires and empowers practitioners to respond in a lawful manner to their everyday work – and it trumps policies and operational procedures.
- ✓ Over two years, terminology has embraced "care plans," "protection plans," "care and protection plans" and "interim protection plans" with no clear direction regarding their relative status.
- ✓ There is a compelling case for adult safeguarding practice "shadowing" the practice envisaged if adult safeguarding legislation is to be introduced.
- ✓ The expectation that Care Managers operating as *HSC Investigating Officers* should ensure "a safe and high-quality service" strays into inspection territory.
- ✓ The profile and impact of the work of Adult Safeguarding Champions is low. Their work has not developed in the way that was envisaged in *Adult Safeguarding: Prevention and Protection in Partnership.*
- ✓ There has been no evaluation or impact assessment of the quality and effectiveness of adult safeguarding in Northern Ireland, taking account of the contrasting priorities and arrangements of RQIA inspections, professional regulation, law enforcement, complaints, clinical governance, serious adverse incidents and internal disciplinary processes.
- ✓ The policy and operational procedures were intended to result in regional coherence and a unified approach. This has not happened. Each HSCT has adopted different criteria, processes and documentation.
- ✓ The training and development of professionals involved in safeguarding practice merits a higher profile.

66. A professionals' workshop during February 2019 concluded that Adult Safeguarding was prone to a "loss of focus."
"The process has become the focus and common sense is lost. //Protecting the person is de-prioritised as you work your way through the procedure. //It takes over from Person-Centered care. //The person should be our first priority and the form-filling a secondary consideration. //All we are doing is tracking what's been done. It doesn't keep anyone safe. // Safeguarding can result in automatic suspension [of staff] – so why would you report? //Everything comes to us…We're overloaded. //Professionals are working to different thresholds. //There's a reluctance to engage in institutional investigations yet over half of the referrals concern homes. //Different Trust responses are confusing for the homes. //Why are pressure ulcers coming to safeguarding? // There is currently no culture for us to reflect – to look back and question whether or not different approaches might have helped. // We don't want to feel judged because there is no clear way of responding. // We want space to explore alternative

pathways…to think about the evidence base for recovery…and for communicating. // We gather so much data and no one is looking at it. // RQIA won't consider anything that they describe as "third party information." They ask us to get on with the safeguarding investigation and "let us know what happens."//Such skewed priorities – the damage to public confidence is terrible. //The care management role is now a social work role…but for those people in long term placements, we should not be doing the job of the regulator. // Trusts should not have inherited the task of inspecting homes from the regulator."

67. The loss of focus is played out in (a) the "Interim Protection Plans," for example: *body map completed…30 minute observations…NOK informed…GP to be contacted…had a meeting…family do not wish to make a formal complaint to the Police;* and (b) decision-making following a safeguarding referral, for example: *NFA…Please complete the relevant forms and forward to QA and Support Team for clarification…ASGT were initially given an incorrect bruise measurement…wish to inform QAST about this practice concern.*

Section C: How the Adult Safeguarding System works

> "It's all disconnected and disjointed" – relative of a DMCH resident
>
> "Nurses don't want to work in homes because of safeguarding requirements. They are worried they will miss something and get into trouble"- Care Home Manager

Home Truths

68. The evidence gathered during the COPNI investigation at DMCH and reported as *Home Truths* supported the following conclusions:
    - *The most important theme emerging from the investigation, and one which covers a broad range of issues, is safeguarding. This theme is about the importance of protecting those most vulnerable in our society.*
    - *Most of the residents in Dunmurry Manor were vulnerable adults at risk of harm as defined in the 2015 Adult Safeguarding Prevention and Protection in Partnership Policy (the 2015 Policy). Their personal characteristics and life circumstances resulted in their exposure to harm through abuse exploitation or neglect being increased.*
    - *Many of the residents in Dunmurry Manor were adults in need of protection. They were unable to protect their own wellbeing and rights, and the action or inaction of another person or persons, of the RAs[23] under investigation, caused them to be harmed.*
    - *The findings show that there was a clear and immediate risk of harm. Evidence gathered demonstrates this abuse materialised in the form of physical abuse, psychological abuse, institutional abuse and neglect* (p13).
69. COPNI's evidence[24] included: failures to report notifiable incidents; assaults by residents on each other; inconsistency between HSCTs over what constitutes a "quality monitoring" incident and what constitutes an "adult safeguarding issue;" physical security issues; lack of contemporaneous recording of observations; a confusing variety of documentation; lack of evidence of 15 minute observations taking place, the purpose of which was unclear; fear of residents entering other residents' rooms at night; reported incidents of locking bedrooms from the outside; incomplete safeguarding records; medication errors; inadequate HSCT and RQIA responses to evidence of institutional abuse; delays in calling ambulances and/or GPs; and inhuman or degrading treatment.
70. *Home Truths* recommended:
    i. *An Adult Safeguarding Bill for Northern Ireland should be introduced without delay. Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom.*
    ii. *The Safeguarding Bill should clearly define the duties and powers on all statutory, community, voluntary and independent sector representatives working with older people. In addition under the proposed Adult Safeguarding Bill there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is*

[23] Relevant Authorities
[24] The Review has not re-investigated the COPNI's findings.

an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.

iii. *All staff in care settings, commissioners of care, social care workers, and regulators must receive training on the implications of human rights for their work.*

iv. *Practitioners must be trained to report concerns about care and treatment in a human rights context.*

v. *Policies and procedures relating to the care of older people should identify how they meet the duty to be compatible with the European Convention on Human Rights.*

vi. *The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights.*

vii. *The Department or RQIA should produce comprehensive guidance on the potential use of covert and overt CCTV in care homes compliant with human rights and data protection law* (p30).

71. The Review Team drew on the findings documented in this Evidence Paper to advise DH on its possible responses to COPNI.

POINTS TO CONSIDER – Learning and Change

- ✓ It is understood that the shortcomings of the current arrangements are acknowledged and it is accepted that change is required prior to the enactment of legislation.
- ✓ The requirements of legislation could be initiated via consultation and the perspectives of principal stakeholders shared with an incoming Minister.
- ✓ Given the high profile of the covert use of CCTV, RQIA should be invited to consider undertaking a consultation to build on the guidance it issued during May 2016.[25] The latter is unequal to the challenges which have arisen in care homes and hospitals across the UK, appears dismissive of people's relatives taking matters into their own hands by installing cameras[26] and is unprepared for residents who use social media, e.g. patients' sharing pictures of hospital food in England and Wales.[27] The likelihood of care homes promoting digital - visual and text - communications is increasingly attractive to residents and their relatives. It has the potential to provide "real time feedback" to RQIA concerning residents' and families' experience of care homes.
- ✓ The provisions of the Regional Contract embed essential training requirements. Independent sector providers should be engaged to ensure an overview of all existing training and ensure that it incorporates human rights.
- ✓ A regional, outcomes-based model of evaluation of learning, that is relevant to care homes and inclusive of human rights, should feature in the commissioning and design of training.

[25] www.rqia.org.uk/RQIA/files/01/01e1fbdb-8b2e-4c20-b102-6215cce13961.pdf (accessed 18th July 2019)

[26] Paragraph 5.2 of RQIA 2016 guidance states: *Where [covertly secured images are] related to allegations of abuse of vulnerable persons or other unlawful acts, it is likely that these will be passed to relevant law enforcement and safeguarding agencies without first being viewed by RQIA.*

[27] https://www.bbc.co.uk/news/uk-49450595 (accessed 24 August 2019)

- ✓ Policies, procedures and monitoring of training by RQIA is part of its registration, inspection and annual assurance processes.[28] Inspectors are well-placed to establish their compatibility with the European Convention on Human Rights and all legal obligations.

Adult Safeguarding Data concerning Dunmurry Manor Care Home

72. The Review Team collected and considered adult safeguarding data related to DMCH. Some of the information provided concerned individuals and was shared by their relatives. Some had been gathered for the Commissioner's investigation[29] during 2017, and some with the assistance of the DH during December 2018. The Review was not charged with re-investigating matters that COPNI had already considered nor was it duplicating the DH's audit.[30] The Review has sought to examine the system and identify data which showed how well the various processes served care home residents.

Data provided to COPNI

73. Adult safeguarding is a relatively new, yet fast growing area of work. Its lack of boundaries is reflected in the nature of the HSCTs' referrals made between DMCH opening in July 2014 until 31 March 2018. The absence of a consensual view *within* two HSCTs on whether there should even be a safeguarding referral is reflected in Table 1. The HSCTs were exercised by the task of collating the referral data for the purposes of the COPNI investigation since there are several, summarised versions of safeguarding events in residents' lives. It is possible that COPNI's *Home Truths* and this Review are disadvantaged by the HSCTs' summarising processes which, it is speculated, involved selecting, simplifying, possibly paraphrasing and transforming accounts of adult safeguarding incidents into Tables. There is no material which suggests that the HSCTs were familiar with the task of coding either incidents or the responses to these for the purpose of within-HSCT analysis. Given the different approaches of the HSCTs, the region is poorly placed to organise across-HSCTs safeguarding information in such a way that conclusions may be drawn and verified. The Review Team draws on the data that is available.

[28] These include an annual calling to account – objective challenge (primarily by the DH), in terms of following up and following through on what has been planned; and scrutinizing how the organisation addresses material risks – including the unexpected which may interfere with the achievement of strategic objectives. To what extent does the material RQIA places in the public domain - most particularly the annual report – fairly reflect its operations?

[29] The Review Team was not confident that all safeguarding information from the HSCTs had been accurately presented to COPNI. During the review, adult safeguarding information was revised to give assurance of completeness and accuracy. That process revealed new information

[30] See paragraphs 7, 133 and 199

Table 1 Examples of resident on resident harm and actions taken [31]

HSCT	Events	Action Taken
Belfast	"Resident on resident altercation"	Decision: Level 2 [32]
	"Resident on resident – grabbed by the neck"	Decision: Level 3
	"…was deliberately elbowed in the face by a male resident"	"no injury sustained…no further action"
South Eastern	"Punched on cheek…"	"GP and Next of Kin (NoK) informed; screened out of VA (Vulnerable Adult) process"
	"Resident on resident incident. Unwitnessed by staff"	"Closed as risk management. Paperwork to be completed"
	"Resident allegedly struck another resident. Resident fell – no injuries"	"Dementia/ risk management by community team"

74. Table 1 underscores a critical need to reformulate the practice of adult safeguarding. The demands of presenting events, incidents and accidents in writing are considerable. The adult safeguarding information submitted to COPNI and the different information shared with the DH and Review Team demonstrates that the post-event information gathering is ambiguous about whether or not incidents merit directing to safeguarding, contract compliance, quality monitoring, care management, complaints, the RQIA (via notifications) or the police, for example. The administrative retrieval of safeguarding information from all HSCTs within the 2014-2017 timeframe begs two questions:
    - What it is the purpose of gathering this information?
    - Why was scrutiny of a "file audit" necessary to ensure that the safeguarding information was comprehensive?
75. A spotlight on one Table spanning 77-pages features the processes adopted by a single HSCT. There are five columns of information: "Process – ASG, Complaint, Quality etc; Date; Issue/ concern; Client/s involved; Staff/s involved; [and] Outcome and date." A caveat at the end of the Table states, *Please note that Adult Safeguarding referred cases may have screened out to Quality Monitoring, risk management or dementia management*. This suggests that information within the Table requires more explanation than that which has been entered.
76. The most frequently cited process concerns "Quality Monitoring" [17 citations, QM], followed by "Vulnerable Adult" [13, VA], then "Complaint" [5] with the following cited on two occasions each: "Adult Safeguarding…Fall…Medication…email."

[31] From information submitted to COPNI

[32] Although the levels do not feature in either the regional policy or procedures, they are deployed by the Gateway Team as follows: level 1 – *screened but is determined as not requiring a safeguarding investigation…Level 2 are referrals that are screened as requiring a safeguarding investigation, but this is undertaken by the Community Social Work Team…Level 3…screened as requiring as safeguarding investigation, but this is undertaken by the Adult Safeguarding Team*

77. It is not clear why "email…incident…physical injury…QM referral re poor documentation… compliment and staff behaviour" are listed as processes. More understandable processes are "Contracts…RQIA information…RESWS and Trust contracts meetings." However, it does not make sense to scrutinise these processes as distinctive and separate because their content is not exclusive and more than one process was invoked for some residents e.g. "VA transferred to QM."
78. Turning to the column "Outcome and date," the latter is occasionally recorded, sometimes with the bracketed reference to the dates of emails. With few exceptions the outcomes listed are process-oriented, that is, the results or consequences for individual residents are not described. The following examples illuminate the process-oriented approach which is characterised by a telegram style:

    Case closed. // Trust formally request an action plan. // Risk Management. // Incident not reported to care manager therefore not recorded in the file. // Requested additional information. //…felt it was a Quality Monitoring. // Screened out of ASG process for progression under Risk Management. // Quality Management referral completed…to address the issues raised. // Meeting arranged [then] cancelled. // To ensure RQIA are informed. // Referred to keyworker for dementia management. // Closed to Risk Management. // Arrange a review. // Assistive technology discussed. // Case reviewed. // Enhanced monitoring nurse. // Ongoing enquiries. // To progress under risk/ dementia management. // Concluded investigation and shared the findings with NISCC. // Investigated. // Quality Monitoring addressing. // Requested update re the home's internal investigations. // Untoward incident report completed…I requested a copy…this had not been received. // Human Resource investigations. // To address with staff – no other outcome recorded. // Investigated and allegation substantiated. // Audit may be completed by Trust quality monitoring.
79. One "issue/concern" states, "[named professional] carried out an unannounced inspection" and the "outcome and date" states "No issues/concerns identified…we will complete an in-depth audit of documentation through the clinical facilitators." It does not appear that this refers to a regulatory inspection because the RQIA is not cited in the "process" column.
80. The "issue/concern" column is illuminating since it describes in an edited way the events in residents' lives and the preoccupations of their relatives. For example, tangible evidence of inattention to:

    a) residents' hygiene, comfort, grooming and personal care:

    - *…in pyjamas and poorly shaven*
    - *…to be showered x3 daily and…teeth cleaned daily…doubts this is happening*
    - *…continence needs were not met…*
    - *Hair not washed regularly*
    - *…residents wandering in [relative's] bedroom…*
    - *…witnessed staff stripping [relative]…on the toilet [and] staff washed [relative] down with a face cloth…did not dry [relative] …feet filthy and black with dirt…*
    - *…call twice daily to ensure [relative] is having food and drinks*

- *Missing clothes on an ongoing basis…clothes soiled with faeces left in wardrobe with clean clothes*
- *clothes disheveled and what appeared to be vomit down [resident's] side*
- *…witnessed staff removing a wet pad and putting on a clean one without cleaning [resident] or using…barrier cream…resulted in…raw skin*
- *…other people's clothes were always found amongst [relative's]*
- *…toenail grew over the top of [relative's] toe*
- *…needed support tights…not used…*
- *[relative advised that resident was] playing up because you are here.*

b) Residents' medication, healthcare,[33] nutrition and hydration

- *Food served is of a very poor quality*
- *no assistance with eating or drinking*
- *…dehydration highlighted…*
- *…the home failed to provide the appropriate aftercare e.g. hospital appointments not attended*
- *…significant weight loss from admission…*
- *fall mat never activated*
- *[after a resident's fall out of bed, relative was told that bedrails were] "not allowed"*
- *…staff told [relative that resident] was falling deliberately*
- *flu vaccination not received*
- *home failed to complete basic physical checks e.g. infection, medication*
- *lesions…on [resident's] buttocks*
- *medication increased without GP calling. It was directed over the telephone"*
- *[resident's] medication was incorrect for three weeks*
- *Home had not noticed the bruise*
- *Tablet found on [resident's] floor*
- *Medication administered by unqualified staff*
- *[Relative] left a marked jug of water in [resident's] room…remained untouched/ refilled/ refreshed for three weeks*
- *Poor management of [TIA incident] by the home*
- *CPN records that home continually fail to follow advice provided…verbal information…does not match written reports*
- *supplied dressings not available…lack of nurse training…appropriate level of drugs not ordered.*

c) Residents' quality of life:

- *unattended sitting rooms within the home*
- *new hearing aids missing at times*
- *Lack of activities…bored*

[33] The NIAS reported that its log of calls to DMCH revealed "119 call outs, 8 recorded as falls" between May and December 2015; and "113 call outs, 45 recorded as falls" during 2016. Within this period the NIAS attended four residents on 21 occasions. The process typically involved contact with GPs who advised contacting NIAS

- *no continuity of care*
- *no respect/dignity – unexplained actions*
- *…last fall[34] resulted in a broken hip which [resident] never recovered from*
- *[relative] had a major emotional breakdown on Sunday evening…very distressed and inconsolable… [the following day] the nurse on duty was [unaware of this]*
- *…requested that one male staff swap with female carer…refused*
- *staff slow to respond [to alarm mat]*
- *Continual problem of other residents wandering in and out of mother's room*
- *concerned about [resident's] physical and mental health*
- *…inappropriate moving and handling*
- *resident was left sitting in living room all night…continence needs were not met[35]*
- *[On admission to hospital] improvement in mental and physical health…eating well and seems less anxious*
- *Interaction between staff and residents is lacking...80% of [resident's] clothes missing…poor quality of life due to staff attitudes*
- *curtains…were covered in faeces…*
- *Clothes soiled with faeces left in wardrobe with clean clothes*
- *glasses were broken and no optician services available.*

d) The home's fabric, routines and communications:

- *…has witnessed delays in responding to fire alarm*
- *[relative] allegedly told if you have that many complaints move [resident] to another home. We don't offer 1 to 1*
- *Staff untrained in dementia care*
- *concerned about number of changes in management…*
- *lack of organisation*
- *Too few [staff] on duty…agency staff…many do not have English as their first language*
- *some staff were exceptional, but they left…constant change of manager*
- *…a culture of denial…young girls run the place*
- *Staff were very supportive and cared for [dying relative] a peaceful environment*
- *…frustrated attending meetings and listening to platitudes*
- *permanent staff were very helpful…*
- *…dismayed that [resident] was referred to as a number*
- *…feels the new manager has a poor attitude*
- *Staff approachable and good*
- *Staff when interviewed had an incredible lack of capacity to recall events*
- *[the home's managers] talked the talk but did not address issues*
- *The Dunmurry booklet betrays a fairy tale and is totally misleading*

[34] There were almost 100 residents' falls between 2016-17.

[35] "The resident refused to leave the sitting room and became very anxious when attempts to move her were made. Staff in the home sat with her, ensured she was warm and gave cups of tea and attention until she was willingly ready to go to bed." Information provided by the South Eastern HSCT

- *[Home/ management] did not send their condolences when [relative] died*
- *…when [resident] admitted to hospital [home] staff visited [resident] on their day off…home spotless*
- *[Named professional] called to home to carry out a VA investigation initially was unable to gain entry…eventually a visitor let [professional] in.*[36]

81. During 2016, one family expressed frustration that their relative's Care Manager was "continually off work." During 2017, the distress of a relative who was unable to confirm whether a review had taken place resulted in a HSCT professional providing "[relative] with COPNI number and advised [the relative] of [its] role." Additionally, during 2017, another relative was advised that [named professional] had completed a QM referral in respect of [resident]."
82. Between November 2015 and December 2016, RQIA is cited on ten occasions within the documentation about this HSCT.[37]
    - When visitors "witnessed a resident being manhandled" in "May/July" 2016, it was noted that there was a "Failure to report to Trust or RQIA"
    - During September 2016, "all issues of concern and June RQIA report discussed"
    - During November 2016, a relative had "spoken to RQIA about…concerns"
    - When a resident fell and sustained a fracture during December 2016, it was noted that a "Copy of RQIA notification [was] received 20/12/16"
    - The "actions from the investigation" arising from a resident's admission to hospital during May 2016 noted "Also all actions that were recommended in concluding report such as having processes in place for referrals to Trust RQIA *(sic).*"
    - Re a "resident on resident incident" during August 2016, it was noted, "Advised nurse to ensure RQIA informed and forward copy"
    - "RQIA [were] informed" about an allegation[38] during September 2016 that a carer was locking residents into their rooms
    - An "update" was sought from RQIA during October 2016 concerning its inspection findings and "non-compliances"
    - During November 2016, the RQIA were party to a meeting concerning a resident and "themes emerging from Dunmurry Manor"
    - An unannounced care inspection during November 2015 was cited.
83. A small number of "outcome" examples from the adult safeguarding data suggest that improvements to residents' circumstances *may* have resulted from safeguarding meetings, investigations and processes. For example:
    - *Spoke to [relative]…happy with the placement and feels things have improved since the review…*

[36] Staff were meeting at the time of the visit

[37] Although it is the responsibility of home managers to notify RQIA, the Trust will advise them to ensure a report is made. This may not always be recorded in documentation - SEHSCT

[38] This was "unsubstantiated"

- [Named professional] *is reviewing the incidence of falls in the home…Trust's Falls Coordinator…agreed to provide input…*
- "Training planned" re fire drills
- District Nurse visited and established that the skin integrity of a resident "was good." This followed an allegation by an agency nurse
- *Family have terminated [their] place at Dunmurry Manor*
- The "locker [was] removed" from the room of a resident who had hit their head on it
- Another resident's feet were to be "monitored monthly." It is not known whether this happened
- *…checked curtain…now clean; however, in [resident's] drawer there were bandages with what looked like faeces on them…now removed*
- "Buzzer volume was turned up" after a relative reported "a delay in buzzer response"
- *…the risk to clients has been managed via your investigation and subsequent removal of the alleged perpetrator*
- *…no evidence found to suggest that residents were woken early to complete personal care*
- *In general, a friendly and homely atmosphere. As commissioner of placements within Dunmurry Manor we will complete an in-depth audit of documentation through the clinical facilitators*.

84. A separate, 13-page Table concerning residents from SEHSCT contains a column entitled "Identified learning." This title is misleading because the "identified learning"[39] challenges the appropriateness of the repertoire of the processes invoked and exhorts professionals to attend more carefully to processes:

> *Clear decision-making is required re screening out and recorded on appropriate documentation. // Concern should have been screened out and should not have been recorded on Adult Safeguarding documentation. // As a result of file audit this referral came to light. It was appropriately screened out and managed under risk management. This was not included in the information to COPNI. // DAPO needs to ensure full documentation is fully completed detailing decision-making. // Adult safeguarding referral was not appropriate as this [resident] was causing the harm to another resident…Inappropriate use of ASG documentation. // Appropriately screened out and recorded. // DAPO to ensure timely progression of the investigation and the outcome of the investigation communicated and appropriate recording and use of documentation (sic). // The information sent to COPNI references these as 4 ASG referrals when in fact there were 2 referrals. There was a request for subsequent review following issues raised by NOK about the initial investigation process. // DAPOs reminded to only record Adult Safeguarding documentation if investigation commenced and communicated to NOK. // Appropriate process was disciplinary – managed by DM.*

[39] This seeks to identify areas to be taken forward for learning - SEHSCT

85. One observation merits attention because it confirms that the decision-making rules about the various processes may be trumped by other considerations:

> *Dunmurry Manor had managed the allegation appropriately under their HR process. A report of their findings/ actions was provided to SEHSCT and should have sufficed without instigation of an adult safeguarding review. Pressure from a family member led to attempts to demonstrate that all possible processes had been followed*.

86. A five-page Table identifies the Designated Officers responsible for the adult safeguarding referrals relating to 35 residents. Some of the outcomes cited include:

> *Strategy and case discussion both cognitive impairment. // Protection plan in place. // Cognitive impairment. // Protection plan in place. Care plan for client. // Investigated - closed. // Investigated and recommendations made. // Closed following information gathering. // Unable to confirm what happened Quality monitoring (sic). // Recommendations made. Staff induction process and supervision. // Cognitive impairment. // Not substantiated recommendations made.*

87. A two-page Table summarising the "date, VA, AP, incident, decision [and] PARIS"[40] cites "the red book" in the decision column i.e. "Not in red book" x7. This is a reference to the electronic record of all referrals to the Adult Protection Gateway Team which replaced a red book into which referrals were handwritten.

POINTS TO CONSIDER – Learning and Change

- ✓ There should be certainty that there is a reliable way of collecting, coding, storing, analysing and retrieving data and information about adult safeguarding across the region.
- ✓ Adult safeguarding in NI is a process-creating enterprise. It needs re-orientating towards outcomes for the individuals concerned. Neither "cognitive impairment" nor "dementia" are credible outcomes.
- ✓ The criteria for determining the types of procedural responses to incidents appear unquestioned. This is not the problem of those responsible for inputting or collecting data. Simplifying a confusing array of processes is necessary.
- ✓ Accounts of incidents and events should combine factual description and reasoned explanations.
- ✓ Post-event decisions ought to tackle the causes of harm and identify readily understandable ways of minimizing the risk of further harm.
- ✓ Conclusions drawn depend on the quality and confirmability of the information gathered so that others may reconstruct and corroborate them. The system should be able to depend on documentation, such as risk assessments and management, to prevent harm, protect people and enable practitioners to learn.
- ✓ The decision-making concerning the appropriateness of the processes invoked ought to point towards "learning identified." The Review finds that it does not.

[40] Primary Access Regional Information System

Belfast HSCT's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

88. It took time for the HSCTs to respond to the Office of Social Services' [DH] request for information. The Review Team found it difficult to establish a comprehensive list of all safeguarding referrals made in respect of DMCH. An initial scrutiny suggested that there were 48 referrals associated with 21 Belfast residents. These numbers were subsequently amended since:
    - safeguarding referrals did not align with "file audit"[41] information
    - the criteria for "accepting a safeguarding referral" could not be ascertained from the referral information
    - the ways in which HSCTs' prepare referral information differs
    - terminology appears to have different meanings across the HSCTs
    - matters concerning staff conduct are usually[42] "screened to host Trust"
    - anonymised information concerning similar referrals potentially double-counts incidents/ events
    - the rationale for certain outcomes is not known.
89. With these caveats in mind, within the 2014-2018 timeframe, there were 23 Belfast residents at the home, four of whom were men. There were 54 referrals in total. During 2014 and 2015, there were four and seven referrals respectively. During 2016, there were 27 referrals and during 2017, there were 15. There was a single referral during March 2018. Three referrals concerning three residents pre-dated their admission to DMCH. Two referrals were about men in hospital. The HSCT removed these from the information. [43]
90. It is noteworthy that nine Belfast residents (six women and three men) were the subjects of safeguarding referrals within the first month of their admission to the home.
91. Three residents, two women and a man, were the subjects of between seven and nine referrals.
92. The greatest number of referrals concerned "resident on resident" harm, including residents hitting, slapping, pushing, punching their peers and having verbal altercations. Although one resident had their "hands around neck" of another resident… "no significant harm [was] noted." There is no doubt that some of these incidents would result in foreseeable distress, e.g. "hair grabbed from behind." It is remarkable therefore that within the transcribed "outcomes" are more than 20 assertions of "no actual harm" and more than 20 statements, "No further action" which appears to be synonymous with "safeguarding investigation closed."
93. One referral resulted from a medication error. Others arising from staff behaviour included residents "allegedly verbally abused," and the use of social media. Although these were "screened to SEHSCT as the host Trust…as it related to a staff member as potential abuser

[41] See paragraph 133. File audits were part of inter-HSCT monitoring and were followed up by Quality Monitoring Officers. The Review Team noted criticisms of these, e.g. unplanned monitoring visits; Quality Monitoring Officers' adopting different approaches; and resulting reports unavailable to the homes

[42] There was a dispute about how a referral was handled between the funding HSCT and the host HSCT

[43] Two of these were from SEHSCT. The Review Team understood that they were included because the men later became residents at DMCH

and had wider safeguarding implications," the Human Resources outcomes and/ or impacts on residents were not detailed.

94. One resident returned to the home in which they had lived before DMCH with another resident. Their absence led to the PSNI investigating missing persons. The outcome was "Care plans and risk assessments updated."
95. There were fewer than ten referrals concerning sexual behaviour and potential assault. Some were not directly observed and others concerned touching through clothes.
96. The circumstances of a resident who sustained a fracture were attributed to "a history of falls" and deemed to merit "follow up from Quality Assurance Team." One referral concerned the allegation of a resident's clinical neglect. This resulted in essential medical intervention and ultimately, "in a no prosecution decision" by the Public Prosecution Service for Northern Ireland ("PPS"). Necessarily the PSNI investigated this case and the PPS determined that there were no grounds on which to bring prosecution. It was also involved in discussions concerning five other safeguarding referrals.
97. Five of the transcribed outcomes referred to residents' dementia or memories of incidents. For example:
    - *…unable to contribute to clarity about scratch marks*
    - *Neither had any recall of the incident* [juice was poured on a resident]
    - *Agreed as dementia management and investigation closed* [resident fell following an altercation]
    - *…concluded as dementia management issue* [face slapped]
    - *Unable to recall the verbal abuse* [by staff member]
    - *…screened as behaviour management rather than safeguarding* [face slapped].
98. A referral concerning bruising led to "follow-up" from the community team and liaison with a resident's relative who "had no note of bruising or concern." The family of a resident who was the subject of more than seven referrals "did not wish to take any further action…did not wish to pursue a formal complaint to PSNI…did not wish any further interventions." Another family notified about a referral stated that they had "no particular concerns."
99. The outcomes transcribed appear limited, most particularly when onward referrals are cited. Given the levels of risk to which residents were exposed – most notably from other residents – there is no reference to risk management interventions. "Agreed continuing vigilance with home" or yet more "plans" are barely credible in view of the likelihood of residents harming each other. It is noted of one resident involved in harming another, "there had been two previous incidents recorded." Knowledge of an individual's behaviour is essential if homes are to manage the behaviour and its implications for others. The bruising of one resident was "screened as a quality concern rather than safeguarding as no significant harm noted." The involvement of clinicians such as a GP or specialist medical input at consultant level was rare and associated with a single resident. It was noted of one resident that they had been "transferred" from the home. After five incidents of being hit, slapped, and mistaken as the close relative of another resident, the person concerned was "moved to the residential part of the home."

100. Various claims concerning 19 residents concluded "no harm noted," even though they sustained cuts, "superficial" injury, bruising, falls, scratches and skin marks due to the actions of other residents. It is possible that professionals completing the safeguarding forms were reassured by such recorded statements as *No injury was sustained although [resident] was noted to be distressed at the time. //…was surprised but not hurt and was easily settled. //…no injury noted [resident] distressed initially. //…no ill effect noted. //…was distressed at the time.*
101. Since anyone in pain is locked in a struggle for relief and potentially fearful of recurrence, non-clinical assertions about whether or not individuals have been harmed are ill-judged. People with dementia still register that something they called pain is making an impression on their bodies. They may be unable to articulate this and/ or may express pain through their behaviour. The Review Team's scrutiny of the DMCH referrals found that no safeguarding referrals cite individual's "fears."

POINTS TO CONSIDER – Learning and Change

- ✓ There was a single reference to "risk" in the outcomes transcribed concerning Belfast residents. A regional approach to risk management is required.
- ✓ Only one of the three people subject to seven or more referrals had a "care review" and this occurred after the seventh referral. An eighth referral was "followed up by a care worker." It is important that there is consistency across all HSCTs concerning care reviews; and what these should entail – they should always involve the person who is the subject of the review, family members and carers.
- ✓ The basis on which "no actual harm" is stated is not discernible from the referral information.
- ✓ "No further action" is a frequently cited outcome arising from screening, investigations and claims about whether or not "harm" has been established.
- ✓ The rationale for the processes of onward referrals to the host HSCT or to the Quality Assurance Team/ monitoring is not clear.
- ✓ Determining "dementia management" or "behaviour management" as outcomes should cease. The documentation should record the care and support steps to be taken and describe how the intended and actual interventions result in benefits for individual residents.
- ✓ Families are instrumental in (i) alerting a home to problems and (ii) determining whether or not action is taken as a result of allegations. Attending to their alerts and questions is invaluable to residents and relatives.
- ✓ It cannot be determined from the documentation[44] what resulted from Notifications to the RQIA about the harms sustained by residents.

102. On 18-19 February 2019, Belfast HSCT professionals acknowledged the uncertain distinction between poor and neglectful practices and noted:

[44] Runwood has not provided this documentation although it has been requested on several occasions.

"Where does common sense feature? // Too much time is spent batting concerns about quality to the RQIA who say "it's safeguarding" when safeguarding has no powers! // You hear "It's not in the contract" – why not? // There's no readiness to challenge...it requires courage to complain. // Can anyone explain why acute hospitals are treated differently? Why are hospital wards not regulated facilities? // Who should be taking the lead when, after a safeguarding investigation, the RQIA do an "unannounced inspection" and state that at the time they visited, everything's ok? // We suffer from a lack of Mental Capacity legislation and yet allow people to get tangled in cobwebs with Best Interests decision-making. // We owe it to families to engage with their perspective and to get it right. // We have to be clear about involving the PSNI when crimes are committed. // We try to get the thresholds right but they're different and it becomes a fog!"

South Eastern HSCT's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

103. The South Eastern HSCT ("SEHSCT") is the host HSCT to DMCH. The information it provided to the Office of Social Services included the name of a resident (with an identical birth date but different date of admission to the home) who also features in the listing of Belfast residents. For the purposes of this Evidence Paper, the referral information concerning this resident was transferred to the Belfast data since the latter contained several referrals for this resident, and possibly the one cited by SEHSCT.
104. SEHSCT advised the removal of information concerning a small number of referrals since these pre-dated the admissions of three residents to DMCH. An additional two were identified by the Review Team – one referral had occurred seven months prior to the person's admission. They were removed.
105. Within the relevant timeframe there were 29 SEHSCT residents at DMCH, 13 of whom were men. There were 47 referrals in total. During 2014 and 2015, there were five and 12 referrals respectively. During 2016 there were 21 referrals and during 2017 there were eight referrals. There was a single referral during 2018. This referral pattern resembles that of the Belfast HSCT.
106. Two residents were the subjects of four referrals, two were the subjects of three referrals and eight were the subjects of two referrals. In contrast to the Belfast HSCT, three residents were the subjects of referrals within a month of their admission to the home.
107. Once again, the greatest number of referrals concern residents harming other residents by hitting, grabbing or pushing. Claims such as, *no serious harm…no harm…unsubstantiated, no serious harm* appear unduly reassuring in the absence of corroboration. It was noted of one incident that the, *Investigation could not establish if harm actually occurred*.
108. One referral concerned a medication error for which a GP claimed responsibility. There were around ten others arising from the behaviour of staff at the home regarding "poor" manual handling, staff members shouting at/ being threatening towards residents, the poor handling of a resident and staff declining to assist residents. There were staff suspensions, disciplinary processes were initiated and a member of staff was subsequently referred to the Disclosure and Barring Service by the home's manager.

109. Two referrals concerned two residents exiting the home and another resident found sitting on the wall of an enclosed garden.
110. There were three referrals concerning sexual behaviour and potential assault, one of which resulted in informing the RQIA. It was noted of the others that "there was no evidence to proceed with a criminal process and a PSNI investigation" and "PSNI referral but not involved. NOK did not wish to make a complaint." It is unclear whether all were the subject of referrals to the PSNI.
111. One referral highlighted the neglect of a resident. This was one of three residents who were moved to other homes. It was noted that "issues were raised with Dunmurry Manor" concerning neglect. In addition to a GP and paramedics, the PSNI was notified when a resident was found with several injuries. *This was managed under care planning*.
112. It is speculated that one family did not want their relative to be interviewed because of the potential trauma. Only three referrals referenced people's dementia and its manifestation.
    - *…unable to recall alleged incident*
    - *Both residents had dementia and lacked capacity*
    - [it is] *a feature of [the resident's] condition*.
113. The SEHSCT referrals confirm that contact with residents' families is instrumental in determining whether or not investigations proceed. For example:
    - *NOK consulted and happy that it is screened out*
    - *The family did not wish to pursue the matter*
    - *NOK informed and not wishing PSNI involvement* [there were seven such statements]
    - *NOK informed and did not want further action*
    - *NOK informed and did not want to make a complaint*
    - *[NOK declined to] engage with the investigation nor identify staff*.
114. These 'outcomes' [45] resemble those of the Belfast HSCT insofar as they are characterised by a lack of consistency. However, in contrast to the Belfast referrals, there are many references to risks, that is, *risk minimal. // Risk management meeting. Investigation closed. // Risk management plan in place [x2]. //Risk assessment and management plan. // It was referred to Risk Management [x2]. // …managed under risk management [x6]. // The manager had taken steps to put risk management plan in place*. The other "management" destinations cited are: *Managed under care planning by key worker. // Managed under care planning [x3]. // Referred to the Adult Safeguarding team for review and management. // Managed under complaints procedure. [46]// Managed under quality. // Managed under disciplinary" [x4].*
115. It is not known why a single "altercation" between residents resulted in informing RQIA. The latter was also "informed" about a referral concerning a sexual incident – even though similar incidents were documented about which the RQIA or PSNI did not appear to have been informed.

[45] The heading shaping SEHSCT's response is the "Outcome of screening and reason for decision/ description of concern reported/ record and actual harm"

[46] This concerned a resident who transferred to another home. It is the only reference to a complaints process

116. SEHSCT acknowledges that ten referrals "were not listed on the COPNI information." That is, they came to light during "file audits." A total of 23 referrals were "screened out" and the template indicates that a further three "should have been screened out." These concern a medication error; a relative's "concerns" regarding "low staffing levels…visible stress of staff…manager's ability to manage the home;" and a resident's attempt to leave the garden area.
117. SEHSCT shares non-clinical insights concerning whether residents sustained harm with 28 referrals associated with, *no serious harm*. One cited "significant harm" and arose from a fracture requiring hospital treatment. Typically, when referrals hinge on hospitalisation, neither the Belfast HSCT nor SEHSCT states whether harm is perceived to have resulted.
118. The SEHSCT's own analysis attributes its responses/ referrals concerning DMCH to the implementation of the 2015 regional policy, followed by its 2016 procedures and the accompanying training "regarding the language and new thresholds." The transition from the previous policy and procedures is associated with some "inconsistency." Furthermore, staff were responding to the perceived pressure of relatives "by escalating issues inappropriately under Adult Safeguarding." It was noted that HSCT and DMCH staff believed that they had to "report everything." It was "staff anxieties" about "institutional abuse" that meant "the thresholds dropped" and risk analysis and management were set aside in favour of "escalating everything to Adult Safeguarding." It was noted that discussion with line managers or DAPOs prior to submitting referrals would have constrained "inappropriate referrals." SEHSCT's solutions include a "permanent placement team…to create a relationship approach to support and in-reach" to homes; the creation of an Adult Protection Gateway Team; audits and action planning; the deliberations of a "monthly operational, cross-programme governance group;" and a review of,
    a) NI's Single Assessment Tool [47] and
    b) the regional procedures - which "have been challenging to implement."

POINTS TO CONSIDER – Learning and Change

- ✓ SEHSCT's clear distinction between "screened out" and "investigated" is not evidenced in Belfast HSCT's data.
- ✓ There is overlap, but little correspondence, between the two HSCTs indicating a need for a single regional approach.
- ✓ The "outcomes" cited by both HSCTs do not set out the implications of an incident or event for individual residents.
- ✓ Ensuring the safe juxtaposition and groupings of residents demands professional attention yet is reflected only occasionally by moving residents to other homes or to other areas within a home.

[47] Issued during 2012

Northern HSC Trust's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

119. A single page entitled "Dunmurry Information 1 June 2014-31 March 2018," refers to the "institutional neglect" of three women, one of whom sustained two falls within a year. Although her initial fall was "substantiated," the second one was not, because at the time she had a significant Urinary Tract Infection and she had mobilized unaided. Another concerned a resident being locked in her bedroom. An investigating Officer met with her family who were regular visitors to the home. Since there was no supporting evidence and the family were satisfied with the care provided, this was not "substantiated," that is, no finding of institutional neglect resulted. Finally, the failure to record a resident's repositioning was investigated. However, a relative who was a daily visitor confirmed that the resident "was repositioned throughout the day." Thus, this safeguarding referral was not "substantiated."

Southern HSC Trust's Contract Compliance Process: Dunmurry Manor Care Home

120. The number of people the Southern HSCT had placed at DMCH was not known to the Office of Social Services of the DH. The latter confirmed that between June 2014 - 31 March 2018, this HSCT had received neither safeguarding referrals nor serious adverse incident reporting. However, the Trust did report eight concerns via a Contract Compliance process in relation to three residents, two women and a man. These spanned October 2016 - June 2017.
121. One woman was transferred to another nursing home having been the subject of two "contract compliance issues." Her family had questioned her diet, the quality of food provided, inattention to her care plan, inadequate assessments of her support needs and rough handling. The recorded remedies included the provision of care plans and the promise of an appropriate diet. A follow-up visit noted, *inter alia,* poor record keeping, inconsistent attention to care planning, the woman's "unexplained bruising," and reference to a "DNACPR[48] signed by the GP…" Since the woman's transfer to another home, the "measures to be put in place to prevent occurrences of this nature" included updated care plans and assessments, attention to staffing, the allocation of key workers to residents and the appointment of a Deputy Manager.
122. Another woman had sustained a fracture having stated that she had been pushed by another resident. Scrutiny of her records highlighted an undated and unsigned assessment of needs document, four body maps with "multiple entries" – all unsigned and "no integration of needs assessment and risk assessments into the plans of care." The woman's relatives subsequently discovered an open wound and reported her "unkempt" appearance. The home was reported as acknowledging that communication and documentation were not of the required standard. "The unit is now more stable having a full complement of senior staff…"
123. There were four "contract compliance issues" concerning a male resident. His care plan had been inaccurately re-written by a nurse who did not know him. It included a risk assessment for the use of a rollator which the man neither required nor used. It was noted that staff vacancies and "ongoing recruitment" meant that "all the issues highlighted will be

[48] Do Not Attempt Cardiopulmonary Resuscitation.

addressed..." During a follow-up visit there was no evidence of the promised updates to the man's records. It was expected that there should be

> *…an integration of risk assessments into care plans…informed by the needs assessment…updated risk assessments and information from other professionals as appropriate to devise a person centred plan of care based on best evidence-based practice.*

124. At a later visit it was noted that all care plans had been updated and computerized. However, still later, the man's risk assessments *did not reinforce the nursing assessment or…the overall plan of care.* The man's relatives questioned inattention to cutting his fingernails and it was not known whether an unexplained injury had been reported to the RQIA. It emerged that the bruising he endured was documented in the care record and accident book; *supervision was highlighting duty of care and standards of personal care* [and the] *deputy manager to audit personal care files*.

POINTS TO CONSIDER – Learning and Change

- ✓ The issues addressed by contract compliance resemble those which are referred to adult safeguarding by other HSCTs.
- ✓ It is possible that contract compliance places undue faith in the recruitment of staff and has unrealistic ambitions for the home's recording practice.

Summary of Incidents and Quality Issues

125. An additional wave of scrutiny was set out in a Belfast HSCT document entitled *Summary of Incidents and Quality Issues reported in Period 2015 - 2018: Dunmurry Manor*. This contains summaries of "adverse incidents and quality monitoring." It notes that the work of the Quality and Support Team was compromised by its own "staffing challenges" during 2014 - 2015. This resulted in no analysis of the information received, prompting a statement in the Introduction, "…we cannot be assured that our reporting for this period is accurate." The Introduction goes on to account for Quality Monitoring Reports ("QMRs"):

> *QMRs are incidents, accidents or quality of care issues reported by a member of staff employed by the Trust, from their own observation or through information received from another party, including a service user or family member. The QMR report will include details of the quality issue, accident or incident as reported by Trust staff and will be forwarded to the independent sector provider for further investigation and response.*

126. The first part of this document names 30 DMCH residents and lists 119 "incidents" of which 97 concerned residents' falls. These occurred between April 2016 and May 2017. The most typical "outcome" cited was "checked/assessed." Four residents experienced 57 incidents: nine, 11, 18 and 29 respectively. There is a single reference to "pressure damage" and six to "behaviour." In a column "Actual harm experienced," there are 86 "no injury" citations, yet one resident had six falls on the same day, another had two falls per day on four days. Other outcomes cited include *…close observation. // Training. // First aid administered. // Care plan reviewed/ updated. // Transfer to hospital. // Refer to Adult Safeguarding Gateway Team* ("ASGT"). *// …not recorded. // …reported. //* [and] *ambulance called.*

127. The second part of the document is a Table concerning 10 residents. Its title is, *Reporting from the implementation of the new Care and Support Team and reflect a new method of recording.* It spans January 2018 - March 2018, and confirms that falls remain a significant feature in residents' lives. One resident experienced two falls and another was the focus of three incidents. Although this Table pays attention to "actual harm experienced" and "level of harm," it is the outcomes which merit consideration since they concern the actions undertaken on behalf of residents.
128. For example, *First aid dressing applied to head wound. Neuro observations were recorded [and] 24 hours falls-log completed. Ambulance called…//Laceration cleansed, pressure applied with gauze…both pupils symmetric and reactive to light…GP contacted urgently…// Full body check, falls risk assessment completed and care plan updated…Reg. 30…sent…reassurance and resident reminded to call for help when needed…// Resident comforted, GP, NOK and key worker informed.* While these are more revealing than "checked/ assessed," it is not clear how such information is used.
129. The final part of the document concerns "QMRs from DMCH Sept 2015 - March 2018." These hinge on the circumstances of 11 residents, one of whom was the subject of two QMRs. Of the latter, one concerned the delayed reporting of a resident whose hair was pulled by another resident; and another concerned a resident whose face was marked with nail polish. Other QMRs addressed inattention to residents' personal care needs, management of incontinence, comfort, grooming and care of belongings. Two families questioned the home's inadequate numbers of staff since they associated it with poor practices resulting in pressure ulcers for example. It was noted of a resident who had fallen ten times in six months that the *quality team… advised the care manager that all incidents had to be reported to quality team whether or not client has sustained injury*.

POINT TO CONSIDER – Learning and Change

- ✓ A QMR appears to apply when the matter is deemed a management, practice or complaint/grievance type issue that is referred to the provider to address.

Notifications to the RQIA

130. Section 30 of *the Residential Care Homes Regulations (Northern Ireland) 2005* and the *Nursing Homes Regulations (Northern Ireland) 2005*, states that *The registered person shall give notice to the Regulation and Quality Improvement Authority without delay of the occurrence of:*
    a) *the death of any resident, including the circumstances of his death/* the death of any patient, in the nursing home, including the circumstances of his death
    b) *the outbreak in the home of any infectious disease which in the opinion of any medical practitioner attending persons in the home is sufficiently serious to be so notified/* the outbreak in the nursing home of any infectious disease which in the opinion of any medical practitioner attending persons in the home is sufficiently serious to be so notified;

c) *any serious injury to a resident in the home/* any serious injury to a patient in the nursing home;[49]
d) *any event in the home* which adversely affects the care, health, welfare or safety of any resident*/ any* event in the nursing home which adversely affects the wellbeing or safety of any patient;
e) *any theft or burglary in the home/* any theft or burglary in the nursing home;
f) *any accident in the home/* any accident in the nursing home;
g) *any allegation of misconduct by the registered person or any person who works at the home/* any allegation of misconduct by the registered person or any person who works at the nursing home.

131. It is striking that in the light of harms arising from resident-on-resident "altercations" – some of which resulted in injuries - there are so few references to the RQIA in the documentation shared with COPNI and the DH. Not all of the 10 references to the RQIA in the information submitted to COPNI concerned notifications. There are only three references to the RQIA in materials compiled by the Office of Social Services dated February and August 2015 and January 2017. These concern a resident-on-resident "altercation. Protection Plan in place. RQIA and family informed. No serious harm." Another concerned two residents "found in a bedroom," one of whom was in a state of undress. It was noted that there was a "Risk Management plan in place. Family were informed and RQIA." Finally, it was noted that there was "no RQIA notification completed in respect of [a resident's] injury of unknown origin."

132. In correspondence from the HSCB to the Review Team during August 2019, it was noted of the interface between adult safeguarding and the RQIA:

> *Adult safeguarding is itself a complex system, which operates within a further complex system made up of a very diverse range of stakeholders, interested parties and providers. Within that complexity, it is highly likely that identified strengths in one area of the system are potentially also shortcomings within a different part of the same system. So, for example, the strength of RQIA in setting and monitoring the application of standards and regulations can become a shortcoming when one part of the system experiences that monitoring as either unhelpful or inadequate. Similarly, a strength of the current system is that adult safeguarding is clearly identified as everyone's business. However, in a health and care system under significant pressure, that can be interpreted as someone else's responsibility…*
>
> *NIASP's work with RQIA is shaped primarily by the strength of having an independent regulator who has the authority to require and enforce improvement on all providers. However, the shortcomings of the current arrangements mean that at times RQIA appears reluctant to use these powers in support of adult protection activity…*

[49] *The Northern Ireland Ambulance Service Calls to Registered Nursing and Residential Homes in Northern Ireland 2017/18: Data Summary Review* notes that during 2017-18, the total number of notifications was 15,847. RQIA has clarified that this figure includes notifications in addition to those concerning serious injuries.

At present, HSC adult safeguarding teams do not have automatic right to see the records of individuals living in care home settings e.g. administration of medicines.[50] *This information is, however, available to RQIA. Whilst recognising the importance of individual confidentiality and the provisions of the data protection legislation, it would nevertheless be helpful for clarity to be provided on the limited circumstances where adult safeguarding practitioners can access individual resident records.*[51]

POINTS TO CONSIDER – Learning and Change

- ✓ The regulatory requirement to notify the RQIA of 'any event' or 'any accident' would suggest that all adult safeguarding referrals, adverse incidents and events resulting in Quality Monitoring should be known to RQIA.
- ✓ The basis on which notifications to the RQIA lead to its intervention is unclear from the information shared with the Review Team.

How the system worked at other care homes

133. Following the publication of *Home Truths* the DH detailed a series of measures concerning care home standards.[52] These were:
    - *An independent review of actions by the HSC system in relation to care failings at Dunmurry Manor, with a view to identifying lessons for the future. This will be in addition to the formal HSC response to the Commissioner's report.*
    - *A workshop event involving HSC bodies to address concerns around Dunmurry Manor and care home provision generally – the aim of this will be for lasting improvements and lessons to be embedded into the HSC system. Patient and family voices will be represented at this workshop.*
    - *A scoping review on potential options for additional sanctions for private sector care home providers and companies responsible for serious failings.*
    - *A public campaign to clarify and build awareness of how care home residents, families, staff and other concerned citizens can raise concerns and make complaints.*
    - *An audit of safeguarding investigations in relation to care homes operated by the independent sector.*[53]
    - *Investment in improvement, recognising that, while vitally important, regulation and inspection will not deliver better care by themselves. In this financial year, £325,000 has been allocated to support nursing in-reach from Trusts to care homes. This means*

[50] This statement is contradicted by the SEHSCT which cites the relevant clauses of the Trusts' contracts: ***23.2*** *The Provider must ensure that all information produced in the course of this Contract or relating to the Contract is retained for disclosure and must permit the Trust to inspect such records as requested from time to time.* ***32.2*** *The Provider shall grant to the Trust or its authorised agents, including RQIA, any other Regulatory Body, internal and external auditors and NIAO, such access to those records in relation to the Contract as they may reasonably require*

[51] Correspondence from the HSCB to the Review Team

[52] https://www.health-ni.gov.uk/news/department-health-details-series-measures-care-home-standards (accessed 1st July 2018)

[53] Although the audit work is separate from that of the Independent Review Team, both work streams have shared information and reflections

Trust identified nurses will work with and support the nursing and residential care home staff to look after all the needs of residents.

- *Additional funding of £80,000 will support further enhanced clinical skills to meet complex nursing care needs in nursing homes.*
- *A new senior nursing post at the Public Health Agency is being established, dedicated to working with independent sector nursing homes and acting as a central point for the HSC to enhance quality and safety of care for patients and residents.*
- *Identification of a dependency tool to help ensure appropriate staffing levels for nursing homes. This is the latest stage of the roll-out of Delivering Care, the DH's policy on safe staffing.*
- *A measurement framework for nursing care which has been devised and tested in acute hospital wards will be reviewed for nursing homes. It will include eight key indicators that measure the impact of nursing care.*
- *The DH will support implementation of initiatives aimed at improving the quality of life for people living in care homes such as the My Home Life initiative.*
- *The DH has also recognised the need for long-term transformation of adult social care, as underlined in the expert panel report published in December.[54] A project team is taking this reform agenda forward with a carers' panel being recruited. The next phase will include a far-reaching public debate, highlighting the major challenges for policy makers and society as a result of demographic changes, investment needs and the vital importance of staff recruitment, retention and development. The public concern currently evident on care home provision provides further evidence of the need for change.*

134. This position would be endorsed by families who seek to remedy the bleak experience of their relatives in care homes and long stay facilities because poor and neglectful care is not the sole preserve of residential and nursing homes. What is consistent across settings such as DMCH, Muckamore Abbey Hospital – which was subject to an identical safeguarding system - other hospitals such as Winterbourne View[55] and Whorlton Hall[56] is the disbelief of relatives that the harms endured are neither rare nor occasional; there was no credible risk management; and no one took account of (i) the wide discrepancy between their hopes for care and support and the experience of their relatives; (ii) shameful practices including callous treatment; and (iii) the disquieting behaviour of managers and staff.

135. In preparing this Evidence Paper the Review Team reflected that there appeared to be a perception of residential care and nursing homes as providers of medical care in sub-acute medical settings. This is contrary to most people's understanding of a "care home" because it casts older people's requirements solely in physical health terms. In visits to other care

[54] This refers to Kelly, D, and Kennedy, J. (2017) *Power to People: Proposals to reboot adult social care and support in N.I. – Expert Advisory Panel on adult care and support* Belfast: Department of Health

[55] Flynn, M. and Citarella, V. (2012) *Winterbourne View Hospital: A Serious Case Review* South Gloucestershire Safeguarding Adults Board https://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/ (accessed 15 August 2019)

[56] https://www.bbc.co.uk/news/uk-england-tees-48585903 (accessed 15 August 2019)

homes[57] across Northern Ireland, care staff have described practices with bewildering consequences. For example, care staff are advised that information-posters must be displayed.[58] One resident who was terminally ill was required to move from a room in which they had lived for many years to one in another part of the home because they required "nursing."

136. Discussion with professionals and preliminary feedback from DH's file audit suggests that the poor standard of record keeping at DMCH was replicated at some other care homes. The fault line between the safeguarding policy and procedures in which complaints became "mixed up" with safeguarding is confirmed. Similarly, the distinction between a "protection plan" and a "care plan" is unclear in resident's files. A typical response to a resident's falls, for example, was a "protection plan" requiring "15-minute observations." The purpose of this is unclear since observations, per se, have no credible track record in preventing falls. A visit to one home revealed that 12 residents were subject to "30-minute observations." During challenging staff recruitment times, too much valuable staff time is expended on "observations" and form filling.
137. At DMCH, one-to-one support resulted from some adult safeguarding investigations. However, since some families reported that there were times when there were not enough staff to deliver care, the likelihood of providing either the support or "15-minute observations" was remote. Neither the purpose nor the efficacy of such observations was set out in any documentation. Such practice is questionable in contexts where families have challenged the failure to meet people's care needs.
138. The "outcomes" arising from the safeguarding process in relation to older people suggest some complacent habits of thought. For example, "no serious harm…she's got dementia." Although residents' families reported that their relatives were "frightened," there was no reference to addressing "fear" in any safeguarding responses. Few safeguarding investigations appear to be brought to a clear conclusion. Many investigations were characterised by delays and the absence of any casework with either residents or their families. Home managers and staff typically had no person to person contact with health and social care staff tasked with dealing with safeguarding matters.
139. The terms "safeguarding" and "complaints" were used interchangeably. Too many "safeguarding concerns" were subjected to protracted investigations with uncertain outcomes for individuals.
140. The picture was not a new one since in 2014, the RQIA published an *Independent review of the actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus.*[59] This was in response to a history of allegations, "concerns…whistle-blowing allegations…[and] complaints" from families, staff and relevant bodies including the DHSSPS, the HSCTs, the PSNI and RQIA since 2005. The introduction to the review noted that, *Although*

[57] Members of the Review Team had visited seven care and nursing homes in NI at the time of writing.
[58] The posters were health related – information from the Southern HSCT
[59] By Peter Gibson, Eleanor Hayes and Elspeth Rea. It was an independent review prepared under Article 35 (1) (b) of the 2003 Order.

investigations have been conducted, it is not clear, at this stage, whether all concerns / allegations were investigated - this is because there was a wide range of organisations / individuals and data sources involved (p1).

141. Cherry Tree House was registered to provide care for "Learning Disability, Mental Health Condition, Old Age and Physical Disability" (p5). The review considered:
    - 65 complaints and untoward incidents during 2005 - 2013. These concerned, *inter alia,* allegations of abuse by staff, inattentive personal care and health care, medicines management and inadequate staffing levels
    - 55 whistleblowing events during 2006 - 2013. The abuse of residents, poor care standards, and staffing matters
    - 43 RQIA inspections and three enforcement actions.
142. It was stated, *Cherry Tree House had employed, in senior management roles, staff who had left previous employment following their practice being called into question. They commented that it was too easy for staff who had been dismissed in one home to move to another and felt that there are inadequate controls in place to prevent this happening* (p11).
143. The review confirmed that there were shortcomings in the delivery of care, service commissioning, "robust and responsive regulation" and attentiveness to residents' relatives and advocates. Cherry Tree House did not consistently comply with the minimum care standards, complaints to the home were poorly managed and inspection reports did not use available "intelligence" concerning the home. Identical matters *of concern about care at Cherry Tree House were highlighted on a regular basis and where improvements were made they were often not sustained…Families and others communicated their lack of understanding in escalating complaints about the care in Cherry Tree House to external bodies* (p11-12).
144. The review was critical of the RQIA's limited use of enforcement powers given the home's consistent failure to comply with minimum care standards. Its recommendations included amending regional contracts requiring homes to report all complaints and their outcomes; information packs for prospective residents; timely feedback to complainants; a review of the Public Interest Disclosure (NI) Order 1998; preparation for RQIA inspections to include knowledge concerning complaints, whistleblowing and untoward incidents; and more effective efforts to ascertain the views of residents, families and staff during inspections.
145. In the Foreword to *Home Truths* the COPNI noted:
    In [2014] …the independent review report on the Cherry Tree Nursing Home in Carrickfergus also revealed serious shortfalls in the standard of care and the inspection regime. At the time, there were a number of public commitments made to bring about change and to implement a series of recommendations to prevent a repeat of this happening in the future. Unfortunately, the response to these recommendations has been slow and disjointed, the result being that many of the failures identified in this investigation could have been prevented

or at least managed better had the previous findings and recommendations been acted on more quickly and in full[60] (p3).

146. During August 2017, the RQIA cancelled the registration of Ashbrooke Care Home, Enniskillen which was operated by Runwood. The Press Release of 21 August 2017, stated that the RQIA's action was "in response to safeguarding concerns received by RQIA" on 15 August. An urgent, unannounced inspection identified *systemic care failings and concerns in relation to the management of the home…a serious risk to the life, health and wellbeing of all those living at Ashbrooke Care Home, and…assurances from the provider were not sufficient to address the risks.* Runwood claimed that it did not received prior notification of the closure. By 24th January 2019, the home was to be re-opened as Meadow View Care Home. This has been challenging for the families of residents at DMCH in the light of their endeavours to improve their relatives' circumstances.

147. In the "Lessons to be Learned" section of *Home Truths,* COPNI stated:
What was noteworthy in the evidence gathering was that several RQIA witnesses who gave evidence to the investigation said that "Dunmurry Manor is not the worst." The Commissioner is concerned that there is a degree of desensitivity to what are acceptable norms in a care home. It is clear that RQIA inspectors did not see the extent of the problems at Dunmurry Manor and that if they had seen the totality of the evidence provided to the investigation it is hoped that the action taken would have been different (p150).

POINTS TO CONSIDER – Learning and Change

- ✓ "Home" has many meanings which are tied to the way we live. It is a functional space of nourishment and domestic rituals. It is where we sleep, wash, dress, eat, sit and talk. It is a place of storage. Our homes support our identities and reflect who we are. It is possible to align our understanding of home to the environmental complexities of homes providing people with care, support and/ or nursing.
- ✓ There is immense value in simplifying records.
- ✓ Numerical safeguarding referral data is limited in the absence of explanatory context, e.g. a single person may be associated with many incidents. There is more merit in considering: numbers against standards; objective outcomes; subjective outcomes; and individual stories.
- ✓ The RQIA's role in safeguarding is unclear to practitioners. Similarly, the interface between complaints, safeguarding and notifications is difficult to understand.
- ✓ The public has diminishing sympathy with the promise that 'lessons will be learned' and with 'apologies' from public officials. Learning is integral to a functioning whole system rather than a part of belated breakdown repair.

[60] Progress concerning these and other recommendations were tracked by the DH and the RQIA and respective HSCTs confirmed that the majority had been accepted and enacted.

Section D: Partnerships in Adult Safeguarding

How Adult Safeguarding is experienced

> "Safeguarding shouldn't be overwhelming people with paperwork"
> "There has to be partnership and collaboration in safeguarding. It cannot be achieved through cumbersome systems and processes"
> – contributors to the Adult Safeguarding Workshop – 12 March 2019

148. The March 2019, adult safeguarding workshop confirmed that adult safeguarding's documentation/ template forms are cumbersome and ineffective. Professionals immersed in safeguarding activities are see-sawing between capitulation to different processes and attention to the care and treatment of individuals. They would favour: "less complex policies and guidelines// …more staff to work with people instead of form-filling being stuck behind a computer screen// and less [complexity] re criteria,"
149. Professionals reported being exercised by the roles and responsibilities associated with adult safeguarding, most particularly in the light of different approaches across the five HSCTs. In the absence of a regional approach, the following observations and changes were proposed:
    - "Why is adult safeguarding seen as the be all and end all?
    - There has to be partnership and collaboration in safeguarding. It cannot be achieved through cumbersome systems and processes.
    - We're at a point where everything is safeguarding and we're over-analysing.
    - We have to be able to evidence what we do – not just by referring to processes.
    - We have to be person-centred and not driven by bureaucracy and paperwork that takes us away from good care planning.
    - It's unfortunate that it has taken these scandals to turn attention to safeguarding's systems including social work's and nursing's profile.
    - We should be looking at good case management and fulfilling this to the best of our ability. We want competent and confident case managers. There are multiple and complementary roles in teams.
    - We want a consistency of practice across the Trusts."
150. Professionals identified the following as hurdles to adult safeguarding practice, *If only*:
    - "it was well understood and implemented uniformly on a national level.
    - Social workers applied a more systematic approach to practice where they are more skilled in asking the right question – we might have many fewer safeguarding incidents.
    - [there was] a better understanding of whistleblowing policy by staff members/better support.
    - Professionals were less fearful of safeguarding processes.
    - It felt less isolating and exposing so that practitioners felt safer keeping service users safe.
    - All staff/everyone treated each other [well].

- [We knew] how to disseminate learning from investigations so other facilities don't make the same mistakes.
- [There was] support from RQIA."

151. The workshop confirmed that professionals' responsibilities concerning adult safeguarding are contested. They would favour:
    - "One team [investigating] the cases within the Trust – [it is] not the same across all Trusts
    - [Clarity concerning] staff roles and responsibilities in the community/nursing teams
    - Everyone recognised it was their role and not just social workers and nurses."
152. There was consensus that adult safeguarding practice should be underpinned by legislation, for example, [If] "We had a legislative framework to inform and underpin practice – [it] would vastly support and guide Adult Protection and Safeguarding".
153. Participants want to understand the interfaces between adult safeguarding, contract monitoring and the work of the RQIA. They want the procedures to be "standardised" across the HSCTs less confusing and the learning from investigations disseminated. There was consensus that the use of familiar language would make the practice less daunting for everyone. There is a real appetite for change and for a planned programme of reform which engages everyone.

The role of Northern Ireland Safeguarding Adults Partnership (NIASP)

154. The 2015 Policy describes NIASP as*, a regional collaborative body led by the Health and Social Care Board. 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 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…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 that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation* (p16-17).
155. *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* (p17).

The role of Local Adult Safeguarding Partnerships (LASPs)

156. The 2015 Policy states of the LASPs that they, *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* (p17).

The Joint Approach to Adult Safeguarding

> "There isn't a safeguarding outcome, it's just a process. It's a duplication of incident reporting but safeguarding has taken over. It takes 45 minutes to complete the forms then 20 minutes for me to screen them out" – a nurse

157. *The Protocol for Joint Investigation of Adult Safeguarding Cases* was published by NIASP during August 2016. It is intended to be read with the policy and operational procedures. Its Introduction states that the "Joint Protocol:"[61]
    - *…will provide clarity in respect of the roles and responsibilities of adult protection services where the nature of the harm to the adult in need of protection constitutes a potential criminal offence* (p5).
    - [aims]…*to ensure that the adult in need of protection is supported in a manner which upholds his/her rights, in particular their right to equal access to the criminal justice system and to prevent further abuse through a collaborative multi-agency partnership* (p8).
    - *…aims to provide a framework within which HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime* (p6).

[61] It is understood that the Joint Protocol is under review within the PSNI. No revisions have been made available to the Review Team.

158. The Joint Protocol identifies the "roles and responsibilities of key agencies." For example, the five HSCTs have "Key personnel" with lead responsibility for adult safeguarding, that is, the DAPOs, Investigation Officers (IOs) and Specialist ABE [Achieving Best Evidence] Interviewers. The out of hours RESWS will assume the role of the DAPO in emergencies. The Central Referral Unit ("CRU"), the regional PSNI centre for all referrals associated with abuse, exploitation or neglect will determine which part of the service will lead a criminal investigation. The PSNI will investigate alleged offences. If an identifiable person has committed an offence a file will be forwarded to the PPS. The latter makes prosecution decisions such as the charges to be made and decides whether criminal proceedings should be continued.
159. The PSNI received nine reports from DMCH staff. These concerned missing persons (4); *patient on patient assaults* (2); theft (1); criminal damage (1) and one which resulted in a *safeguarding investigation*. It received two reports from relatives concerning a *patient on patient incident* which resulted in no further action; and one which was reported to the PPS. The latter directed "no prosecution."[62]
160. The Joint Protocol sets out the "reporting and referral arrangements" which are conflated to "referral/report" in the text. Since people's "views and wishes are paramount," their consent should be sought. The HSCTs' Adult Safeguarding Champions *should ensure that a referral to HSC Trust Adult Protection Gateway Service is made*. The PSNI may make "referrals/reports to HSC Trusts," however,
    - *Where a police officer decides that a referral to the HSC Trust against the expressed preference of the individual involved is appropriate the rationale for the decision must be clearly recorded* (p14).
161. With reference to the RQIA:
    - *RQIA's remit…involves prevention, safeguarding and protection of adults at risk of harm and adults in need of protection. With regard to the Joint Protocol RQIA are a key partner in relation to investigations and protection planning in all regulated services* (p12).
    - *Where there is a concern regarding an individual or group of individuals, RQIA should consider whether this has been caused by abuse, exploitation or neglect. In these circumstances a report to the relevant HSC Trust should be made…RQIA will make an immediate report to the PSNI if there is an imminent risk to any service user* (p15).
162. The RQIA made a single referral directly to the PSNI regarding DMCH. This was based on a report from the relative of a resident.[63]
    - *Where an incident relates to a regulated service RQIA will attend adult protection strategy meetings and case discussions to contribute to joint agency information sharing and joint agency action planning* (Appendix 12 notes on p86).
163. The Joint Protocol states that, *the role of the HSCT DAPO is to screen the referral and any other available information to ensure that all relevant HSC processes are implemented as applicable* (p19). A "Joint Agency Consultation" determines "the most appropriate course of action" (p23). This may be a single agency, HSCT investigation, a single agency PSNI investigation or

[62] Correspondence from PSNI dated 16 September 2019.
[63] Correspondence from PSNI dated 16 September 2019.

no further action, for example. Work was undertaken during 2019 to revise the Joint Protocol. However, this was limited to ensuring consistency between the policy, the procedures and the Protocol.[64]

164. The document includes 50 pages of appendices, 18 of which are referral forms. Appendix 7 cites the Human Rights Act 1998 and lists the rights within the European Convention for the Protection of Human Rights and Fundamental Freedoms.[65]

POINTS TO CONSIDER – Learning and Change

- ✓ The adult safeguarding template forms are overloaded.
- ✓ Responsibility for undertaking an adult safeguarding investigation should be transparent and known across the region.
- ✓ The rights of the resident and their representative need to be paramount.

A Memorandum of Understanding

165. During March 2013, a *Memorandum of Understanding* was published. Its full title is *Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland.* The front cover's logos are those of the PSNI, DHSSPS, HSENI and the Courts and Tribunals Service.[66]

166. The document's Foreword notes:
The Memorandum is intended to help:
   - *Identify which organisations should be involved and the lead investigating body;*
   - *prompt early decisions about the actions and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these;*
   - *provide an understanding of the roles and responsibilities of other organisations involved in the memorandum before high level decisions are taken;*
   - *ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned*. (p1)

167. In addition, the Foreword notes that the memorandum defers *to the overarching principle of the protection and preservation of life*.

168. The Memorandum confirms that: its "principles and practices" are applicable to "locations where health and social care is provided;" some accidents to patients or clients are required to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR); *HSE organisations have a responsibility…to ensure the safety and well-being of patients or clients and staff and to investigate when things*

[64] The Southern HSCT notes that clarity is required concerning the strategic direction of adult safeguarding

[65] In this context, the most relevant Articles are 2: the right to life; 3: right not to be subjected to torture, inhuman and degrading treatment; 5: right to liberty; 6: right to respect for private and family life; and 14: and right not to be subjected to discrimination.

[66] http://www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/memorandum-of-understanding_investigating_patient_or_client_safety_incidents.pdf (accessed 21st July 2019)

go wrong…In discharging this responsibility the HSE organisations must have policies and procedures…[and] ensure that the requirements of the memorandum operate effectively alongside procedures and protocols established in …the protection of vulnerable adults (p4).

169. The Memorandum states that a spur to the involvement of the PSNI should be *evidence or suspicion of gross negligence and/ or recklessness…including as a result of failure to follow safe practice or procedure or protocols* (p5). It adds that, *Although HSENI is responsible for enforcing work-related health and safety legislation in a large variety of settings including hospitals and nursing homes, District Councils have this responsibility where the main activity is the provision of permanent or temporary accommodation e.g. statutory residential homes and other residential homes* (p5).
170. The document states, *Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths in cases reported to them that appear to be unexpected or unexplained, a result of violence, the result of an accident, a result of negligence, or a result of any cause other than natural illness or disease" (p5). Medical practitioners have a statutory duty to report such deaths, including for example:*
    - *"…the death of a patient or client who had an accident in the health or social care environment;*
    - *the death of a patient or client where there is an allegation of negligence or of a medical or nursing mishap*. (p12)
171. During August 2019, the Review Team was advised that,
    There were no Inquests relating to the deaths of any residents who died at Dunmurry Manor Nursing Home during the period 16 July 2014 to March 2018. A total of 9 deaths relating to residents at Dunmurry Manor Nursing Home have been reported to the Coroners Service. Of these five residents died in hospital and the remaining four residents died in the Nursing Home itself…[During] 1 August 2018 to 31 July 2019 inclusive…5% of inquests related to persons aged over 75 years and 2% of deaths occurred in either residential care or nursing homes for older people. [67]
172. The Memorandum states that: *Other organisations may also have a role in investigating patient or client safety incidents at local or national level. These include the HSC Board/ Public Health Agency, Regulation and Quality Improvement Authority (RQIA), the Northern Ireland Adverse Incident Centre (NIAIC), and the professional regulatory bodies* (p6).
173. The Memorandum confirms that where more than a single investigation is likely: *In cases where more than one organisation may/ should have an involvement in investigating any particular incident, it is the responsibility of the HSC organisation to report to each of these organisations as appropriate…When organisations are notified of an incident, it is their responsibility to consider if the incident should be investigated by their organisation, or reported to any of the organisations who are signatories to the memorandum. If several organisations are involved they should consider if a Strategic Communication and Decision-Making Group (the Group) meeting is required…The meeting will allow* [*inter alia*]

[67] Correspondence from the Coroners Service for Northern Ireland dated 29 August 2019.

- *organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation;*
- *clarification of the role of individual organisations involved;*
- *determination of the appropriate body with primacy responsibility to investigate and take the lead in coordinating with others* (p6).

Where possible the statutory investigating bodies will come to an early view about the nature of the incident and where responsibility for any future investigation lies (p7).

174. The Memorandum contains eight Appendices: *Reporting deaths to the Coroner; Reporting of Injuries, Diseases and Dangerous Occurrences (Northern Ireland) Regulations 1987* [68] *(RIDDOR); Reporting requirements on HSC organisations under the Memorandum; Other Useful Contacts; Contacting Relevant Organisations; Contacting Professional and Regulatory Bodies; Other Related Documents; and Members of the Review Working Group.*
175. Appendix 3: Reporting Requirements on HSC Organisations under the Memorandum notes: *Until 1st May 2010 HSC organisations were required to routinely report Serious Adverse Incidents to the Department of Health, Social Services and Public Safety. From this date, revised arrangements for the reporting and follow-up of Serious Adverse Incidents (SAIs), pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, transferred to the Health and Social Care Board (HSCB) working in close partnership with the Public Health Agency (PHA) and the Regulation Quality Improvement Authority (RQIA)* (p16).
176. The Appendix states that the HSCB issued a procedure for the *Reporting and Follow-up of Serious Adverse Incidents* for implementation on 1 May 2010. The criteria which determine what constitutes a SAI include [*inter alia*]
    - *serious injury to, or the unexpected/ unexplained death…of a service user…*
    - *Unexpected serious risk to a service user…*
    - *Serious assault (including homicide and sexual assaults) by a service user: On other service users…*(p17).
177. The RQIA *can receive reports of deaths or serious incidents involving patients and clients in relation to (i) Regulated sector services (ii) Mental Health services and (iii) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)* (p19-20).

POINTS TO CONSIDER – Learning and Change

- ✓ There are relatively few inquests concerning older people who were accommodated in residential and nursing homes.
- ✓ The HSENI is focused on facilities issues such as equipment failure and legionnaires disease. It does not address the the clinical care or professional judgements made about the care of residents.

[68] This is an error. It should read 1997

A Regional Approach to Adult Safeguarding

"I find the processes really difficult across NI" - contributor to the Adult Safeguarding Workshop – 12 March 2019

178. The *Ten thousand more voices*[69] project's aim:
    - *…is to identify how the Adult Safeguarding process can be improved to ensure the service user's experience is rights based, empowering, consent driven and as person centred as possible* (p3).
179. The title of the report is potentially misleading since it is based on "167 surveys received from clients" and "27 staff experiences." The 167 adults:
    - *…included all adults who had experience of the adult protection process from the point of strategy planning[70] and were closed to all protective interventions during the period June 2017 - March 2018* (p3).[71]
180. The report conveys a broadly positive account of people's experience of the safeguarding process.[72] However, it is noted that it is *regionally consistent in terms of the benefits of the project…uptake remains regionally lower than expected* (p27). It is difficult to gauge the type of safeguarding challenges faced by staff and/or the people for whom they had responsibility. The highlighted "themes for service improvement" include "communication and being kept informed;" and "professional timeliness."
181. Surprisingly there is a single reference to the "reduction of paperwork" (a plea from one of the 27 members of staff). This is remote from the strongly expressed views of practitioners at adult safeguarding workshops. These were critical of the failure of the policy and operational procedures to credibly connect; of the proliferation of templates and approaches; and of its process-driven nature. Yet *10,000 Voices* does not propose that there is scope for the wide-reaching overhaul of all documentation concerning the adult safeguarding processes which was a resounding theme of the workshops of February, March and July 2019. These were characterised by criticism of the policy and operational procedures.
182. *10,000 Voices* recommends, inter alia, that:
    - *Keyworkers collecting experiences should view 10,000 Voices adult safeguarding service user and carer feedback as a post investigation opportunity for meaningful therapeutic intervention* (p28-29).
183. Two of the five questions asked by the *10,000 Voices* survey hinge on satisfaction:

[69] Health and Social Care Board and Public Health Agency (2018) *Ten Thousand More Voices Project Experience of Adult Safeguarding: Final Evaluation report*, June

[70] The Operational Procedures and the Joint Protocol refer to "strategy meetings" which are defined: *in complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts*

[71] The Southern HSCT have clarified that the title is "Experience of Adult Safeguarding." The Methodology is the overarching 10,000 More Voices Project. There are multiple areas of service delivery across Health and Social Care which have used this project to learn from service user and carer experience

[72] The Southern HSCT note that the Final Adult Safeguarding report was approved by PHA during November 2018

- *To what extent did you feel satisfied with how the safeguarding investigation was carried out?*
- *To what extent were you satisfied with the outcome of the investigation?*

"Satisfaction" is unreliable as an indicator of improvement or driver of service responsiveness.[73] The downside of questions about satisfaction and satisfaction surveys is that they are hardly pertinent to people who use a service unwillingly. Care home services are often "distress purchases," that is, they are made at a time when people are vulnerable and disempowered. Surface satisfaction responses such as "I'm fine// It's ok" may mask deep distress and resentment which is unlikely to be elicited in a brief interview or by a questionnaire. Some people are (a) guarded in expressing their opinions due to their reliance on the goodwill of staff and/ or (b) have become accustomed to poor services; and matters of critical importance such as being treated with dignity and respect, are unlikely to be reflected in measures of satisfaction.[74]

184. For example, the efforts to gather people's experience of safeguarding during June 2019 at Muckamore Abbey Hospital were the result of the *10,000 Voices* project's questions. They were described by staff as "too complicated" for people with compromised cognitive skills.
185. The "recommendations by the PSNI"[75] state:
    - *In general, service users have reflected that they have had a positive experience with police. From the project some felt the criminal justice process was too protracted. There is a need for officers to give clear information on the investigation, and the time it may take to reach an outcome. Consideration should also be given to clarifying service user/carer understanding of the information given to them, especially after a traumatic event. Investigating officers should also ensure there is ongoing engagement to keep service users/ carers updated, manage expectations and share outcomes* (p29).
186. *10,000 Voices* is silent about the COPNI investigation. Although the report concerning DMCH was published during June 2018, the events at the home subsequently received a great deal of coverage in the media. The formal publication of *10,000 Voices* (during November 2018) was not taken as an opportunity to set out the identified learning concerning DMCH.
187. The NIASP website[76] identifies four "key priorities":
    - *Determining the regional strategy for safeguarding vulnerable adults.*
    - *Developing and disseminating guidance and operational policies and procedures.*
    - *Monitoring trends and outcomes.*
    - *Monitoring and evaluating the effectiveness of partnership arrangements.*
188. To do full justice to the complexity of delivering the best possible services, widespread involvement in learning and problem-solving is required.

[73] Horner, L. and Hutton, W. (2011) Public Value, Deliberative Democracy and the Role of Public Managers. In J. Benington and M. H. Moore (Eds.) *Public Value – Theory and Practice* Basingstoke: Palgrave Macmillan

[74] Flynn, M. and Ward, L. (1994) What matters most: disability, research and empowerment. In M. H. Rioux and M. Bach (Eds.) *Disability is not measles: new research paradigms in disability* Ontario: Roeher Institute, York University

[75] It is not explained how widely this position was canvassed within the PSNI.

[76] http://www.hscboard.hscni.net/niasp/ (accessed 27 May 2019)

189. The "trends and outcomes" are derived from the number of investigations (arising from recorded referrals to adult safeguarding), trends in Care and Protection Plans and Joint Protocol investigations across the HSCTs. Scrutiny of the recorded referrals and investigations at DMCH suggests that inconsistency and misunderstanding prevail. There is no evidence of the monitoring or evaluation of partnership arrangements (the NIASP Annual Report April 2017 - March 2019 refers to the Domestic and Sexual Violence Strategy and a peer support network for the Adult Safeguarding Champions). The different and disparate ways of responding to allegations of harm and the unanticipated volume in documentation across the HSCTs is acknowledged by professionals. The IT systems of different HSCTs and agencies compromise the timely exchange of safeguarding related information.
190. Although monitoring and evaluation are often used interchangeably, they refer to distinct processes and have different objectives. It is not clear from the policy, operational procedures or Joint Protocol how the NIASP and LASPs "partnership arrangements" impact on adult safeguarding practice or generate favourable outcomes. This is not a coded way of suggesting that there is no role for partnerships in adult safeguarding. Participants at the workshops were highly motivated to improve "safeguarding" and to learn from its achievements and disappointments. Such learning is enhanced when a variety of perspectives are encouraged to assess progress and seek better ways forward.

POINTS TO CONSIDER – Learning and Change

- ✓ The 2015 policy has not achieved the stated aim of having a regional approach.
- ✓ The profile, authority and influence of the Health and Social Care Board has diminished since its closure was announced during 2015.
- ✓ The membership of the NIASP does not include the Northern Ireland Social Care Council.
- ✓ The emerging role of "contextual safeguarding"[77] merits consideration.

[77] https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding (accessed 3rd February 2019)

Section E: Learning and Change – proposals for action

> "Safeguarding is one-way – the Trusts to care homes - and yet major issues in the Trusts are unrecognized" – participant at Adult Safeguarding workshop
>
> "There's no engagement with the sector, only reporting requirements. // Who in the system supports homes? // We have to share lots of information and we're not getting anything back! // There's a post-COPNI effect of over-diligence. // Too much monitoring and inspections. // Too many forms, monitoring visits – are they duplication? // When there's a concern then everyone descends on the home and swamps the Manager. // The process and investigations are unbelievable. "Pop-sock gate" [was how one home described a safeguarding investigation about] a resident being assisted to put a pop sock on when the elastic snapped and hit her leg. // The regional safeguarding policy is not being followed by the Trusts. // Adult safeguarding is a disgrace. // Safeguarding? Waste of time! // [We want] clarity about the monitoring role of Trusts; [an] evaluation of policy, guidance, data collection and stats; a single portal for reporting incidents; credible investigation and review processes; one approach; focus; consequences and a clear process for care homes when we are not happy with Trusts' approaches" – Care home owners, providers and staff working session 15 and 20 May 2019

Analysis

Overview

191. This Evidence Paper has drawn on an incomplete jigsaw of sources to build on COPNI's findings concerning the experience of older people at DMCH. Whilst there are undoubtedly more pieces, the Review Team can share the emergent picture in terms of learning and proposed change. The analysis draws on the POINTS TO CONSIDER identified throughout the Paper. It seeks to offer opportunities for learning at policy, procedural and practice levels for adult safeguarding partners, the organisations and practitioners involved. It brings forward some pragmatic proposals for change – ones with the potential (i) to contribute to implementing the COPNI recommendations concerning adult safeguarding and human rights; (ii) to be welcomed by organisations, professionals and managers who participated in the Review's working sessions; and (iii) to be recognised by families as the type of practical actions that will reduce the likelihood of harm and neglect of their relatives living in care homes.
192. The analysis opens with a summary of learning from research (see Appendix C). It considers the purpose of the adult safeguarding system - its values, principles and the human rights' background. It goes on to look at governance, leadership and management and closes with an analysis of the main practice points around safeguarding in care homes including the communal context, risks, admissions practice, complaints, care management and the use surveillance technology.
193. It seems that safeguarding practice with care home residents is founded on doing things right rather than doing the right thing. That is, procedures typically prevail over residents' best interests. There are examples of time and effort invested in incorrect and disparate activities due to divergent safeguarding practices across Health and Social Care Trusts. The HSCTs apply

different processes to similar scenarios, resulting in "investigations" and "monitoring" at the expense of care management. Forms and records are inconsistent between HSCTs and often not fully completed. Not enough credence is given to basic "fact-finding" by care homes and/or practitioners with lead responsibility when assessing a referral. It appears that an adult safeguarding referral is the standard response to every incident, error, mishap and conflict in care homes.

194. Remedies require a contextualised approach to preventing harm and neglect. All agencies should fulfil their remit, exercise their powers and deploy their resources to protect care home residents. Practitioners must use their knowledge, skills and experience to support people whilst recognising the risks and realising the benefits of living in a care home community.
195. Much safeguarding practice is premised on the conviction that people must be kept safe at all costs. There is a gap between this conviction and the (i) methods invoked, (ii) consideration of individual outcomes, (iii) use of this information and (iv) research to shape future practice. In the absence of such scrutiny, safeguarding is a blunt and heavy instrument in care homes. It appears that an adult safeguarding referral is the standard response to every incident, error, mishap and conflict in care homes. It appears that safeguarding is the only tool within reach. There are better ways of producing more of what is required and less of what is unhelpful.

Learning from Research

196. Adult safeguarding resides in the territory of errors, oversights and unheeded warnings. It is not new. Recorded history of "institutional care" confirms that some adults' lives have always been characterised by the destructive impacts of cruelty, violence, neglect and fear of harm.[78] In 2019, adult safeguarding remains an untidy topic which has grown to take in domestic violence, hate crime and Female Genital Mutilation, for example.
197. It is a difficult topic because it requires us to consider the distress of people with limited articulacy, matters of sexuality and the violation of norms in our homes – where we should be most safe. Yet accurate definitions continue to preoccupy professionals because if we are unclear about the subject we face, our work is unfocused. Appendix C sets out a research context. This is informed by "givens" such as: abuse is destructive and it steals lives; it is well-served by minimization and denial; its consequences reach beyond human suffering; and it exacts tolls on services which are tasked with the processes of (i) assisting individuals and their families to recover (ii) enabling services to enter into restorative partnerships and (iii) learning about effective prevention as well as how individuals and organisations surmount abuse.
198. The summary confirms that there is little research concerning the abuse of older people in the UK. With reference to those in care homes, what we do know is that once harm is alleged or known to have occurred, safeguarding activities are reactive and prone to disputes concerning "thresholds" or about prospective contributors to strategy discussions for

[78] For example, Abel-Smith, B (1964) *The Hospitals 1800-1948: A study in social administration in England and Wales* Boston: Harvard University Press

example. We learn that more thorough ways of assessing the suitability and personal values of Registered Managers and potential staff are required. Experienced health and social care staff – and residents' families – who visit services are attuned to "signs" that a service is deteriorating. The research indicates that any structural reform has to parallel reform at an individual level and this should always emphasise compassion and dignity over price, most particularly since care homes are increasingly regarded as providers of palliative care. Furthermore, the regulator's scrutiny in terms of improving the sector and preventing abuse has unproven effectiveness.

Purpose of the Adult Safeguarding System

199. The evidence gathered by the Review revealed that the specifics of interpretation and compliance with the spirit of the 2015 policy and 2016 procedures vary across Northern Ireland. Safeguarding responses at DMCH have shown that procedural "fixes" neither prevented nor tackled the harms to which adults were exposed. The purpose of safeguarding interventions cannot be determined from systems which have spawned new systems and requirements.
200. The Review Team endorses the Office of Social Services' position[79] that "there is real concern about the Governance [of adult safeguarding] at the Regional and Trust level." There was little consistency across the files reviewed. Forms from the Operational Procedures were typically incomplete and some were illegible. A section concerning human rights was rarely completed. The parallel processes which have developed are plagued by inconsistent recording, inadequate "investigations" and needless back-and-forth between safeguarding investigations, Quality Monitoring, Risk Management and contract compliance processes, for example.
201. Few reports concerning DMCH were made to the PSNI – a decision which was the responsibility of adult safeguarding leads and the RQIA. Typically, the views of people's relatives were sought about contacting the police. Where the COPNI report cited examples of potentially criminal acts, the Review Team could not reconcile these with PSNI activity at the home. This was of concern where the incidents of assault were indicated.
202. Adult safeguarding practice in Northern Ireland poorly served the people residing in DMCH. Attempts to advance a coordinated and multi-agency approach to the tasks of protecting and promoting the welfare of older people living in care homes using complicated procedures has failed. A Registered Manager's perceptions about the significance of certain acts are the result of prior experience, knowledge and understanding of risk-taking. DMCH was registered by the RQIA even though it had no Registered Manager. It is anomalous that evidence of inadequate attention to older people's hydration, nutrition and pressure ulcers, for example, results in vague adult safeguarding "investigations" when urgent, clinical responses are required.[80]

[79] See paragraphs, 7, 72 and 133

[80] Although SEHSCT placed nurses at Dunmurry Manor and provides training and support regarding tissue viability concurrently with safeguarding investigations to address clinical issues, this practice is not sustainable

Principles

203. The principles shaping adult safeguarding practice should be set within a **Human Rights Based Framework** and emphasise dignity, fairness, equality, respect and autonomy. They should be manageable in terms of quantity; understandable - perhaps adopting terms such as "adult protection/ keeping people safe;" and consistent if there is to be confidence in the judgement of professionals. For example, principles such as:[81]
    - Supporting people who have care and support needs to **nurture their welfare and well-being** and **reduce the risk of harm**.
    - Giving **people** at the heart of service provision an equal say in the support they receive
    - Driving service delivery through **partnership and co-operation**.
    - Promoting the **prevention** of escalating need and providing **timely assistance**.
    - Encouraging residents, family members and staff to **be involved** in the design and delivery of services – "co-production."
    - Being **accountable** to the public and to the statutory agencies from which local partners are drawn. Publication of data, trends and findings as well as plans for change, are a vital means of ensuring accountability.

    The principle of **proportionality** is fundamental to the European Convention on Human Rights.
204. The Review found that compatibility with human rights remains to be fully embedded in the practice and care of older people. It would be helpful if there was a clear statement of purpose at the point of a care home's registration, monitored through inspection by the RQIA and reported to its Board in its annual assurance process. At the time of registration and in subsequent inspections, all provider policies and Regulation 29 visits should address how the human rights of residents are working in practice.
205. Care home providers and care managers should play a vital role in promoting residents' rights. In the care setting it is the responsibility of the provider to ensure that the social care workforce receives human rights' training. Providers should anticipate being supported by NISCC, RQIA and commissioners in this endeavour.

Governance

> "…safeguarding adult reviews and their multi-agency "action plans" are not the most suitable vehicles for achieving better lives for adults with assessed care and support needs. These reviews are partial and highly variable descriptions of a complex whole – regardless of whether they concern individuals or groups of individuals in residential and nursing settings. They are no substitute for effective commissioning, professional case management, assured service providers that are precisely registered and proportionately inspected…
>
> It appears that the purpose of safeguarding has been subverted to setting out (a) what it is that providers, service commissioners, contract monitors and inspectors should be doing

[81] The guiding principles of *My Home Life* are premised on human rights.

anyway, in addition to (b) the remit, powers and enforcement resources of the organisations concerned.

… "lessons learned" are not in fact resolving anything in a permanent way. It seems to us that, despite hectoring recommendations, rarely are the systemic concerns around commissioning, the nature of the market and its regulation the subject of embedded change.[82] What is achieved is often dependent on individual champions, soon eroded by an unreceptive climate, as well as fragile and short-lived organisational memories… what reviews identify is a need to reassert the primacy of professional leadership, most particularly among social workers and nurses. In addition, such leadership is essential at the helm in social care in the guise of the Registered Manager. It is only here that lessons can be truly learned and handed on to future generations, with accountability to be readily demonstrated by people in the know rather than through reviewers." [83]

206. Good governance of a care home is about purposeful decision-making and how professionals give expression to person-centred values. It is the responsibility of leaders and managers to ensure that care homes are well-led with a statutory duty falling on the Registered Provider and its Responsible Individual.

207. The governance of adult safeguarding has been identified by research[84] has having five components:

    i. *clarity of goals, scope of activity and purposes, including shared principles, multiagency commitment and strategic leadership*
    ii. *structures, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity*
    iii. *membership, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management*
    iv. *functions, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance*
    v. *accountability, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships*.

[82] In the absence of a national database or directory, the challenge of creating sustainable change is considered in Preston-Shoot, M. (2018) *Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change* Journal of Adult Protection 20 (2) 78-92 https://www.emerald.com/insight/content/doi/10.1108/JAP-01-2018-0001/full/html (accessed on 4th September 2019)

[83] Flynn, M. and Citarella, V. (2019) Connecting people's lives with strategic planning, commissioning and market shaping. In S. Braye and M. Preston-Shoot (Eds.) *The Care Act 2014: Wellbeing in Practice* London: Sage Publications, Learning Matters, 2020

[84] Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research *The Journal of Adult Protection* 14 (2), 55-72

208. NIASP states[85] that it *prepares an Annual Report on activity and key challenges and/or achievements in relation to prevention, protection and partnership working. The Annual Report also contains a review of the action plan for the previous year and sets out the NIASP action plan for the incoming year. NIASP Annual Reports, once approved by the HSCB Governance Committee, are submitted to the Department of Health and the Department of Justice and placed on the NIASP webpage of the HSCB website. NIASP contributes to, and works within, the framework of the planning, commissioning and performance framework established by the HSC Board in partnership with the PHA and has regard to the requirements of partner organisations. In addition, HSC Trust activity in relation to adult safeguarding is a standard agenda item for Delegated Statutory Functions meetings between HSC Trusts (Adult Services) and the Social Care and Children's Directorate of the HSCB. A summary report on HSC Trust adult safeguarding activity and performance is an integral part of the general overview report on HSC Trust performance in relation to Delegated Statutory Functions which is submitted to the Department of Health.*
209. With reference to NIASP's membership, it notes:
At the time that NIASP was first established, letters were sent to all voluntary and community sector organisations known to the HSCB at that time, outlining the purpose and role of NIASP and the Local Adult Safeguarding Partnerships (LASPs) and inviting interested parties to self-nominate for either NIASP or a LASP. This ensured that as many interested organisations outside the core group as possible were able to engage with either NIASP or a LASP.
210. NIASP acknowledges *a complex web of governance, accountability and contractual relationships which can impact negatively on the delivery of support to adults at risk where it is thought that additional intervention is required. HSC Trusts hold ultimate responsibility for the safety and welfare of the service user and, on occasion, this has resulted in the HSC Trust assuming responsibility for interventions that would, in many situations, be better delivered by the provider organisation… Analysis of Serious Adverse Incidents in relation to adult protection and the inclusion of adult safeguarding in the core agenda for Delegated Statutory Functions also provide positive opportunities for working alongside not only adult safeguarding teams within the HSC Trusts, but also the broader systems that operate to support adults within HSC Trust structures and processes. The related shortcoming in this process, however, is that issues can become very formal very quickly and the opportunity to "move fast and fix things" can be lost.*
211. The analysis finds conflicting remits between the primary duty of a care home provider to keep residents safe from harm and neglect and the procedural interventions of the multi-agency safeguarding partners. Adult safeguarding is complex, not tailored to care homes as communal settings, demoralising for staff and confusing for residents and their relatives. At worst, adult safeguarding turns a complainant into a victim and a competent home manager into a bewildered bystander. Its potential strength is that it coordinates multi-agency action

[85] Correspondence from NIASP dated 1 August 2019.

and support to effect timely change and give residents, relatives and staff confidence that their rights will be protected and the likelihood of harm and neglect reduced.

212. The evidence points to weak links between the leadership of NIASP members and executive operations in responding to failing care homes, such as DMCH. This may be a result of the diminishing profile, authority and influence of the HSCB since 2016.

Quality Assurance

213. Safeguarding processes are founded on the distinction between the person who has been harmed and the person who is responsible for the harm. If "the system" is identified as the the perpetrator, accountability is dispersed and distorted. Whilst it is the care provider (or its staff) that is alleged to have perpetrated harm and neglect, it is in the interests of the purchaser of the sub-standard service to distribute responsibility for this around the system through the safeguarding processes. The use of consumer and contract legislation by commissioners would provide an apposite response to harmful service provision. However, this would necessitate intelligent commissioning, active care management and contract management.[86]

214. Typically, the terms of reference of commissioned reviews in England may be clustered under four headings, commissioning, care management, the provider and quality assurance.[87] As in Northern Ireland, although the adult safeguarding system is a single aspect of quality assurance, there is no evidence of its principles and practices permeating the "whole system." Other quality assurance activities are those of the provider, the Care Manager and/or contract monitor on behalf of the commissioner and service user and of the RQIA on behalf of the public. The figure below has been used during the Review's adult safeguarding workshops. Using a care home as an example, it separates the remit of care management and commissioning from service provision and from quality assurance and regulation.

215. It is significant that adult safeguarding does not feature in this figure. Adult safeguarding is most commonly invoked when the assess, plan, do and check cycle has broken down for an individual resident or for all residents. Since tiers of quality assurance processes have been unequal to warning, predicting and preventing harmful practices, adult safeguarding processes cannot feasibly remedy the failings of commissioners, Care Managers or a home's workforce. Crucially, it has no legal powers.

[86] For a study in blurred accountability, see Flynn, M. (2015) *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine* Welsh Government

[87] The terms of reference for the Whole Systems Review of Safeguarding and Care at DMCH have these in its scope.

216. The onus is on the care home provider to demonstrate that its service is effective, compassionate, safe and well-led. The Review identified a need to raise the profile of the key players – the Registered Manager, the Responsible Individual and Adult Safeguarding Champions – in this undertaking.

Commissioning and Care Management

217. In its consideration of adult safeguarding the Review Team learned about commissioning and contracting processes, care management, including admissions practice, complaints, reporting and recording and the approaches of providers to communal living. The Review Team came to the view that if each of these were performed to the required standard the need for safeguarding interventions in care homes would be obviated. Safeguarding in care homes is an activity caused by "failure demand."[88]

Data and Information

218. The Review Team sought to secure and reconcile sources of safeguarding data to either challenge or reinforce what was revealed in interviews and workshops or observed in practice. It concluded that the existing information and data culture in adult safeguarding is not subordinated to identifying the most effective use of resources. Too much is at stake for this under-developed "hit or miss" approach to gathering safeguarding data to continue.

219. The Review has revealed the need for improved information communication across the system. Partners do not understand each other's remit, duties, powers and resources - which

[88] "Failure demand" is a systems concept articulated by Professor John Seddon as demand caused by a failure to do something or do something right for the customer. See https://vanguard-method.net/2018/02/failure-demand-whats-the-big-secret/ (accessed 29 December 2019)

are not reflected in lists of "roles and responsibilities." It is not surprising that service users, their families and the general public struggled to comprehend which organisation does what.

220. Information should use precise language whether it is addressed to professionals or the public. For example, a complaint is a statement that something is unacceptable and it merits the attention of the service which gave rise to the complaint; no organisation's remit states that the permission of families should be sought before action is taken; the PSNI has the powers to investigate potential criminal activities; and the HSENI has the powers to undertake inspection and investigation activities. HSCTs have neither investigatory powers nor powers of entry.

Proposed Actions

221. The following actions are addressed to leaders at all levels to support: a strong commitment to people's human rights and freedoms; the use of readily understandable language; the development of all training within a human rights-based framework; modelling behaviour which is true to human rights and doing so in ways that sustain people's dignity and respects their humanity. The actions prepare the ground for an Adult Safeguarding/Protection Bill, strengthen governance and demonstrate a pragmatic and data dependent approach to the leadership, management and practice of safeguarding in care homes. They should be prefaced by (i) a *Statement of Commitment* from DH to facilitating change in adult safeguarding practice and (ii) laying out the requirements of an Adult Safeguarding/ Adult Protection Change Programme.

a) Establish an Adult Safeguarding/Adult Protection Change Programme

The DH should commit to effective governance by setting up an Adult Safeguarding/Adult Protection Change Programme to enact the requirements deemed essential from *Home Truths* as well as the Review's proposals. In addition to a representative group of older people and families, the Change Programme will require the involvement of care home providers and their Registered Managers, the HSCTs, RQIA and PSNI to achieve a more accountable, regional approach and more active oversight and governance. A formal and accessible structure should bridge the gaps between: (i) a Human Rights Based Framework and the operational realities; (ii) a regional approach and the different approaches of the HSCTs; and (iii) those who use care home services and those who provide them.

The work for the Change Programme over the next year includes:

- Drafting an Adult Safeguarding/Protection Bill and consulting on this
- Setting out and consulting on the contents of statutory guidance – clarity is sought on thresholds, decision-making, timely support and intervention and use of joint protocols/memoranda of understanding for example
- Developing adult safeguarding training and leadership plans
- Introducing accessible and regionally consistent safeguarding documentation.

Ultimately Adult Safeguarding/Adult Protection in Northern Ireland requires an understandable, formal structure and an arms-length arrangement with the DH. The DH

should appoint an Independent Chair and members of a Northern Ireland Independent Safeguarding Board (Adults) to advise the Permanent Secretary and Ministers on the safeguarding and protection of adults. The Northern Ireland Independent Safeguarding Board (Adults) should work alongside local groups and partnerships to secure improvements. Appointments to the NIISB (Adults) should be time limited.

b) Assert adult safeguarding/adult protection principles

The purpose of adult safeguarding and the occasions when it is invoked should be explicit and known to care home residents and their families. Actions arising from clear safeguarding principles should be proportionate and shaped by the following criteria:

- effectiveness – what evidence do we have that it works?
- balance – what account is taken of the different interests?
- the least intrusive interference possible - do professionals' actions deprive the person of the very essence of their right? [89]

Principles require the strong and sustained support of people, care homes and organisations at all levels. They should inform the basic values which provide the impetus and set the direction for all professional activities.

c) Set out a Human Rights Based Framework

The Department of Health should set out a Human Rights-Based Framework which confirms that human rights have a direct bearing on care and support.[90] The basic rights and freedoms to which every person is entitled must be given expression in preparing any new care and support provision or adult safeguarding/adult protection legislation, regulations, policies, consistent with professionals' Codes of Conduct and the common law. The Framework should promote risk-benefit assessments with the involvement of individuals, their families and/or their advocates. It should guide professionals' practice in adult safeguarding and in respect of the Mental Capacity Act (NI) 2016.

A 'Framework' carries the expectation that all care home providers have an approach to care and support that reflects the significance of human rights, the primacy of home and the maintenance of family relationships. A clear statement of purpose at the point of care home registration will facilitate the Framework's integration in practice and should be checked through inspection.

The RQIA is required to approve a Statement of Purpose at the point of a care home's registration, ensuring that a home's policies, Regulation 29 reports,[91] training programmes and practice of adult safeguarding and complaints' investigations are compatible with the

[89] Fordham, M. and de la Mare, T. (2001) Identifying the principles of proportionality. In J. Jowell and J. Cooper (Eds.) *Understanding Human Rights Principles,* Oxford: Hart Publishing

[90] Age UK sets out relevant human rights at: https://www.ageuk.org.uk/information-advice/work-learning/discrimination-rights/human-rights/ (accessed 8 November 2019)

[91] These concern visits by a registered provider or designated person to a nursing home or residential care home. See Nursing Homes Regulations (NI) 2005 and Residential Care Homes Regulations (NI) 2005

European Convention on Human Rights. This will require consultation with care home providers to establish how this is plainly reflected in practice and day to day care.

In addition, the HSCTs should explore (i) how change programmes demonstrate approaches to care and support which reflect human rights. Engagement with NISCC, the Northern Ireland Practice and Education Council for Nursing and Midwifery ("NIPEC"), the Royal College of Nursing and projects such as *My Home Life* at the University of Ulster would enhance this work; and (ii) the introduction of a regional model of training underpinned by the Human Rights-Based Framework. NIPEC's work concerning safeguarding, record keeping and competencies could be disseminated and built on.

The approach to care and support could be presented in a publication entitled "Human Rights and Living in a Care Home." As part of a "tenure agreement"[92] this would show how values such as respect, right of choice and dignity fulfil the human rights responsibility. The publication would be provided to individuals and families in advance of people taking up occupancy in care homes.

d) Draft and consult on an Adult Safeguarding/Protection Bill

A key task for the Adult Safeguarding/Adult Protection Change Programme is to set out the content of an Adult Safeguarding/Protection Bill – which should take account of COPNI's *Home Truths'* recommendations and those of his predecessor. A comprehensive consultation could, for example, agree and endorse safeguarding principles, such as giving people at the heart of service provision an equal say in the support they receive; define an "adult at risk of harm;" create duties to (i) report adults at risk of harm (ii) to make enquiries and (iii) replace the NIASP with a Northern Ireland Independent Safeguarding Board (Adults) with clearly defined duties, such as making an annual report[93] to the Permanent Secretary and Ministers. The Northern Ireland Independent Safeguarding Board (Adults) should publish annual plans and reports to inform the HSC system's annual reporting cycle. An annual accountability conference which included families would be a welcome development. By consulting on the key provisions of an Adult Safeguarding/Protection Bill, Northern Ireland will be well placed to work out and guide the interventions of all relevant authorities to provide support and avert older people's neglect or harm.

The Adult Safeguarding/Adult Protection Change Programme should draw together what is known about adult safeguarding training in NI to develop a regional model that is relevant to care homes. Training should include promoting the rights of individual residents and making safeguarding enquiries. Every opportunity for web-based education tools should be explored with a view to these being supplemented with interactive raining events and supervision. Access to online HSC Clinical Education Centre resources should be extended to the independent sector.

[92] The Regional Contract makes provision for a 'residency agreement'

[93] For example, reporting on trends and topics and identifying best practice and areas for improvement or for greater scrutiny in the coming year

e) Identify and publicise what organisations have the legal powers to do

The Adult Safeguarding/Adult Protection Change Programme should oversee the scope of adult safeguarding activities. It should identify lead responsibilities until they are established in law. This points to the need to draft an information leaflet (which may be uploaded onto relevant websites) which sets out:

- the remit, legal powers and resources of agencies
- the implications for professionals and managers
- the implications for care home owners as service providers and employers
- the implications for joint working between agencies.

Implementing the Change Programme prior to legislation will inform the development of an Adult Safeguarding/Protection Safeguarding Bill; and ensure that there is a credible, regional reporting system in the event of harm or neglect. It is too important to be left to the discretion of individual HSCTs.

f) Practice collective and pragmatic leadership

Leadership creates the environment for change. Leadership should articulate why change is necessary. It focuses and motivates managers and professionals, a team or organisation to achieve its aims. It is becoming a safeguarding mantra that it is "everyone's responsibility." It is leadership which can give the refrain meaning by, for example, asserting that all practitioners should be responsive to families reporting indifferent and harmful care home practices and take action when adults are at risk of abuse or neglect.

The *HSC Collective Leadership* Strategy[94] should support the Adult Safeguarding/Adult Protection Change Programme since it requires leaders at all levels to take a fresh look at their practices and the ways in which these benefit people. It should emphasise the context of group living and the nature of care home cultures. As well as promoting values and personalised practice it must empower the multi-professional team to make the most of their knowledge, skills and experience to prevent harm and protect care home residents. Adult safeguarding, in any setting, should not be reduced to procedures and it should not be assumed that safeguarding practice concerning children and young people is directly transferable to adults.

When commissioning a service from a care home, the HSCT should be assured that it is fully compliant with all the RQIA regulations and standards.[95] Additionally, it is responsible for ensuring that the home can meet the needs of an older person. The Registered Manager is expected to carry out a pre-admission assessment and is expected to provide a detailed care plan based on the assessed needs, wishes and choices of the individual person. The RQIA has a duty to regulate the whole service. Care homes are responsible for supplying what is

[94] Department of Health (2017) *HSC Collective Leadership Strategy: Health and Wellbeing 2026 Delivering Together* Belfast: DH

[95] See for example, the Republic of Ireland's Health Information and Quality Authority and Mental Health Commission (2019) *National Standards and Adult Safeguarding* Dublin: HIQA and MHC

specified in contracts and in residents' care plans within the law and regulations under which they are governed.[96]

Those charged with the leadership of adult safeguarding should be clear that it is not a system to remedy the shortcomings of strategic planning, commissioning, care management, inspection or policing of care homes. Adult safeguarding must be purposeful and understood and its benefits to residents known and acknowledged.

Leaders across care homes – the Registered Managers and Responsible Individuals[97] - should promote the principles and values of people's human rights and freedoms. Their networks should anticipate being supported by the NISCC, Royal College of Nursing, NIPEC, RQIA and commissioners in this endeavour.

Questions for collective leadership include:

- Are the remits of Adult Safeguarding Champions and Designated Adult Protection Officers still relevant? Or, in what way can these professionals be empowered and trusted to fulfill their responsibilities?
- What steps should Care Managers take to ensure that residents have relevant care plans?
- Does professional decision-making concerning basic fact-finding, information-gathering, and report writing require attention?
- How might examples of care homes creating value be shared?

g) Introduce action learning, research and training renewal

To create momentum, and with the endorsement of the DH, the Change Programme should engage facilitators to establish Action Learning Sets[98] with leaders from clusters of care homes, Adult Safeguarding Champions and their linked Care Managers. Since Care Managers from four HSCTs placed people at DMCH, geography need not be the determinant. Action Learning Sets will allow certain types of situations and issues, such as resident-to-resident aggression, to be explored and probed with a view to taking purposeful action as opposed to "referrals, protection planning, contract compliance [and] quality monitoring." The challenge for leaders is in permitting this to take place, learning from 'what works' and assessing the impact of outcomes. The benefits will be derived from the empowerment of key people in the system.

[96] Flynn, M. and Citarella, V. (2020) Connecting people's lives with strategic planning, commissioning and market shaping. In S. Braye and M. Preston-Shoot (Eds) *The Care Act 2014: Wellbeing in Practice* London: Sage Publications, Learning Matters

[97] The Registered Provider must appoint a Responsible Individual *who is a director, manager, secretary or other officer of an organisation and is responsible for supervising the management of an establishment or agency* – RQIA Guidance Notes. In so doing the owner, company or charity remain accountable for the care home. https://www.rqia.org.uk/RQIA/files/fa/faf9a8ca-b8fa-415d-b52f-69079d56a387.pdf (accessed 5 August 2019)

[98] Action Learning Sets are a structured method of enabling groups to work collectively to problem-solve, innovate and develop practice

The appointed facilitator/research partner should work with identified Registered Managers, Adult Safeguarding Champions and Care Managers to prepare an account of the experience, setting out what worked, how residents and families were involved and what merits testing more widely. These contributions should be presented to the Change Programme as well as resident and family forums.

The objective is to create a contextual framework for safeguarding practice in care homes that is based on data and knowledge sharing which includes perspectives from residents and families. It would do this by understanding and problem-solving harm prevention and safety that arise in care homes. Pertinent questions are:

- How might adult safeguarding data contribute to improvements in outcomes for residents?
- Can safeguarding referrals be avoided through better ways of responding to and resolving complaints?
- How might basic fact-finding and decision-making by care home managers and/or Adult Safeguarding Champions be improved? How might the communications between Care Managers and care homes be improved?
- How might risk assessment and risk management in care homes be supported and improved?
- How can the reputation of care homes be improved? How might the care home sector engage with the media?

The merits of Action Learning Sets include:

- making knowledge, skills and experience available to participants;
- taking stock of the occasions that professionals have visited their homes for the purposes of adult safeguarding, contract monitoring and/or to address complaints;
- building networks to support better ways of working, learning from each other and understanding approaches such as risk assessment and benefits;
- improving the relationships with residents and their families and confirming their role in caring and supporting the resident that maintains the family relationships and bonds; and
- setting out ideas for alternative approaches to scenarios of harm and neglect whilst maintaining a commitment to ensuring that all statutory requirements are met.

The proposal is borne of the evidence gathered by the Review which indicates that the safeguarding system is not suited to communal living. It is too procedural, it does not solve problems, it fails to involve residents and their families and it does not prevent harm or protect people. Outcomes are expected to be practical solutions to scenarios that arise in care homes and premised on “what works.”

Independent facilitators/researchers should be commissioned, by the Adult Safeguarding/Adult Protection Change Programme, to recommend common goals, keep track of the learning process and record the ideas with the best chance of making a positive

difference – bearing in mind that learning involves creativity, risk-taking, trying something new and taking actions which might not work. The intention is to move away from safeguarding as sets of procedurally driven tasks to a learning and knowledge sharing model.

Safeguarding practice can be innovative and successful when it is based on effective risk assessments suited to the individual, combined with clarity of purpose and a vision of a good life in a care home. Senior staff in homes must be empowered as Adult Safeguarding Champions to have an active part in decision-making. The initiative proposed will be the start of safeguarding practice in care homes learning how to embed effective and practical ideas and stem the spiraling demands which arise from failures.

Training concerning adult safeguarding/adult protection in a human rights context requires renewal if it is to recover relevance. Its emphasis on generic forms of abuse and navigating the policy and procedures has not enabled professionals to re-examine and refine the challenges of risk assessments for example. The key underpinnings of the Human Rights Act 1998, the legislative architecture of Northern Ireland, the remit and powers of professionals, should orient the training and their implications for safeguarding/protection in care homes and other settings. The use of real case-studies such as DMCH and Cherry Tree House should provide situational insights, attention to different perspectives and nurture enthusiasm for interactive learning.

h) Detect what matters and use data and information to make a difference

Drawing on RQIA's work concerning "signal detection,"[99] a complementary feature may be developed for use by Responsible Individuals, commissioners, prospective residents and their families. The idea is that signals developed within homes are routinely tested and shared by the care home's Registered Manager with the possibility of providing a valuable supplement to information, inspection and Regulation 29 reports. The Adult Social Care Reform Programme could provide direction and energy to how signals can be identified involving residents, families and staff.

The Review Team notes that DH and RQIA have started more proactive engagement with care home managers and providers with encouraging attendance at the timetabled sessions. This should provide a foundation for a more formal DH-led programme of work with residential homes, nursing homes, older people, people with experience of visiting relatives in care homes and the RQIA. It should use the information gained to identify a small number of "well-being signals."[100] Since too much information gathering is duplicated and unevenly dispersed, it makes sense to identify "signals" of how well a home is functioning. It is possible to elaborate on what these may be with examples of proxy activities and approaches. However,

[99] The "risk-adjusted dynamic and responsive" (RADaR) model is designed to detect meaningful signals of risk from patterns of data.

[100] Similar to healthcare's "vital signs" of body temperature, pulse, blood pressure and respiratory rate which are important indicators of the body's essential functioning; COPNI's 'red flags' and 'warning signs' are cited in *Home Truths*. The Review Team proposes a model which seeks data about a home's strengths.

the task is one that should be undertaken with residents, families and staff. To do otherwise would risk creating another process and lose the simplicity of focusing on what matters.

The task is not to generate hundreds of signals, rather ones which highlight residents' and families' experiences of care homes that may be easily documented and shared by a Registered Manager. The importance of this is not to reinforce or duplicate performance management data and information – systems that many homes have already - but rather to sharpen the focus on what matters to care home residents.

Although comparisons of adult safeguarding referral data with previous years cannot be made without validation checking, it may be helpful to consider adult safeguarding data to date as experimental. The question is: how data and information might be useful to residential and nursing homes in terms of (i) relevance, (ii) accuracy and reliability (iii) timeliness (iv) accessibility and clarity and (v) coherence and comparability.

Subsequent Evidence Papers will similarly reflect on "what matters" and on "what works." Residents' human rights should be reflected in the sum of their care home experience – not just in adult safeguarding practice. Using data and information to promote and check self-actualization, esteem, love and belonging is less straightforward than data which reveals changes in a person's health status, for example.[101] The Review Team's proposed action is based on knowledge about the importance of the six senses[102] – security, belonging, continuity, purpose, achievement and significance - to people's well-being. Here we are making a proposal about safety and security, the second step in Maslow's hierarchy and the first of the senses, to develop an equivalent to the "vital signs" of bodily functioning.

Conclusions

222. Implementing this Evidence Paper's proposals and the recommendations of *Home Truths* (R1-R7) will be important in managing and mitigating the high risks of harm, which prevailed at DMCH, from becoming neglectful and abusive.
223. Adult safeguarding in Northern Ireland has diminishing persuasive power because its practice has strayed too far from the policy intentions of 2015 and from residents' human rights. It is to the credit of leaders in NI that some of the proposed actions are underway and it is primarily to the credit of families that they elevated their unheeded complaints to orchestrate necessary change.
224. The main findings documented in the Evidence Paper are:
    - Families' voices were repeatedly unheard at DMCH and the home did not improve.
    - Adult safeguarding practice did not actively contribute to the task of keeping DMCH residents safe.

[101] Maslow, A. (1943). A Theory of Human Motivation. *Psychological Review*, 50(4), pp.370-396

[102] *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice* (GRiP) Report No 2. Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/280/; (accessed 4th September 2019)
Nolan, M. Lundh, U., Grant, G. and Keady, J. (Eds.) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press/ McGraw-Hill Education, 2003

- The HSCTs' practices concerning adult safeguarding would suggest that they have developed independently and without exposure to critical questioning or impact assessments – even though they have been working through similar problems.
- The boundaries of adult safeguarding have expanded to embrace care home surveillance, monitoring and inspection without legal powers or evidence of efficacy. 'Monitoring', as an activity, appears excessive, unplanned and lacking in purpose and outcome. Arguably this expanded work programme has fed a false assumption that all care homes are 'risky' and 'abusive' environments.[103]
- The public's perception of care homes is shaped by the media and most particularly via the reporting of scandals. There is no vehicle for care homes to demonstrate how they are successfully reflecting residents' support and care needs and interests. The provision of valued care in care homes is of public interest and providers must be accountable.
- Although residents' relatives knew a great deal about inattention to people's care and support, this did not impact on adult safeguarding practice or RQIA inspections. There was an asymmetry of information – the HSCTs were gathering a lot of data in their own, pre-defined terms which was not in formats which could be easily shared or understood.
- Data concerning adult safeguarding requires attention because it is unreliable, not easily retrieved and it is unequal to informing learning about types of harm and ways of preventing harm.
- An approach to risk management is required that distinguishes mistakes, accidents and questionable care practice from negligence, abuse and suspected crimes.
- All incidents and subsequent referrals require risk assessments that consider the benefits as well as potential harms of exposing people to risks.
- Professionals do not want to be party to increasing procedural baggage, sporadic actions and onerous form-filling. Their training should have a clear focus on how they gain an insight into what positively and adversely influences "the care, health, welfare or safety" of care home residents. It is in everyone's interests that they understand and promote the former and it is their duty to prevent the latter and to report harm and neglect.
- Care home providers have little influence in safeguarding practice or its follow up and yet they are expected to conform to procedures, processes and practices with few meaningful outcomes. This approach is having a detrimental impact on individuals and the collective workforce in care homes. Providers and managers describe how they are left 'in limbo' for many months before many referrals are closed quickly without a credible rationale.

[103] Data from England reveals that people are at greater risk in their own homes than in care homes. See https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf (accessed 12 November 2019)

- Complaints to the COPNI were ultimately more effective than either adult safeguarding or RQIA inspections. Improving complaints procedures and access to them is the main priority for change. Systems tend to favour the articulate and assertive and not necessarily people with more serious complaints. At DMCH neither the articulate and assertive, nor those with the most serious complaints were listened to.

225. The starting point for an Adult Safeguarding/Adult Protection Change Programme is the question: if the DH had a 'clean sheet of paper' what would an adult safeguarding service for care homes look like? The Review's proposals begin to answer this question.

Appendix A: Sources of Data and Information

a) meetings[104] with:
   - 103 family members of residents in care homes, 86 of whom were DMCH resident's relatives, including two who wished to remain anonymous. There were 17 family members related to residents in other care homes, including one from another Runwood home and four who wished to remain anonymous. In all but two cases, they told of elderly relatives being harmed and/or neglected. Six of the DMCH families loaned documents, including video recordings, photographs and contemporaneous records of failings in care.
   - 406 care home managers and providers;
   - Four voluntary sector agencies and charities; Age NI, Alzheimer's Society, Association for Real Change, Action on Elder Abuse;
   - Eight PSNI personnel;
   - Policy advisors, MLAs and local councillors;
   - NIASP professionals with lead responsibility for drafting the adult safeguarding policy and operational procedures;
   - 176 individuals with responsibility across the five HSCTs for operationalising the policies and procedures.
b) Scrutiny of 12 filing cabinet drawers of documents submitted to COPNI from HSCTs and the RQIA; an analysis of the 100 plus safeguarding referrals concerning DMCH;
c) Safeguarding fact-finding across the HSC system through: a workshop and meetings with c.100 Belfast HSCT professionals concerning adult safeguarding practice (on 18-19 February 2019), a workshop focusing on Adult Safeguarding for over 40 practitioners from across the HSCTs on 12 March 2019; a workshop with the RQIA on 12 June 2019; an Adult Safeguarding workshop for the Directors and senior managers of HSCTs on 11 July 2019; meeting with the Northern Ireland Ambulance Service on 30 August 2019; and a meeting of hospital social workers on 19 September 2019.
d) Two working sessions attended by 78 people from across NI – Care home owners, providers and staff on 15 and 20 May 2019.
e) A meeting held on 25 May 2019, by the Transformation Team at the PHA, with 91 attendees.
f) Managers networks' meetings convened by the RCN and NISCC.
g) A meeting of the Adult Safeguarding Champions convened by ARC.
h) Correspondence and meetings with the senior managers at the Health and Social Care Board (HSCB) with responsibility for the Northern Ireland Adult Safeguarding Partnership (NIASP).
i) Meetings with the Northern Ireland Ambulance Service.

[104] In respect of family members this includes individual and group meetings, informal discussion meetings when visiting DMCH, the families' meeting called by DH, as well as telephone and email contacts. Contact ranged from multiple with some family members to a single instance with others

Contributions were sought from

a) Runwood which provided policies and procedures as well as documentation of its current approach to care practice.
b) GPs providing treatment to the residents of care home settings.
c) The HSCTs' commissioners of domiciliary care arrangements.
d) The clinicians and professionals, including social workers and nurses associated with discharging older people from hospital directly to care homes.
e) The Presiding Coroner for NI.
f) The PSNI.
g) Trade Unions, The RCN and Unison.
h) Professional Associations, the BMA, NIPEC and the RCGP.
i) Health and Social Care Regulators, NMC and NISCC.
j) Nurse consultants and academics.
k) Professor Assumpta Ryan and Sarah Penney, University of Ulster.
l) Gary Mitchell, Queens University and Kathy Fodey, as part of the Transformation Team.
m) Other Government Agencies and public bodies such as the Health and Safety Executive for Northern Ireland and the Regulation and Quality Improvement Authority.
n) The Independent Health Care Providers as the main trade association.

Appendix B: The Legislative Architecture

The legislative architecture in Adult Safeguarding is complex because reliance is placed on a range of legislative provisions that are not centred on safeguarding. The impact of the Northern Ireland legislature not being operational at the time of writing means that more creative approaches are required to enable change and reform. The following list of legislation is not meant to be prescriptive, but illustrative of the range of legal powers that may be deployed in adult safeguarding. There is a clear need for codification, consolidation and a planned system of legislative timetabling. The uncertainty of timing and the phased implementation of legislation such as the Mental Capacity (Northern Ireland) Act 2016, has led to some confusion and stress in the system. It is understood that the shortcomings of the current arrangements are acknowledged and it is accepted that change is required prior to the enactment of legislation. The overriding need for it to be enacted in the public interest has been the subject of much debate and appears to have cross-party support. There is therefore a unique opportunity to lay legislative foundations and to enable change to happen.

- Criminal Law (Northern Ireland) Act 1967
- Mental Health (Northern Ireland) Order 1986
- The Police and Criminal Evidence (Northern Ireland) Order 1989
- The Public Interest Disclosure (Northern Ireland) Order 1998
- The Criminal Evidence (Northern Ireland) Order 1999
- Family Homes and Domestic Violence (Northern Ireland) Order 1998
- Health and Personal Social Services Act (Northern Ireland) 2001
- The Health and Personal Social Services (NI) Order 2003
- Safeguarding Vulnerable Groups (Northern Ireland) Order 2007
- Sexual Offences (Northern Ireland) Order 2008
- Health and Social Care (Reform) Act (Northern Ireland) 2009
- Mental Capacity (Northern Ireland) Act 2016

Appendix C: Learning from Research

A number of comments and suggestions were made…

- *Developing clear and particular pathways for referrals arising in residential/nursing homes…which acknowledged the issues peculiar to each*
- *Introducing a fact-finding or screening stage, which was transparent, aimed at ensuring referrals were well founded and appropriate*
- *Clarifying and, where necessary, specifying the purposes of the strategy planning meeting, the circumstances under which case conferences were convened and the functions of such a meeting*
- *Introducing support for service users, alleged perpetrators and those staff involved at any stage in the adult protection process*
- *Underlining the importance of protection planning including risk assessment throughout the process* (p45).

This quotation is from a research paper published in 2000 about practice and procedures in adult protection in the Southern Health Board.[105] It sought to renew the foundations for an improved service response and proposed the introduction of a board-wide recording system enabling: activity to be enumerated; consistency with regard to activating the process; procedural dovetailing to avoid duplication; on-going education; and greater ownership among professionals and agencies since the integration of health and social care had not resulted in multidisciplinary ownership of adult protection (social workers were expected to assume the lead role). Good evidence that adult safeguarding is a long-standing and pressing matter in Northern Ireland.

The abuse of older people in residential/institutional settings is an enduring fact.[106] It has many manifestations including inattention to people's physical care; organisational factors leading to poor standards of care; fraud; the use of restraint; mistreatment by peers; and sexual assaults which tend to be under-reported and under-investigated. Research concerning the risk factors for the abuse of older people identify: the emotional and mental health problems of the person(s) responsible for harming others; a previous history of harming others; and the dependency needs of the people who are harmed – which exceed the capacity of caregivers. It is acknowledged that it is difficult to determine whether the causes of abuse hinge on the individual failings of caregivers or managerial weaknesses. Certainly, absent or deficient education concerning the care of older people; work-related

[105] Douglas, H. and Halliday, B. (2000) Reviewing practice and procedures in adult protection in the Southern Health Board *Journal of Adult Protection* 2: 2, 41-49

[106] For example, Clough, R. (1999) The abuse of older people in institutional settings: the role of management and regulation. In N. Stanley, J. Manthorpe and B. Penhale (Eds) *Institutional abuse: perspectives across the life course* London: Routledge

stress/burnout; a poor working environment/inadequate resources to provide good care; and the expectations imposed on a low paid workforce of mostly women play their part.[107]

With reference to sexual assaults in residential homes, research confirms that its discovery brings forth hitherto unexpressed views and attitudes concerning the sexuality of older people which impact on how allegations are addressed. For example, views concerning the appropriateness of an assumed relationship may be "resolved" by separation to different parts of a home and reference to mental capacity. A source of keen frustration for homes' managers and staff is discussion concerning allegations of sexual assault and adult protection investigations which are "unproven."[108]

A key structural cause of the neglect of older people in nursing homes is *the law's emphasis on physical disability and frailty and its underestimation of time needed to care for people suffering with dementia* (p15).[109] A consideration of the findings arising from 251 qualitative interviews in eight nursing homes, a survey among 22 nursing home staff and an analysis of cases known to law enforcement and "nursing home control agencies" in a single German state reported paternalism, infantilisation, psychosocial neglect and verbal aggression more frequently than physical assaults, neglectful care or the inappropriate use of restraints, for example. While incidents of physical violence against residents were generally of low to moderate severity, the picture changed *if reports from observers were included…night shifts are characterised by especially low staffing which may imply extreme work stress and a low chance of detection and prosecution of misbehavior…nurses behaviour seemed to be triggered by residents' faecal incontinence* (p18). In contrast to physical violence, specific incidents of neglect were perceived as something for which individual nurses were not responsible. The survey revealed that almost ¾ of 361 staff reported that they had witnessed a at least one harmful incident performed by a colleague in the preceding 12 months. They estimated that four out of five incidents of abuse and neglect were not reported to managers. Analysis pointed to the role of qualified nurses in reducing "residents' risk of victimisation" (p21). In almost 40% of inspections, evidence of abuse or neglect was identified. Analysis of 35 public prosecutor files revealed two types of cases relating to (i) neglect and insufficient medical treatment in nursing homes and (ii) cases of physical maltreatment, including sexual assaults by nursing staff, managers and owners. The strengths and limitations of the respective approaches demonstrate that the combination of qualitative and quantitative information and *a multitude of perspectives and data on detected and undetected cases produce a more comprehensive picture of abuse and neglect in institutions of long-term care* (p25).

There is a comparative dearth of primary research on elder abuse in the UK which, compounded with difficulties in reporting cases, has led to difficulty in reporting figures

[107] Parker, J. (2001) Seeking effective approaches to elder abuse in institutional settings *Journal of Adult Protection* 3:3, 21-29

[108] Jeary, K. (2004) Sexual abuse of elderly people: would we rather not know the details? *Journal of Adult Protection* 6:2, 21-30

[109] Goergen, T. (2004) A multi-method study on elder abuse and neglect in nursing homes *Journal of Adult Protection* 6:3, 15-25

(p28).[110] This problem is exacerbated by different levels of understanding concerning abuse and the actions which should be taken. This is confirmed by a small study which sought the views of care home managers and residents[111] about how different types of harm to residents might be addressed. It revealed that managers' perceptions of the seriousness of an incident, prior experience of dealing with abuse scenarios and confidence in seeking external advice and support determined their responses. There were wide variations in the reporting of certain incidents. Similarly, residents' views differed with some expressing sympathy with the challenges of working in a residential service.

An analysis of calls to Action on Elder Abuse's helpline between 1997 and 1999 showed that almost 30% concerned abuse in care homes and hospitals.[112] Subsequent studies[113] suggest that this considerably underestimates the extent of harm in care homes. However, prevalence figures vary according to the sources of data, the methods and timeframes used.

There are elements of service cultures and environments that are associated with the potential to provide early warning or indicators that all is not well.[114] Managerial failings at all levels are associated with abusive environments. Staff attitudes and behaviours have a significant role in maintaining or infringing residents' safety – highlighting the importance of skilled and competent managers promoting the development and maintenance of staff skills, knowledge and understanding. Isolation is a key element of abusive services as staff become removed from new ideas and unable to recognise the poverty of conditions and practices. Service design, placement planning and commissioning may result in failure to deliver agreed plans; and failure to recognise the ways in which residents may express their harmful experiences or their propensity to harm others are consistent with themes arising from enquiries.

Efforts to abstract learning from adult safeguarding reviews exercises practitioners and their organisations. An overview of adult Serious Case Reviews in two English local authorities identified the importance of considering levels of outcome.[115] (The content of Table 1 has been slightly modified to reflect Northern Ireland's authorities.)

[110] Manthorpe, J. Perkins, N., Penhale, B., Pinkney, L. and Kingston, P. (2005) Select questions: considering the issues raised by a Parliamentary Select Committee Inquiry into elder abuse *Journal of Adult Protection* 7:3 19-32

[111] Furness, S. (2006) Recognising and addressing elder abuse in care homes: views from residents and managers *Journal of Adult Protection* 8:1 33-49

[112] Bennett, G. Jenkins, G. and Asif, Z. (2000) Listening is not enough: An analysis of calls to Elder Abuse Response *Journal of Adult Protection* 2:1 6-20

[113] For example, Cambridge, P. Beadle-Brown, J. Milne, A. Mansell, J. and Whelton, B. (2006) Exploring the incidence, risk factors, nature and monitoring of adult protection alerts, Canterbury: Tizard Centre

[114] Marsland, D., Oakes, P. and White, C. (2007) Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings *Journal of Adult Protection* 9:4 6-20

[115] Brown, H. (2009) The process and function of serious case review *Journal of Adult Protection* 11:1, 38-50

Table 1: Layers of outcome

Levels and contexts	Outcomes
For the person who has been harmed	Attention to immediate safety, possibly an emergency medical response; a risk assessment; a review of the care plan and risk management; longer term support for recovery; redress; appropriate reporting; clinical review.
For the person(s) associated with the harm	Criminal justice; employment, disciplinary action; barring from the workforce; fitness to practice procedures by the regulator; extra assistance, training and supervision if a service employee; other civil enforcement such as an injunction; extra assistance and enhanced care, support and communication, if a relative.
For the provider service	Review of RQIA registration requirements and a service's adherence to its registered purpose; scrutiny of its policies and procedures; scrutiny of RQIA inspection reports; use of regulatory enforcement, including closure; professional advice and consultation; communication with relevant authorities.
For the HSCTs	Changes to contracts; monitoring of contracts; re-provision of the service; interagency support; review of suitability of individual provision; liaison with person harmed and their family.
For the HSCB	Commissioning health and social care services for the population of Northern Ireland**.** Oversight of the Regional Contract and procurement of care home services with specific reference to safeguarding.
For the Health Minister	The HSCB is accountable to the Health Minister, for turning their vision for health and social care into a range of services that deliver high quality and safe outcomes for patient and service users. The Minister discharges this duty through the DH.
For the Legislative Assembly	Acknowledgement of gaps in remit, powers and duties of the HSCTs and RQIA; setting legislative direction and changes in policy.
Secretary of State	The Assembly has jurisdiction over areas that are not explicitly reserved to the Parliament of the United Kingdom. If the devolved legislature is in a period of suspension - as it was at the time of writing - its legislative powers can be exercised by the UK Government at Westminster. The Secretary of State for Northern Ireland is the Principal Secretary of State with responsibilities for Northern Ireland.

The Table underlines the importance of describing an incident and the conditions which led to it; identifying the key events and failures; and setting out the management and organisational factors that allowed it to happen. The author notes that *the misreading or failure to reach consensus about the respective contribution of individual culpability and corporate responsibility…seem to be the main challenges that test a system that was originally conceived of as a way of addressing one-off incidents caused by individuals, as opposed to the realities of ongoing, poor quality care or badly managed or resourced service provision* (p46-47). Decision-making may be compromised by the challenges of untangling *the relative contributions of different agencies and departments within those agencies, to the conditions pertaining in a poorly performing service…There are many and sometimes too many parties at the table in some instances* (p48).

Efforts to improve the quality of care of people receiving services in a Welsh Borough Council were occasioned by the "dilemma of how failing services are supported."[116] That is, should a local authority wait for a provider to demonstrate improvements while assisting the provider? Should a local authority respond to requests from providers to supply staff at care and managerial levels? This local authority's experience of using embargoes showed that *they are effective in making short-term improvements…but it is questionable as to whether they are effective in achieving sustained improvement* (p10). Additional dilemmas concern a provider's self-imposed embargo. Should the local authority accept this or layer on another embargo? Should reassurance be offered to service users that although new placements are not being commissioned, *monitoring and improvement meetings are taking place"? The local authority identified two key themes: (i) there is conflict when poor performance is associated with inadequate numbers of staff and (ii) changes of management are an "early indicator" of potential risk.* It noted that the quality of a service improves or deteriorates in response to a change of manager, *compounded by the fact that leadership, supervision and the ability to recognise and challenge poor practice may not be cascaded down through the tiers of staff below* (p11). The benefits of the provider performance monitoring included improved relationships with the majority of providers; improved understanding and communication between internal departments and external agencies; an enhanced quality monitoring profile; and strategic commitment to the early identification of potential risks.

Research evidence concerning "training transfer – the use of acquired knowledge or skills once back at work" identifies the significance of the training provider, the delegate and the delegate's organisation/manager.[117] Four factors in particular are identified as being important in influencing training transfer: individual characteristics e.g. motivation and perceived utility of attending; training design and delivery e.g. content relevance to job and follow-up; transfer climate e.g. manager and peer support and opportunity to use training;

[116] Giordano, A. and Street, D. (2009) Challenging provider performance: developing policy to improve the quality of care to protect vulnerable adults *Journal of Adult Protection* 11:2, 5-12

[117] Research in practice for adults (2012) *Training transfer: getting learning into practice* Dartington: RiPfA

and subject climate e.g. the match between what training says should happen and what happens.[118]

A Serious Case Review in England concerning a single care home, Summer Vale Care Centre for older people,[119] found that it did not ensure the safety of its residents; although the exact number of abusive incidents in the home was unknown, a dismal picture of the lives of residents emerged; a woman who was a National Health Service Continuing Healthcare funded patient was repeatedly physically and sexually assaulted; there were lots of incidents and concerns and even though there were around 60 professionals involved in making sense of this information, all of whom agreed that something should be done, no one asked searching questions and no one assumed a lead role; Summer Vale Care Centre did not train or supervise its staff; those who asked the home to provide placements and those who inspected it believed the home's managers when they said that they were "monitoring" residents who were either violent and harmed people sexually or were the victims of assaults.

The safety of healthcare workers supporting people with dementia[120] was explored via a postal survey (with a 35% response rate) in care homes in the independent sector in Northern Ireland. Of these respondents, two thirds reported that they had experienced incidents which caused them to fear for their safety. The most serious events which respondents were involved in or witnessed included being grabbed around the neck, kicked on the chest and sexually harassed, for example. The study concluded that healthcare workers frequently fear for their safety. How staff make sense of the events and reflect on the threats posed are unrelated to the injuries sustained. Most assaults take place during care interventions and care staff were wary of working alone with residents whose behaviour was aggressive. The experience of urgently seeking the assistance of colleagues was reported as distressing. While the support of peers at work was valued, formal managerial support was less forthcoming.

Little is known about the employment of agency staff to fill staffing gaps.[121] Typically agency staff are under contract with an employment agency or business and are not permanent members of staff. The employment agency is responsible for their recruitment, and the workers themselves offer and have to accept flexibility, sometimes in return for higher rewards than they might earn in permanent posts. A mixed methods study found that agency staff were most likely to be recruited when posts required filling quickly and "safeguarding issues were involved." Private sector home care and care home providers rarely sought agency care workers due to the costs and business viability. The research concluded that

[118] Pike, L., Gilbert, T., Leverton, C. Indge, R. and Ford, D. (2011) Training, knowledge and confidence in safeguarding adults: results from a postal survey of the health and social care sector in a single county *Journal of Adult Protection* 13:5, 259-274

[119] Flynn, M. (2011) Serious Care Review Executive Summary: Summer Vale Care Centre, Leicester

[120] Scott, A., Ryan, A., James, I.A. and Mitchell, E. (2011) Psychological trauma and fear for personal safety as a result of behaviours that challenge in dementia: the experience of healthcare workers *Dementia* 10:2 257-269

[121] Manthorpe, J., Cornes, M. and Moriarty, J. (2012) Considering the safeguarding risks presented by agency or temporary social care staff: researching findings and recommendations *Journal of Adult Protection* 14:3, 122-130

agency or temporary staff in care homes and community settings should be considered as part of "risk-minimisation strategies." However, they need to know about, *inter alia,* safeguarding practice since the poor management of agency workers may pose a risk rather than the fact of agency working itself. The study concludes that commissioners should consider making safeguarding training available to agency staff.

A consideration of the factors which enable the abuse and maltreatment of older people[122] opened with older people's categorisation of the abuse of older people as determined by the World Health Organisation in 2002:[123]

- Deprivation: of choices, decisions, status, finances and respect
- Violation: of human, legal and medical rights
- Neglect: isolation, abandonment and social exclusion.

The Joint Committee on Human Rights[124] inquiry into breaches of older people's human rights in the UK suggested that older people in hospital and residential care "routinely receive inhumane and degrading treatment." Structures which emphasise liberty, individual freedom, responsibility, free markets and minimal state intervention have resulted from the deregulation of economic activity. In addition, the increased privatisation of previously publicly delivered services to older people – or "consumers of care" – implies choice and an ability to buy private care. This neatly transfers responsibility from the state to the individual. Practice which might constitute abuse and maltreatment is not recognised as such and may be tolerated in an effort to meet organisational needs. Structural reform has to parallel reforms at an individual level and this must emphasise dignity over price and compassion over cost.

It is recognised that the experience of poor treatment in care homes for older people cannot be separated from broader institutional and societal issues which underpin homes and their related systems.[125] Care home residents cannot avoid contact with staff and/or other residents and there is a requirement to submit to the home's routines. Although human rights are closely aligned to adult safeguarding and there are many examples of actual or potential breaches of human rights in care homes and nursing homes, "policy priorities" have not favoured older people being supported in their communities. In contrast, the care home and nursing home sector has grown – which is arguably an anti-human rights development.[126] How may a care home give expression to the right to liberty if residents with mental capacity

[122] Galpin, D. (2012) The role of social defences and organisational structures in facilitating the abuse and maltreatment of older people *Journal of Adult Protection* 14:5, 229-236

[123] World Health Organisation (2002) *Missing Voices: Views of Older Persons on Elder Abuse* Geneva: WHO

[124] House of Lords House of Commons Joint Committee on Human Rights *The Human Rights of Older People in Healthcare.* 18th Report of Session 2006-07, Vol 1 Report and Formal Minutes. HL Paper 156-1, London: The Stationery Office

[125] Phelan, A. (2015) Protecting care home residents from mistreatment and abuse: on the need for policy *Risk Management and Healthcare Policy* 8: 215-223

[126] Quinn, G. (2013) *Age: from human deficits to human rights – reflections on a changing field.* Launch event – Human Rights and Older People Working Group, *Human Rights and Older People in Ireland*

are not allowed to leave unless they are accompanied? *In the context of care deficiencies, it is imperative that a multi systems approach requires attention not only to emergent issues but also on how such issues are interrelated to produce maltreatment, missed care, failure to rescue or never events…Policy needs to acknowledge the macrosystem within which beliefs and values of societies in relation to older people emerge and acknowledge how such perspectives (such as ageism) can have an impact on care delivery and care experience…a global debate is necessary on the need to diversify care delivery options as care homes are the most dominant and, in many countries, unilateral way of caring for older people with heightened care needs* (p219).

Although the media have a prominent role in exposing poor practice in care homes, care staff report problems in raising questions and concerns in certain workplaces.[127] It was the serendipitous broadcast of an undercover TV documentary during a study of England's social care workforce that led to consideration of its impact. Spins on the coverage involved the "CCTV industry – which was positive about the ethics of using CCTV technology;" speculation that families were given "the green light to spy" on care homes; and the dismay of consultants specialising in the care of older people that if local clinicians had been on task, some people might have been enabled to remain in their own homes. Subsequent data from interviews with 112 care home managers and 117 staff revealed that most were positive about the role of the media in exposing abuse. However, they acknowledged that cameras, per se, are not a solution to whole system issues, not least because media coverage impacts on the reputation of all care homes.

An explorative, quantitative study of Norwegian nursing homes for older people secured information from over 600 staff and home managers.[128] The most consistent finding was that "resident aggression" increased the probability of inadequate care, abuse and neglect. It appears that the probability of inadequate care of an emotional and physical type increases significantly in rural areas. However, it acknowledges the possibility that more skilled staff are drawn to urban areas.

It is widely accepted that organisational cultures are critical to promoting harm and mistreatment. A qualitative study about "early indicators of concern"[129] in residential services for older people identified six significant domains which may guide and inform. That is:

i) management and leadership
ii) staff skills, knowledge and practice
iii) residents' behaviours and well-being
iv) the service resisting the involvement of external people and isolating residents

[127] Manthorpe, J., Njoya, E., Harris, J. Norrie, C. and Moriarty, J. (2016) Media reactions to the Panorama programme "Behind Closed Doors: Social Care Exposed" and care staff reflections on publicity of poor practice in the care sector *Journal of Adult Protection* 18:5, 266-276

[128] Malmedal, W., Hammervold, R. and Saveman, B. (2014) The dark side of Norwegian nursing homes: factors influencing inadequate care *Journal of Adult Protection* 16:3, 133-151

[129] Marsland, D., Oakes, P. and White, C. (2015) Abuse in Care? A research project to identify early indicators of concern in residential and nursing homes for older people *Journal of Adult Protection* 17:2, 111-125

v) the way services are planned and delivered

vi) the quality of basic care and the environment.

This study endorses the perceptions of experienced health and social care staff who visit residential services for older people. Since they are attuned to signs that a service is deteriorating, their judgement and discretion is more effective than disputes concerning safeguarding thresholds for example.

A review of the neglect of older people in care homes in south east Wales[130] described the indifferent care home practices which harmed older people. Their relatives were unaware of the poor reputations of the GP owners, the homes' managers or of the homes where the relevant regulations were repeatedly tested and breached. Families perceived the inattention to residents' hydration, nutrition, physical comfort, hygiene, unexplained injuries and deep pressure ulcers as the abandonment of common humanity and a reflection of the unchecked greed of the businesses which owned the homes concerned. Between 1994-2006, the Health and Safety Executive had issued 12 improvement notices to the GPs' homes. The regulator was required to demonstrate that reasons for deciding to close a home remained compelling at the point of closure – which was compromised by health and social care agencies "stepping in" to shore up failing practice since this masked the failures of the registered provider. The regulations at the time required inspectors to take action on a home by home basis. There were mistakes and errors of judgement. The Crown Prosecution Service's assertion that the case would have fallen on the basis of lack of evidence should have been tested before a jury; the legal context of residential services and corporate governance require attention; better corporate safeguards are required to ensure good governance; the poor standards of care provided by the GPs' companies may have rendered them liable in contract to commissioners and proceedings could have been taken under the Company Directors Disqualification Act 1986; extensive media coverage and safeguarding investigations proved insufficient in securing a fair and legally sanctioned resolution; no single agency or profession assumed a lead role in addressing breaches of trust, neglected contractual duties or the harms endured by older people; the parameters of the police investigation were too broadly drawn; inter-organisational cooperation was overshadowed by ambiguity and suspicion as the police investigation extended; aspects of palliative care such as the management of pain and the provision of emotional comfort were remote from the experience of older people within the GPs' homes. One of the lessons from the review was, *private interest pursued at the expense of others has a long history. However, the public interest cannot be subordinate to the short-term personal gains or even the criminality of a minority of care home directors* (p231).

The repetitive familiarity of particular forms of abuse – rough handling, dangerous lifting techniques, insults and tormenting, which sometimes arise in the same care homes, prompts

[130] Flynn, M. (2015) *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine* Cardiff: Welsh Government

the question: is safeguarding a job for life?[131] The staff of five new care homes responded to an anonymous questionnaire concerning witnessed or suspected abuse. The findings indicate that the abusive realities of care homes evade detection by regulatory and monitoring activities. The research concludes that more thorough ways of assessing the suitability of potential care staff and regulation are required that look *beyond the relatively superficial artefacts of care home organisation* (p224).

The concealment of abuse in care homes[132] is attributed to intimidation, fear of eviction and reprisals, for example. Staff may fear such personal consequences as victimization, intimidation, ostracism and loss of employment. It brings into question the distance between worthy policy and the prevailing practice environment. Interviewees were dismayed by the quasi-judicial, fault-finding approach of safeguarding inquiries and regarded this as a deterrent to honestly reporting events. The research confirms the significant under-reporting of abuse and the failure of existing regimes to protect older people in residential services.

The recurring and persistent challenges to effective inspection and regulation are not new.[133] For example, beliefs about the causes and effective treatment of "lunacy" in nineteenth century Scotland shaped the design of inspection services. In 1822 there was *an average of one Commissioner for every 4,400 lunatics in Scotland* (p120). Using Scotland's Care Inspectorate's four themes employed in its grading (care and support, environment, staffing, leadership and management) to make time comparisons revealed that: nineteenth century standards hinged more on the environmental features of care and the site of asylums; and an early interest in staff "characteristics" gave way to the importance of specialist training. The importance of management to ensure the fidelity of patient care was evidenced in early inspections. Scotland's emergent inspection practice is driven by the need for a balance between evidence and value-based judgements as well as "best value" considerations. It is recognised that there is *no ideal format or comprehensive system of inspection of services as yet*. However, *a publicly available ratings approach was more likely to be successful for social care*… and difficult decisions remain about the most effective methods of regulation and inspection.

Safeguarding functions are predominantly reactive to the abuse of older people in residential services. An investigation of personal value frameworks[134] conducted in 12 care homes revealed that these are significant factors in the creation of circumstances in which abuse may occur. However, the assumption that all staff positively value older people in their care is typically untested. Unless the decision to work in a home is positive, premeditated and

[131] Moore, S. (2016) Safeguarding vulnerable older people: a job for life? *Journal of Adult Protection* 18:4, 214-228

[132] Moore, S. (2016) See no evil, hear no evil, speak no evil? Underreporting of abuse in care homes *Journal of Adult Protection* 18:6, 303-317

[133] Campbell, M. (2017) The journey from first inspection to quality standards (1857-2016): are we there yet? *Journal of Adult Protection* 19:3, 117-129

[134] Moore, S. (2017) What's in a word? The importance of the concept of "values" in the prevention of abuse of older people in care homes *Journal of Adult Protection* 19:3, 130-145

regarded as a worthwhile choice, practices will prevail which are incompatible with valuing older people.

Adult safeguarding experience in Northern Ireland *has moved towards a more person-centred approach with a drive to involve service users in shaping services* (p237).[135] Specialism dictates responses. That is within the five integrated HSCTs, there are either specialist teams managing the referrals deemed to be "high risk" with generic locality teams attending to the lower-risk referrals, or all cases are managed by generic practitioners trained to combine the tasks of investigation and adult protection. A pilot study sought to adapt a method of gathering feedback (10,000 voices) from those involved in services to adult safeguarding experiences. Out of 36 people, 35 provided a narrative account of their experiences and provided "an opportunity for debrief and closure." People's responses were largely positive and where it was offered, negative feedback focused on matters not being addressed and inconclusive outcomes.

The public communications of care homes concerning human rights are revealing in terms of corporate responsibility.[136] Based on a qualitative content analysis of the websites of 71 large commercial care home providers, a study revealed that although providers use value-based public communications, these "may or may not be interpreted to be an express commitment to human rights" (p358). Since the Human Rights Act 1998 is directly relevant to registered providers, the actions of all public authorities must be compatible with human rights under the 1998 Act. Accordingly, the English regulator adopted a human rights approach to regulation and inspection.

Are regulation, inspection and commissioning ineffective in combating abuse?[137] Regardless of the introduction of National Minimum Standards in 2002, which are grounded in good practice, the Care Quality Commission reported that 26% of care homes and 41% of nursing homes were rated as either "inadequate" or "requires improvement."[138] Therefore it appears that there is a limit to the effectiveness of the regulator's scrutiny in terms of improving the sector and preventing abuse. In addition, the contract monitoring function regarding care homes is "superficial and reactive…many of the staff employed…to manage and monitor contracts…often lack the skills and experience to do so" (p422-423). A "back to basics" approach is advised which hinges on the personal value frameworks of potential home staff and managers, scrutiny during the evenings and at weekends and the introduction of surveillance technology.

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[135] Montgomery, L., Hanlon, D. and Armstrong, C. (2017) 10,000 Voices: service users' experiences of adult safeguarding *Journal of Adult Protection* 19:5, 236-246

[136] Emmer de Albuquerque Green, C. (2017) Exploring care home providers' public commitments to human rights in light of the United Nations Guiding Principles on Business and Human Rights *Journal of Adult Protection* 19:6, 357-367

[137] Moore, S, (2017) If you always do what you have always done, you will always get what you have always got: commissioning and regulating care homes to prevent abuse *Journal of Adult Protection* 19:6, 418-430

[138] Care Quality Commission (2016) *The State of Health and Social Care in England 2015/2016* Newcastle-upon-Tyne: CQC

A Knowledge Transfer project in Northern Ireland[139] sought to improve the quality of older people's lives in nursing and residential care homes. It began in 2013, with 15 care home managers implementing practice development initiatives about: facilitating a positive transition for residents and relatives; maintaining dignity and identity; sharing decision making; and creating and maintaining community links. The project went on to facilitate the leadership skills of 49 home managers and to enhance relationships within the home and with residents' relatives. The authors proposed that such findings should *be disseminated to balance the negative public image of care homes that currently prevails* (p1).

Interviews with three former care staff "who had committed abusive acts" reveal their discomforting perceptions and values.[140] Although they had not planned to become care workers, they needed employment and there were no barriers to their appointment. There was no rigour to their interviews, there were no checks on their references, their induction was superficial, their early experience of work in care homes was poor and their movement between homes was unhindered. They each conformed with the harmful and disrespectful practices they encountered at the outset of their employment in care homes. Their need for salaried work trumped their conduct as employees. Their unchallenged perceptions of older people were that they are entirely without worth and less than human. The three ex-employees were wholly dismissive of external scrutiny which gathered nothing of prevailing care practices.

Hospital admissions from nursing homes generally hinge on GPs' decision-making.[141] Interviews with 21 GPs confirmed that their starting point was the assessment of the patient's medical condition and the risks versus benefits of hospital admission. The patient's own wishes and those of their relatives had significant roles in decisions, in addition to medico-legal matters. Access to information was similarly instrumental in determining whether an admission should proceed with GPs more likely to admit if information was missing. The capability of the home care staff and their attitudes towards palliative care were considerations. Younger GPs were perceived to admit more readily than more experienced GPs. Ideas for improving practice concerned: improving communication; increasing nursing home training; using specialist nurses; and peer support for GPs.

Since older people living in residential care homes have limited life expectancy, care homes are increasingly regarded as providers of palliative care for older for older people.[142] Six homes in three English localities were the focus of one study. During its timeframe, 23

[139] Ryan, A. and Penny, S. (2018) *Improving quality of life in nursing and residential homes by implementing an evidence-based programme of best practice and person-centred care: My Home Life* Northern Ireland. Belfast: HSC Public Health Agency, Research and Development Division

[140] Moore, S. (2019) Paths to perdition: exploring the trajectories of care staff who have abused older people in their care *Journal of Adult Protection* 21:3, 169-189

[141] McDermott, C., Coppin, R., Little, P. and Leydon, G. (2012) Hospital Admissions from nursing homes: a qualitative study of GP decision-making *British Journal of General Practice,* August 2012, e538-e545

[142] Barclay, S., Froggatt, K., Crang, C., Mathie, E., Handley, M., Illife, S., Manthorpe, J., Gage, H. and Goodman, C. (2014) Living in uncertain times: trajectories to death in residential care homes *British Journal of General Practice,* September 2014, e576-e583

residents died out of 121. Interviews and scrutiny of case notes led to the identification of four trajectories:

i) anticipated dying – this affected the largest number of residents
ii) unexpected dying – these residents had been stable until an illness that was not obviously life threatening but which led to death within days
iii) uncertain dying – although these residents were unwell, they were not close to death but were admitted to hospital for further investigations or treatment
iv) unpredictable dying – these residents had been stable but experienced an unexpected and acute event.

Primary care services have an increasing role in the care of frail older people.[143] A study seeking to determine the long-term outcomes of older people discharged from hospital following short admissions (of under three days) took into account their frailty status. It found that people deemed to be frail, who are discharged from hospital, are at high risk of poor outcomes, that is, they experience increased mortality and resource use. Thus, there are compelling reasons to avoid even brief hospital admissions. However, since falls, delirium or sudden loss of mobility are typical "frailty crises," there is an incentive to invest in their primary prevention and in enhancing community support to those being discharged.

Taken individually, the research cited is narrow in focus and limited in its contribution to our understanding of the abuse of older people in care homes. Together however, the studies provide a wide-angled picture, including the "signs" that things are going wrong. The themes and insights are true to the complexity of the topic – which is not new to Northern Ireland. It is evidenced in all forms of residential care and institutions where people have interdependent relationships. The values and behaviour of the manager are pivotal. A change of manager is a time of risk. The most important job of that manager is the selection of care practitioners, their training, supervision and support.

There can be no guarantees of absolute safety in care homes. What is possible is the provision of timely support to residents associated with harm and to the Registered Manager since practice is necessarily highly situational. Managers must be alert to identifying the "signs" of potential problems and preventing these from becoming harmful crises.

It follows that research points to investing in Registered Manager development and succession planning; in making the Responsible Individual's position one for competent and experienced people; in making the Regulation 29 reports readily available to all visitors, most particularly residents' relatives; and seeking forms of training, inspection and governance that are attuned to the signs associated with an increased likelihood of abuse and neglect.

[143] Keeble, E., Roberts, H., Williams, C.D., van Oppen, J. and Conroy, S.P. (2019) Outcomes of hospital admissions among frail older people – a 2-year cohort study *British Journal of General Practice,* August 2019, e555-e560

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Legislative options to inform the development of an Adult Protection Bill for Northern Ireland

Consultation document

17 December 2020

CONTENTS

FOREWORD FROM ROBIN SWANN MLA

MINISTER OF HEALTH

Adult Safeguarding is about protecting an adult's right to live in safety, free from abuse, exploitation and neglect. It involves people and organisations working together to make sure adults who may be at risk of harm are protected, and intervening effectively if abuse is taking place. Importantly, it is also about empowering individuals to be independent and make choices about how they want to live.

Following the widely publicised safeguarding failings at Muckamore Abbey Hospital and Dunmurry Manor Care Home, it has become clear that there is a need to review and improve our Adult Safeguarding policy. In September 2020, following the independent review into the situation at Muckamore, I announced my intention to consult on a range of legislative options on safeguarding before Christmas.

I am therefore delighted to bring forward this consultation into a proposed Adult Protection Bill. Such legislation would give a statutory footing to our policy around Adult Safeguarding, and would bring us in line with other parts of the UK where such legislation already exists.

Following this consultation, my officials will move forward with the development of a draft Bill that will take into account the views of all key stakeholders, interested parties, and all those who take the time to respond to this consultation. I am determined to lead social care into a better place in Northern Ireland, and an Adult Protection Bill will help to make that a reality.

I want to encourage as many people as possible to respond to our consultation, in order that the draft Bill is fit for purpose. Please send us your thoughts and

comments, or take part in one of the socially distanced consultation events we will be organising. We will be grateful for your help in developing robust legislation that will help to protect adults at risk in Northern Ireland.

CONTEXT AND OVERVIEW

Introduction

1.1 Building on the response to the Commissioner for Older People's Home Truths Investigation into Dunmurry Manor Care Home and CPEA's Independent Review into Safeguarding and Care at Dunmurry Manor, the Department of Health ('the Department') is undertaking a public consultation to inform the development of an Adult Protection Bill, subject to the approval of the Northern Ireland Executive.

1.2 This consultation offers the public the opportunity to share their views on the broad content of the Bill. The paper also highlights legislative reform which has taken place in Scotland, England and Wales over the years (each having adopted a different approach) and seeks views on whether similar reforms should be introduced in Northern Ireland.

'Adult Safeguarding' and 'Adult Protection'

1.3 Two important terms, 'adult safeguarding' and 'adult protection', should be clarified at the outset. These terms are often used interchangeably which can sometimes be unhelpful as there is an important difference in the types of arrangements and in the types of risk they describe.

1.4 Adult safeguarding is the term used to describe the arrangements put in place to keep adults safe who are at an increased risk of harm from abuse, neglect or exploitation due to their personal characteristics and life circumstances.

1.5 For example, some adults may be exposed to such risk due to an underlying health or social care need and because they live with few or no social contacts or in situations where they rely on others for daily support. Other adults may have a greater exposure to risk of abuse due to their level of cognitive ability and because they may lack capacity to be aware of what may

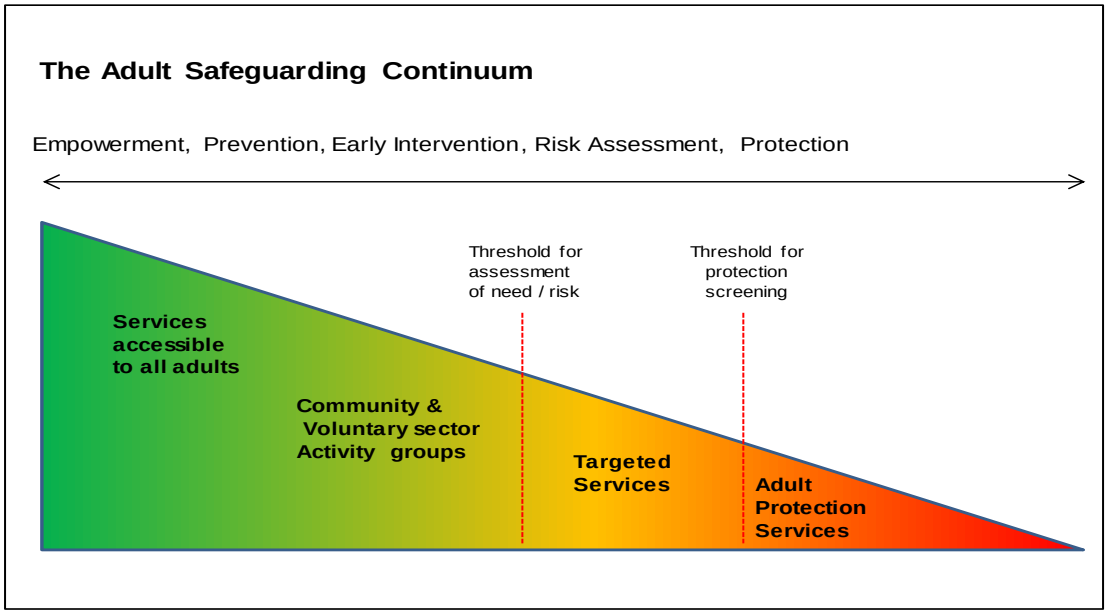
be happening to them or to take action to protect themselves or to seek help to do so.

1.6 Safeguarding arrangements range from preventive safeguarding such as training staff to recognise and report abuse, to protection interventions, which may involve criminal investigations as well as statutory interventions by the Police Service of NI ('PSNI') and the Health and Social Care Trusts ('HSC Trusts') in order to protect a named adult or a group of adults from suspected or confirmed abuse, neglect or exploitation.

1.7 'Adult safeguarding' is therefore a continuum of activity of which adult protection is a specific part. It is the adult protection process that legislation will strengthen and so for clarity, we are proposing to name the Bill the **'Adult Protection Bill'**.

Current policy framework

1.8 Adult safeguarding as a continuum of activity is set out in the regional Adult Safeguarding Prevention and Protection in Partnership Policy, published jointly by the Departments of Health and Justice in 2015 –



Empowerment

1.9 All adult safeguarding activity must be guided by five underpinning principles: a rights-based; empowering; person-centred; consent-driven and collaborative approach.

1.10 Throughout the safeguarding continuum it is important to recognise the importance of promoting the empowerment and self-determination of individual adults who are at increased risk of harm or who are in need of protection from abuse, neglect or exploitation; and that all adults as citizens are empowered to make decisions about how they live their lives.

1.11 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 in partnership.

Prevention

1.12 Safeguarding includes a range of preventative measures (practical help, care, and support) designed to promote the safety, well-being and rights of adults at risk of harm which reduce the likelihood of, or opportunities for abuse, neglect or exploitation to occur. It is a responsibility of a wide range of organisations, agencies and HSC professionals. Indeed, it is the responsibility and concern of us all as good citizens and neighbours to where possible, prevent the abuse, neglect or exploitation of adults at increased risk of exposure to these types of harm.

1.13 The policy recognises that adults at increased risk will, in the first instance, be supported by their families and friends and by local community involvement**.** Safe social, recreational and family networks and safe communities can help adults keep themselves safe, to minimise risk and to exercise their rights to live full active and independent lives.

1.14 Recognising, responding and reporting risk is key to how community, social and family supports can help adults at risk to stay safe and to mitigate against an increased risk of harm from abuse, neglect or exploitation.

1.15 The policy expects organisations providing community based activities to have a culture of zero-tolerance of harm; to take steps to reduce the opportunities for harm to occur; and to know how and when to report concerns, whether in the person's own home, a care setting, in the community or within organised community or voluntary activities.

Early intervention

1.16 Intervening early is key to preventing escalation of the risk of harm, to help and support adults and families to avoid problems reaching a crisis point. Very often it is the GP who will be the first point of contact when an individual's needs are changing and they require further support.

1.17 Where organisations providing 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 HSC Trust for a professional assessment of needs and/or risks. More targeted services may then need to be put in place for the individual such as domiciliary based care, supported living, residential or nursing care, or direct payments.

1.18 The policy expects all providers of targeted services to be zero-tolerant of harm and to have robust governance and safeguarding procedures in place (this is also expected by commissioners of services as part of service level agreements and contracts). Providers must also nominate an Adult Safeguarding Champion and adhere to relevant standards and regulations, including professional regulation.

Adult Protection

1.19 If there is a clear and immediate risk of harm to an adult from abuse, neglect or exploitation and the adult is unable to protect themselves because of their

personal circumstances, a referral should be made to the relevant HSC Trust or to the PSNI if a crime is alleged or suspected.

1.20 This is at the higher end of the continuum, where serious harm from abuse, neglect or exploitation is suspected, has occurred, or is likely to occur without intervention. Each HSC Trust has an Adult Protection Gateway Service and referrals can be made from any source. It will then be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met. The seriousness and the degree of risk of harm are key to determining the most appropriate response.

1.21 Protection interventions, if required, are led by social workers and/or PSNI officers; the latter primarily where a crime is alleged or suspected. They will engage with the adult and require information and support from other disciplines and organisations to contribute to the development and delivery of a care and protection plan or to assist a criminal investigation.

Purpose of new legislation

1.22 The regional policy will, for the moment, continue to provide the broader framework for adult safeguarding activity. The purpose of new legislation is to introduce additional protections to strengthen and underpin the **adult protection** process.

1.23 The law in this area is complex, with a patchwork of legislation having evolved over the years. There are, for example, powers and duties under wider criminal law; regulated services provided under health and social care legislation; and protections under mental health and mental capacity legislation. As evidenced in the Independent Review, the net result is confusion for those providing services and for service users and their families.

1.24 The Department did consult (jointly with the Department of Justice) on the need for legislation to underpin the regional policy in 2014/15, following the former Commissioner for Older People's recommendations in A Call for Adult

Safeguarding Legislation. However, no clear consensus emerged at the time on both the need for legislation itself and on what it should contain.

1.25 Five years on and, following serious care failings at Dunmurry Manor Care Home and Muckamore Abbey Hospital, there are once again clear recommendations for legislative reform in this area. An announcement from the Health Minister followed, on 10 September 2020, to confirm that a Bill would be brought forward to make lasting improvements in adult safeguarding and to bring Northern Ireland in line with other parts of the UK.

1.26 There are very different legal approaches across the UK jurisdictions with variations in the powers and duties afforded to healthcare professionals, which the Department and consultees will wish to consider. Scotland has the largest number of measures having legislated specifically under the Adult Support and Protection (Scotland) Act 2007. In England, provisions are included in the wider Care Act 2014, and in Wales the broader Social Services and Well-being (Wales) Act 2014. There is currently no specific adult protection legislation in the Republic of Ireland.

1.27 Significant progress has already been made in Northern Ireland through the enactment of the Mental Capacity Act (Northern Ireland) 2016. When fully commenced, this Act will afford new protections for individuals who lack capacity to make decisions for themselves about their care, treatment or personal welfare. This Act provides a rights-based approach to decision making underpinned by a presumption of capacity and importantly, the right to make an unwise decision.

1.28 All adults, including adults at risk of harm from abuse, neglect or exploitation, have the right to make unwise decisions, including the choice not to take action to protect themselves. It will therefore be important that the Adult Protection Bill strikes a balance between empowerment and protection. This is a key difference between safeguarding adults and safeguarding children.

2. LEGISLATIVE OPTIONS

2.1 This part of the consultation paper seeks views on the following legislative options:

- Defining the scope of the Bill
- Principles
- Duties to (i) report and (ii) make enquiries
- Power of entry to interview an adult in private
- Independent Advocacy
- Independent Adult Protection Board
- Cooperation and information sharing
- Offences of ill-treatment and wilful neglect
- Statutory Guidance

2.2 These options have been informed by the Commissioner for Older People's recommendations in Home Truths as well as the proposed actions in the Independent Review into Safeguarding and Care at Dunmurry Manor Care Home. Recommendations presented by the former Commissioner in A Call for Adult Safeguarding Legislation, which the Department consulted on in 2014/15, have also been revisited.

2.3 Other UK legislation is referenced in this section with provisions summarised from:

- Care Act 2014 (England)
- Social Services and Well-being (Wales) Act 2014
- Adult Support and Protection (Scotland) Act 2007

2.4 A number of questions have also been posed throughout and are summarised at paragraph 4.1.

Defining the scope of the Bill

2.5 The Commissioner for Older People highlighted in 'Home Truths', that unclear thresholds and definitions have contributed to a lack of clarity about roles and responsibilities in the adult protection process. Similar findings were noted in the Independent Review which concluded that new legislation should ***"define an adult at risk of harm"*** (an approach taken in other parts of the UK) although the Review did not set out what that definition should look like.

2.6 The Department agrees that it will be important to define the scope of the Bill to set out a clear legal framework for how key organisations across health and social care and other parts of the system, should work together and understand the roles they must play in adult protection. There are a number of options set out in this consultation paper on how we could achieve this, such as new duties to report and make enquiries. These provisions would also need to be accompanied by a clear definition of an **'adult at risk and in need of protection'** to enable professionals to decide which adults require support under the legislation.

Current position

2.7 In Northern Ireland, we have already moved away from terms such as 'vulnerable adult' towards the concept of 'risk of harm' in adulthood. Under the 'Adult Safeguarding Prevention and Protection in Partnership Policy', an 'adult at risk and in need of protection' is:

a) a person aged 18 or over;

b) whose exposure to harm through abuse, neglect or exploitation may be increased by their personal characteristics;[1] and/or life circumstances;[2]

c) who is unable to protect their own well-being, property, assets, rights or other interests; and

[1] 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.
[2] Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

2.8 It is the whole of an adult's particular circumstances that combine to make the individual an adult at risk and in need of protection. Importantly, it is not any harm but rather harm that arises from abuse, neglect or exploitation (where there is a relationship of trust) that may warrant an adult protection intervention.

Legislation in other parts of the UK

2.9 The threshold of abuse and neglect is also used in England and Wales. Both jurisdictions chose not to follow the Scottish route (which focuses on a broader 'harm' threshold) when legislating in 2014. Scotland was first to legislate in 2007.

(1) 'ADULT AT RISK':

England	Wales	Scotland
'Adult at risk' is not explicitly defined instead the legislation provides a threshold for making enquiries. That is, where an adult: a) has needs for care and support (whether or not the authority is meeting any of those needs); b) is experiencing or is at risk of **abuse or neglect**; and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.	'Adult at risk' is defined as an adult who: a) is experiencing or is at risk of **abuse or neglect**; b) has needs for care and support (whether or not the authority is meeting any of those needs); and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.	'Adult at risk' is defined as an adult who: a) is unable to safeguard their own well-being, property, rights or other interests, b) is at risk of **harm**, and c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

(2) RELATED DEFINTIONS:

England	Wales	Scotland
Definitions of abuse etc. are included in Statutory Guidance however legislation does clarify that: Abuse includes **financial abuse** which includes having money or other property stolen; being defrauded; being put under pressure in relation to money or other property; and having money or other property misused.	**Abuse** means physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place). **Financial abuse** includes having money or other property stolen; being defrauded; being put under pressure in relation to money or other property; and having money or other property misused. **Neglect** means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example an impairment of the person's health).	Adult is **at risk of harm** if: a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

Key considerations

2.10 Defining the scope of the Bill so that it remains targeted on those who require the adult protection process is an important consideration. Our existing definition of 'adult at risk and in need of protection' provides a starting point and we would welcome views on the inclusion of the following elements -

(a) The presence of abuse, neglect or exploitation

2.11 It is the Department's view that the definition should have a continued focus on harm arising from abuse, neglect or exploitation. Harm (without the

presence of abuse, neglect or exploitation) is a much broader concept, likely to encompass many aspects of risk that may be present in day to day living arrangements which do not require an adult protection response from the HSC Trust or the PSNI.

2.12 The existing policy framework also defines other key terms such as 'harm' (including serious harm); 'abuse' (along with different types of abuse, including financial abuse); and neglect. The Department will consider similar definitions in either the legislation or in Statutory Guidance, mindful that the latter has the advantage of being more flexible and can be reviewed and updated relatively quickly in line with practice developments.

(b) A threshold of serious harm from abuse, neglect or exploitation

2.13 The Department would welcome views on whether the threshold for adult protection should be 'serious harm'.

2.14 The Independent Review notes that ***"the culture within which safeguarding is operating has resulted in the 'risk averse' practice of reporting everything".*** Similar findings were also highlighted in a recent audit undertaken by the Department (see paragraphs 2.33 – 2.41 for further detail, which consider the introduction of a duty to report).

2.15 If a duty to report was to be introduced in Northern Ireland, the number of reports could go up significantly, which may not all be justified and which could result in focus being lost on the most critical cases. Setting a higher threshold could be one way to mitigate against this. However, the Department is mindful that this would be a higher threshold than other parts of the UK.

2.16 It is important to clarity that the threshold for adult protection is only one part of a continuum (as illustrated at paragraph 1.8). All harm requires a response but that response will vary depending on whether preventative or protective safeguarding is required. The exercise of skilled assessment by HSC professionals in the determination of the appropriate response is crucial in this

context to ensure a proportionate, balanced and rights based approach. Guidance and training will be required in addition to the legislation to ensure that all thresholds at different points of the continuum are understood and assessed at the right level to ensure consistency and better outcomes for all adults.

(c) Health and social care needs

2.17 The existing policy definition states that an 'adult at risk and in need of protection' is a person whose exposure to harm through abuse, neglect, or exploitation may be increased by personal characteristics and/or 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. We would welcome views on whether the Bill should adopt a similar approach.

2.18 It will be important to consider a future definition of 'adult at risk and in need of protection' in the context of the different powers and duties considered throughout this paper, as ultimately the definition will trigger their use. Further detailed drafting work will therefore be required to refine the definition once the results of the consultation on the broader content of the Bill, have been analysed.

Consultation Questions

1. **Do you agree with the title 'Adult Protection Bill'?**
2. **What are your views on a definition of 'adult at risk and in need of protection'?**

Principles

2.19 The Independent Review recommended that ***"the basic rights and freedoms to which every person is entitled must be given expression in preparing any new… adult safeguarding/adult protection legislation"***.

2.20 As outlined previously, the purpose of the Bill is to set out a clear legal framework for how key organisations across health and social care and other parts of the system should work together and understand the roles they must play in adult protection. Principles, whether on the face of the Bill or in Statutory Guidance, could provide those acting under the legislation with a core set of values that must be considered as part of any decision making process.

Current position

2.21 Under the 'Adult Safeguarding Prevention and Protection in Partnership Policy', all adult safeguarding activity must be guided by five 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… 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.
- 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.
- 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 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.
- 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.

2.22 It is the Department's view that these existing principles provide a good foundation for new legislation. We also believe they are broadly consistent with the suggestions put forward by the Independent Review -

"The principles shaping adult safeguarding practice should be set within a human rights based framework and emphasise dignity, fairness, equality, respect and autonomy."

"For example, principles such as:

- ***Supporting people who have care and support needs to nurture their welfare and well-being and reduce the risk of harm***
- ***Giving people at the heart of service provision an equal say in the support they receive***
- ***Driving service delivery through partnership and co-operation***
- ***Promoting the prevention of escalating need and providing timely assistance***
- ***Encouraging residents, family members and staff to be involved in the design and delivery of services: 'co-production'***

- ***Being accountable to the public and to statutory agencies from which local partners are drawn***
- ***The principle of proportionality is fundamental to the European Convention on Human Rights."***

Legislation in other parts of the UK

2.23 Although some variations, our existing principles are also broadly similar to the approach taken in other UK legislation (or Statutory Guidance in England) -

England	Wales	Scotland
Statutory Guidance states that the following principles should underpin all adult safeguarding work: *Empowerment:* people being supported and encouraged to make their own decisions and informed consent. *Prevention:* It is better to take action before harm occurs. *Proportionality:* the least intrusive response appropriate to the risk presented. *Protection:* support and representation for those in greatest need. *Partnership:* Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. *Accountability:* Accountability and	Overarching duty (when carrying out functions under the act) to - In so far as reasonably practicable, ascertain and have regard to the adult's views, wishes and feelings; Have regard to the importance of promoting and respecting the dignity of the individual; Have regard to the characteristics, culture and beliefs of the individual (including e.g. language); Have regard to importance of providing support to enable the adult to participate in decisions particularly where adult's ability to communicate is limited; Have regard to importance of beginning with the presumption that the adult is best placed to judge their well-being; and the importance of promoting the adult's	As a general principle, if carrying out functions under the Act, any intervention in an adult's affairs should benefit the individual and be the least restrictive to the adult's freedom. Must also have regard to the adult's ascertainable wishes and feelings (past and present); Any views of the nearest relative, primary carer, guardian or attorney etc.; The importance of the adult participating as fully as possible, providing the adult with information and support to enable their participation; The importance of ensuring the adult is not treated less favourably than the way in which any other adult (not at risk) might be treated in a comparable situation; and

transparency in delivering safeguarding. The legislation also places a general duty on a local authority to promote an individual's well-being which includes protection from abuse and neglect.	independence where possible. A person exercising functions under the Act must seek to promote the well-being of a person which includes protection from abuse and neglect. They must also have due regard to the UN Principles for Older Persons (Independence, Participation, Care, Self-fulfilment and Dignity).	The adult's abilities, background and characteristics (including the adult's age, sex, sexual orientation, religious persuasion, racial origin, ethnic group and cultural and linguistic heritage).

Key considerations

2.24 The Department can see value in having principles to guide the implementation of the legislation. Having considered the approach taken across the UK and the recommendations of the Independent Review, we would welcome views on the following as an outline approach at this stage:

- **Autonomy**: A presumption that adults have capacity to give or withhold consent.
- **Empowerment**: To empower and support adults to make informed choices about their lives, taking into account their views, to maximise their opportunities to participate in wider society and to keep themselves safe and free from harm from abuse, neglect or exploitation.
- **Dignity**: A rights based approach, promoting and respecting the dignity of adults.
- **Proportionality**: Any intervention in an adult's life should be the least restrictive option.
- **Partnership**: Communities have a part to play in preventing, detecting and reporting abuse, neglect and exploitation.
- **Accountability**: Accountability and transparency with roles and responsibilities clearly understood.

Consultation Questions

> **3. Do you agree with the list of principles proposed? If no, what would you suggest as an alternative approach?**
>
> **4. What are your views on principles being set out on the face of legislation or in Statutory Guidance?**

Duties to (i) report and (ii) make enquiries

2.25 The Commissioner for Older People recommended in 'Home Truths', that ***"there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries"***. A similar proposal was recommended in the Independent Review.

2.26 A statutory duty is something that an individual or organisation **must** do, rather than something they can choose whether to do or not.

Current position

2.27 The 'Adult Safeguarding Prevention and Protection in Partnership 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, to know how and when to report concerns. It states that if there is a clear and immediate risk of harm from abuse, neglect or exploitation, a referral should be made to the HSC Trust Adult Protection Gateway Service or to the PSNI if a crime is alleged or suspected.

2.28 It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met. Protection interventions, if

required, are led by social workers and/or PSNI officers; the latter primarily where a crime is alleged or suspected. A Protocol for Joint Investigation of cases provides a framework for HSC Trusts and the PSNI to work together.

2.29 There is currently no general legal requirement to report adult protection cases in Northern Ireland. However, there are a number of other duties to report across existing pieces of legislation that may be relevant in such cases. For example:

- Under the Safeguarding Vulnerable Groups (NI) Order 2007, certain individuals/organisations who manage or supply people to work in a 'regulated activity'[3] are required to refer to the Disclosure and Barring Service when they have removed an individual because they have harmed a 'vulnerable person' or put a 'vulnerable person' at risk of harm.
- HSC Trusts, managers of independent hospitals, nursing homes or residential care homes and the Regulation and Quality Improvement Authority (RQIA) must notify the Office of Care and Protection of any person incapable by reason of mental disorder, of managing their property and affairs under the Mental Health (NI) Order 1986, if there are no arrangements in place to protect the person.
- The Criminal Law Act (NI) 1967 places a duty on us all to report information to the police if we suspect a serious offence has been committed.

2.30 There is also an expectation that individuals use their professional judgement and duty of care when it comes to reporting. This is included in Codes of Practice for HSC staff registered with the NI Social Care Council, for example.

2.31 The Public Interest Disclosure (NI) Order 1998 alongside the Employment Rights (NI) Order 1996 protects those who 'make a disclosure in the public interest', commonly referred to as whistleblowing, and who suffer victimisation

[3] 'Regulated activity' includes providing health care, personal care and social work; assistance with general household matters because of age, illness or disability; assistance in the conduct of an individual's affairs; or conveying.

or unfair dismissal as a result of their actions. It sets out examples of wrongdoing that qualify for an employee to disclose information, such as criminal activity and health and safety compromises.

2.32 The Department is also considering the introduction of a statutory duty of candour to ensure a consistent culture within the health service which allows staff and patients to speak up when things go wrong. This will be taken forward as part of a separate consultation.

2.33 Data collected by the Health and Social Care Board[4] shows that levels of reporting in adult protection were at their highest around the time of the publication of the 'Adult Safeguarding Prevention and Protection in Partnership Policy' (2015) with numbers decreasing in recent years. However, on average, only 50% of referrals to the Gateway service met the threshold for adult protection.

Year	Total number of referrals	Number that met protection threshold
2015-16	7090	4167
2016-17	5749	3234
2017-18	3137	2518
2018-19	5707	2666

2.34 The Independent Review, highlights that a ***"confusion about what to report"*** has meant that ***"the culture within which safeguarding is operating has resulted in the 'risk averse' practice of reporting everything"***.

2.35 Whilst the Policy recognises that not all issues require an adult protection response, a recent audit undertaken by the Department, identified the reporting of a diverse range of concerns across the system. A wide variety of presenting issues of risks have been referred to adult protection rather than the referrer exercising professional judgement to determine the appropriate

[4] HSCB, Delegated Statutory Functions Reports

response. The audit found that in many instances referrals were made to Adult Protection Officers without a rigorous determination of the need to do so.

2.36 Decisions about what steps to take in response to abuse and neglect are not always straightforward. A warning sign may be difficult to spot but it also doesn't automatically mean that there is abuse present.

2.37 The Commissioner for Older People's investigation into Dunmurry Manor Care Home also concluded that ***"it is unclear from the policy what the threshold is… to report concerns to the HSC Trust"*** which can equally result in concerns not always being reported.

2.38 It is important that we take these findings into account when deciding whether a duty to report is the right approach for adult protection in Northern Ireland. It could bring benefits. It could send a clear message and increase awareness of the importance of reporting, which could lead to more cases of abuse being identified. However, there could also be unintended consequences.

2.39 A new duty to report could encourage a culture of reporting and paperwork rather than one that focuses on improving the quality of interventions. The number of reports could go up significantly which may not all be justified and which could result in focus being lost on the most critical cases.

2.40 It could also result in cases being reported where an adult has capacity and is refusing consent. This would not only undermine the rights and autonomy of the individual but it could also lead to a loss of trust and therapeutic relationships with healthcare professionals.

2.41 Currently, the 'Adult Safeguarding Prevention and Protection in Partnership Policy' adopts a rights based approach to promote and facilitate full participation of adults in decisions affecting their lives taking full account of their views, wishes and feelings.

Legislation in other parts of the UK

2.42 England chose not to introduce a statutory duty to report, recognising that the issue was complex and that it could result in an increased number of unsubstantiated referrals (although England did introduce a duty to make enquiries). Scotland and Wales did introduce a statutory duty to report (along with a duty to make enquiries) with key provisions as follows -

DUTY TO REPORT:

Wales	Scotland
Duty on the police, any other local authority, probation service, young offender teams, local Health Board; NHS Trust The 'relevant partner' organisation must report to the local authority If they have reasonable cause to suspect that a person is an 'adult at risk'	Duty on the Mental Welfare Commission for Scotland; Care Inspectorate; Healthcare Improvement Scotland; Public Guardian; all councils; Police; the relevant Health Board The public body or office holder must report the facts and circumstances of the case to the council If they know or believe that a person is an 'adult at risk' and that action needs to be taken in order to protect that person from harm

DUTY TO MAKE ENQUIRIES:

England	Wales	Scotland
Where a local authority has *reasonable cause to suspect* that an adult in its area (whether or not ordinarily resident there) is an 'adult at risk' it must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and if so, what and by whom.	If a local authority has *reasonable cause to suspect* that a person in its area (whether or not ordinarily resident there) is an adult at risk, it must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken and, if so, what and by whom; and decide whether action should be taken.	A Council must make enquiries about a person's well-being, property or financial affairs, if it *knows or believes* that the person is an adult at risk and that it might need to intervene in order to protect the person's well-being, property or financial affairs.

Key considerations

2.43 The Department is considering introducing a new statutory **duty to report** and would welcome views on the following provisions:

(a) Who should be subject to the duty?

2.44 The Department is considering placing a duty to report on the HSC Trusts, PSNI, HSC Board, Public Health Agency (PHA), RQIA and Independent providers commissioned/contracted to provide health and social care services (at both an organisational and individual level). The Department is also considering the inclusion of a regulatory making power so that additional organisations can be added to the list if required, at a later date.

(b) What must be reported?

2.45 The Department is considering requiring the organisations listed in (a) above to report cases where they believe there is reasonable cause to suspect that an 'adult is at risk and in need of protection'.

(c) Who must the report be made to?

2.46 The Department is considering requiring reports to be made to the relevant HSC Trust. Statutory Guidance would also clarify that where a crime is alleged or suspected, that it must also be reported to the PSNI.

2.47 As a follow up to a duty to report, the Department is also considering placing a duty on the HSC Trust **to make enquiries** into an adult's case, as recommended by both the Commissioner for Older People and the Independent Review. Statutory Guidance would also be required to explain the outworking of both duties and any further requirements.

Consultation Questions

5. Do you agree with mandatory reporting? Should there be a new duty to report to the HSC Trust where there is a reasonable cause to suspect that an 'adult is at risk and in need of protection'?

6. Should a new duty be placed on HSC Trusts to make follow up enquiries?

Power of entry to interview an adult in private

2.48 This section seeks views on whether a new power of entry should be provided for in the Bill to support a new duty to make enquiries. The scenario we are consulting on is where a HSC professional has reasonable cause to suspect that an adult is at risk of harm from abuse, neglect or exploitation and is in need of protection; and that professional is unable to gain entry to the adult's dwelling (or another premises) to speak with the adult in private to ascertain if they are making decisions freely. This may be because access to the premises is being refused by a third party, such as a family member or carer. In such circumstances, the HSC professional would require a legal power to enter the premises, accompanied by the PSNI.

Current position

2.49 Legal powers already exist for gaining access in specific circumstances, for example -

- If a person suffering from mental disorder has been, or is being ill-treated, neglected or is living alone and unable to care for themselves, the court may issue a warrant under the Mental Health (NI) Order 1986, giving the PSNI, accompanied by a medical practitioner, power to enter the premises and remove the person to a place of safety with a view to detaining the patient in hospital under the Order.
- Under the Mental Capacity Act (NI) 2016 (when fully commenced), the court may issue a warrant giving the PSNI, accompanied by a medical practitioner and if required an Approved Social Worker, power to enter a premises and remove a person where admission is being refused, if the person is liable to be detained in circumstances amounting to a deprivation of liberty, for the care and treatment of the person.
- If any person is at risk of 'serious bodily injury' or property is at risk of serious damage the PSNI has power under the Police and Criminal Evidence (NI) Order 1989, to enter and search any premises to save 'life or limb' or prevent serious damage to property.

- Where a person with a grave chronic disease, is aged, infirm or physically incapacitated, is living in insanitary conditions; and is unable to properly care for themselves (or be cared for by others living with them or nearby) the court may issue an order under the Health and Personal Social Services (NI) Order 1972, giving a HSC professional power to enter a person's home and remove them so that they receive necessary care and attention.
- If an adult with mental capacity is at risk of abuse or neglect and is impeded from exercising that capacity freely the High Court may, under its inherent jurisdiction, make an order which could relate to gaining access to an adult.
- The PSNI also has a common law power to enter and arrest a person to prevent a breach of the peace.

Legislation in other parts of the UK

2.50 Both Wales and Scotland introduced a power of entry but to varying degrees -

Wales	Scotland
An authorised officer[5] may apply to a justice of the peace for an 'Adult Protection and Support Order' to enter any premises[6] (if reasonable cause to suspect that a person is an adult at risk, it is necessary to gain access to assess them and doing so will not result in them being at greater risk of abuse or neglect). The Order allows the authorised officer and a police constable (using reasonable force if necessary) to enter; to speak with the adult in private to ascertain whether they are	A council officer may visit/enter any place (or adjacent place) to assist with their enquiries, to decide whether action needs to be taken to protect an adult at risk. The Council may apply to the Sheriff for a warrant to enter any place, including any adjacent place where that visit/entry has been or reasonable expects to be refused. This allows a council officer[7] and a police constable (using reasonable force if necessary) to enter and

[5] An authorised officer is defined as a person who has completed appropriate training and is an officer of the authorising authority (the relevant local authority) subject to minor exceptions.

[6] Statutory guidance clarifies that "premises" includes a domestic premises; a residential care home; a nursing home; a hospital or any other building, structure, mobile home or caravan in which the person is living.

[7] Social workers, occupational therapists and nurses with at least 12 months' relevant experience.

making decisions freely; and to assess whether the person is an adult at risk and if action needs to be taken.	interview in private any adult found in the place.

ADDITIONAL POWERS ON ENTRY:

Wales	Scotland
No additional powers	The Council may apply to the Sheriff[8] for: An **Assessment Order** to take an adult from a premises visited to a more suitable place to interview and/or medically examine in private, to determine if adult is at risk and if further action is needed. There must be reasonable cause to suspect the adult is being, or is likely to be, **seriously harmed.** *There is no power to detain with this order, the adult may chose to leave the place where they are being assessed at any time.* A **Removal order** to remove an adult at risk from a premises to another place for up to 7 days if likely to be **seriously harmed** (if not moved). The Council must also take steps to protect the property of the adult following their removal. *There is no power to detain with this order, the adult may chose to leave the place they have been removed to at any time.* A **Banning order** can ban a person from being in a specified place for up to 6 months, if the adult is being or is likely to be **seriously harmed** by that person; and the Sheriff is satisfied that banning the subject of the order from the place will better safeguard the adult at risk's well-being or property than by moving the adult. A power of arrest may be attached. The adult who would be safeguarded by the order; any other person entitled to occupy the property; or the Council may apply for a banning order.

2.51 In Scotland, the Sheriff must not make a protection order if it is known that the adult at risk has refused to consent to the granting of the order. Similarly a person must not take any action to carry out the order if there is no consent.

[8] The Sheriff must not make a protection order if known the adult at risk has refused to consent to the granting of the order. Similarly a person must not take any action to carry out the order if no consent. *However, consent may be ignored if it is reasonably believed that the adult at risk has been unduly pressurised to refuse consent and there are no other steps that could be taken to protect them from harm with consent.*

However, consent may be ignored if it is reasonably believed that the adult at risk has been unduly pressurised to refuse consent and there are no other steps that could be taken to protect them from harm with consent.

2.52 Wales provides a balance between England's minimalist approach and Scotland's more intrusive model. However, it has been questioned whether a right of entry is beneficial without further supporting powers (to remove an adult at risk from their home, for example) or if it could in reality expose individuals to further harm.

2.53 In England, the UK Government consulted specifically on whether or not to introduce a power of entry but concluded that responses did not provide a compelling case to legislate: *"it was a very sensitive and complex issue which divided opinion… we particularly noted the strength of feeling from members of the public who were against such a power and the risk of unintended consequences."* The consultation raised concerns that, in some cases, the power could result in the risk of abuse escalating for individuals. It was also felt that there were only a small number of cases where the power would be used.

2.54 There is limited data available on the implementation of powers of entry in other parts of the UK. It would appear that the powers of entry and additional protection orders in Scotland are rarely used and act mainly as a preventative measure. The Department understands that the Adult Support and Protection (Scotland) Act 2007 is under review and will take account of any findings available to inform legislative developments in Northern Ireland.

Key considerations

2.55 The Department recognises that a power of entry is a sensitive issue and that many individuals and organisations will have strong views on this subject. We do not want to intervene in people's lives unnecessarily. Everyone has the right to a private life and a home life. Any new legislation needs to be

compatible with the European Convention on Human Rights and any interventions need to be justified and proportionate with adequate safeguards.

2.56 As an alternative approach, we could raise awareness of the range of existing powers of entry available by developing clearer guidelines on what organisations have the legal powers to do. However, the Department is mindful that some have questioned whether there is a gap where a person's ability to make a choice is thought to be restricted by the behaviour of another person (as demonstrated in the case study below). We would welcome your views.

2.57 The following extract is taken from the report, 'A Call for Adult Safeguarding Legislation' by the former Commissioner for Older People -

Case scenario:

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 the 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: *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.*

Consultation questions

7. What are your views on a power of entry to allow a HSC professional access to interview an adult in private? Do you think any additional powers should be available on entry?

8. How many times in the last 12 months, have you been aware of a situation where, had a power of entry existed, it would have been appropriate to use it? What were the circumstances?

Independent Advocacy

2.58 The former Commissioner for Older People recommended, in 'A Call for Adult Safeguarding Legislation', that there should be a duty to provide appropriate services to an adult at risk, such as independent 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.[9]

Current position

2.59 The 'Adult Safeguarding Prevention and Protection in Partnership Policy' recognises that -

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

[9] Adult Safeguarding Prevention and Protection in Partnership Policy 2015

the adult at risk, but always work in partnership with the adult they are supporting.

Legislation in other parts of the UK

2.60 England, Wales and Scotland have gone a step further and reflected the importance of advocacy support in legislation –

England	Wales	Scotland
Where a local authority is making an enquiry or carrying out a review of a case (re a living person) it must arrange for an independent advocate to be available to facilitate the adult's involvement if the adult has substantial difficulty in understanding, retaining, using/weighing information or communicating their views wishes or feelings.[10]	There is a power to make regulations to require a local authority to arrange for advocacy services. To date, the statutory Code of Practice states that local authorities must arrange an independent advocate when a person can only overcome the barrier(s) to participate fully in the safeguarding processes with assistance from an appropriate individual.	If after making enquiries a council considers that it needs to intervene to protect an adult at risk, the council must have regard to the importance of the provision of appropriate services including, in particular, independent advocacy services, to the adult concerned.

Key considerations

2.61 The Mental Capacity Act (NI) 2016 when fully commenced, will require an independent mental capacity advocate to be appointed to represent and support a person who **lacks capacity** during the best interest determination, when certain serious interventions are required in that person's life and they lack capacity to make that decision for themselves.

2.62 It is important that we take this into account when deciding on any additional advocacy requirements as part of the adult protection process, as there will be

[10] This duty does not apply if another appropriate person to support the adult or the adult has capacity and has not consented. If an adult lacks capacity appointing an advocate must be in their best interests.

similarities. The Department believes that it would be prudent (pending commencement of the relevant Mental Capacity Act provisions), to include a regulatory making power in the Bill to set out any future requirements in respect of Independent Advocacy including any eligibility criteria. This would facilitate further consideration of the interface with the Mental Capacity Act.

Consultation question

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9. What are your views on statutory provision for independent advocacy in the context of adult protection?

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Independent Adult Protection Board for NI

2.63 On 10 September 2020, the Health Minister confirmed plans to stand down the Northern Ireland Adult Safeguarding Partnership (also known as 'NIASP') in a move towards the establishment of an Independent Adult Safeguarding/Protection Board, at arms-length from the Department. This was a key recommendation of the Independent Review:

"Replace the NIASP with a Northern Ireland Independent Safeguarding Board (Adults) with clearly defined duties, such as making an annual report (for example, reporting on trends and topics and identifying best practice and areas for improvement or for greater scrutiny in the coming year) to the Permanent Secretary and Ministers. The Northern Ireland Independent Safeguarding Board (Adults) should publish annual plans and reports to inform the HSC system's annual reporting cycle.

Current position

2.64 The move to an independent structure will take time as it requires a statutory footing. As an interim arrangement, the Health and Social Care Board will set up and chair a new interim Adult Protection Board to replace NIASP, which will report to the Department pending the enactment of new legislation.

Legislation in other parts of the UK

2.65 England, Wales and Scotland have already established statutory inter-agency Boards or Committees as they are referred to in Scotland.

2.66 There are variations across the three jurisdictions, however, the Boards/Committees have some key functions in common which have been set out in legislation and statutory guidance. They have a role to play in preventative safeguarding (raising awareness, education and training) as well as adult protection.

CORE FUNCTIONS:

England	Wales	Scotland
Safeguarding Adults Boards must: (a) arrange for a Safeguarding Adult Review to be carried out if it knows or suspects that an adult has experienced serious abuse or neglect or has died as a result (b) to publish a strategic plan each year (c) to publish an annual report	**The National Independent Safeguarding Board must:** (a) provide support and advice to Safeguarding Boards with a view to ensuring they are effective (b) report on the adequacy and effectiveness of arrangements to safeguard adults in Wales (c) make recommendations to Ministers on how those arrangements could be improved	**Adult Protection Committees must:** (a) keep under review safeguarding procedures and practices of public bodies (b) give (safeguarding) information or advice, or make proposals, to any public body (c) make, or assist in, or encourage the making of, arrangements for improving the skills and knowledge of officers or employees of public bodies who have safeguarding responsibilities (d) any other function as specified in regulations

2.67 Structures across the UK are similar with a main Board/Committee and a number of sub-groups which vary based on subject. There is also a common core membership including the local authority (which established the Board), the chief officer of Police for the area and the local Health Board or equivalent body.

2.68 Boards/Committees also have the **power to request the supply of information** for the purpose of enabling or assisting the Boards/Committees to carry out their functions.

Key considerations

2.69 The Department intends to establish a statutory Independent Adult Protection Board for Northern Ireland, through the Adult Protection Bill, with the following core functions set out in the primary legislation:

- **To publish a strategic plan each year;**
- **To publish an annual report; and**
- **Make arrangements and have responsibility for Serious Case Reviews**

  Serious Case Reviews will be new to adult protection in Northern Ireland. These are multi-agency reviews that look into the circumstances surrounding the death of, or serious harm to, an adult at risk and in need of protection. Their purpose is to establish whether there are lessons to be learned from a case about the way in which agencies and professionals work together; and to action change as a result. Statutory guidance supporting the legislation will be required to provide further details on eligibility criteria and to consider the interface with other review mechanisms such as Domestic Homicide Reviews.

2.70 It is also the Department's view that the new Adult Protection Board for Northern Ireland should be given the power to request the supply of information relevant to the exercise of its functions, similar to provisions included in other UK legislation.

2.71 The Department also intends to include a regulatory making power to set out further operational details around the Board's membership and procedures.

Consultation questions

10. Do you agree that an Independent Adult Protection Board should be established and placed on a statutory footing?

11. Do you agree with the introduction of Serious Case Reviews?

Cooperation and information sharing

2.72 Adult protection is not the responsibility of one organisation alone, nor can it be seen solely as a health and social care responsibility. There are many different agencies involved, each bringing different skills and perspectives.

2.73 The Independent Review highlights ***"the need for improved information communication across the system"***. The Department agrees with this statement and is considering further provisions that will require organisations to work more effectively to share information. One option is to introduce a duty on specific organisations to cooperate with each other, as introduced in other UK jurisdictions.

Current position

2.74 Currently, the 'Adult Safeguarding Prevention and Protection in Partnership Policy' promotes multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. The Protocol for Joint Investigation also provides a framework within which the HSC Trusts, PSNI and RQIA can work in partnership.

2.75 The sharing of information between organisations is covered under other existing laws such as the common law duty of confidentiality, the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). However, it is clear from the Independent Review that the question of information sharing raises complex issues in adult protection and that

interagency protocols or memorandums of understanding may not be providing sufficient clarity. It may also be necessary to introduce a specific duty to place an onus on certain organisations to cooperate where an adult is at risk and in need of protection.

Legislation in other parts of the UK

2.76 Other UK jurisdictions have placed a duty on local authorities/councils to make enquiries where an 'adult is at risk' (and a similar duty is being considered for HSC Trusts in Northern Ireland). To assist with these enquiries, a duty is also placed on relevant organisations (listed below) to **cooperate** with the local authority/council and vice versa.

DUTY TO COOPERATE:

England	Wales	Scotland
All local authorities NHS England Clinical Commissioning Groups NHS trusts Department for Work and Pensions Police Prison service Probation service	All local authorities Police Probation service Local Health Board NHS Trust	All councils Mental Welfare Commission Care Inspectorate (similar to RQIA) Health Improvement Scotland Public Guardian Police Relevant Health Board

2.77 Provisions around compliance are included in the English and Welsh legislation. The duty to cooperate must be complied with unless it would be incompatible with the duties of the local authority or relevant organisation, or would otherwise have an adverse effect on the exercise of its functions (such as being bound by the duty of confidentiality). Furthermore, if either the local authority or relevant organisation decide not to cooperate they must provide a reason (in writing) for not doing so.

2.78 Legislation in Wales also clarifies that the local authority and relevant organisations **may share information** with each other.

2.79 Scotland goes further again by providing councils with a **power to examine records** relating to an adult at risk:

A council officer may require any person holding health,[11] financial or other records relating to an individual whom the officer knows or believes to be an adult at risk to give the records, or copies of them, to the officer. Such a requirement may be made during a visit [to the adult] or at any other time… Records may be inspected for the purposes of enabling or assisting the council to decide whether it needs to do anything in order to protect an adult at risk.
*In Scotland an adult at risk is defined as an adult who is unable to safeguard their own well-being, property, rights or other interests, is at risk of **harm**, and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected*.

Key considerations

2.80 The Department is considering placing a **new statutory duty** on the following organisations to cooperate with the relevant HSC Trust (and vice versa), when the Trust is making enquiries into a case where there is reasonable cause to suspect that an 'adult is at risk and in need of protection' and it does not conflict with the exercise of its functions -

HSC Trusts, PSNI, Probation Board for NI, HSC Board, PHA, RQIA and Independent providers commissioned/contracted to provide health and social care services.

2.81 This duty could also include a provision to clarify that organisations may share information with each other and a provision requiring organisations to explain in writing any reasons for not complying with the duty (similar to the approach taken in England and Wales).

2.82 The Department would also welcome views on whether there should be a new **power to access financial records** where there is reasonable cause to suspect that an adult is at risk of financial abuse and in need of protection.

[11] Health records are relating to an individual's physical or mental health which have been made by or on behalf of a health professional in connection with the care of the individual. Only a health professional may inspect health records.

2.83 The former Commissioner for Older People considered that there may be merit in providing "a relevant, identified organisation" with such a power in cases where an adult "***has mental capacity, but perhaps does not 'possess all the facts relating to the spending' in order for them to make an informed decision… 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… person of whether financial abuse is occurring and any appropriate interventions required."*** Consultees may wish to again consider in light of the case scenario presented at paragraph 2.57.

2.84 The Department recognises that accessing a person's financial records is a sensitive matter, which indeed the former Commissioner also acknowledged: ***"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."***

2.85 The introduction of such a power therefore requires careful consideration and it is important that we hear from consultees so that all views can be taken into account.

Consultation Questions

12. Do you agree with the proposal to introduce a duty to cooperate? Are there any aspects of the duty that you would change?

13. Do you think there should be a new power to access an adult's financial records as part of an adult protection enquiry? If yes, which organisation(s) should be given this power?

Offences of ill-treatment and wilful neglect

2.86 Actions which amount to abuse, neglect or exploitation may constitute a criminal offence under various pieces of existing legislation. This section seeks views on whether any new offences should be considered.

Current position

2.87 The Mental Capacity Act (NI) 2016, as currently commenced, provides an offence of ill-treatment and wilful neglect in respect of a person who **lacks capacity** in relation to a deprivation of liberty. When fully commenced the offence will extend to situations where a person lacks capacity and where there are care arrangements, detentions or attorney or deputies appointed. Currently, an offence of ill-treatment and wilful neglect only applies in relation to patients in mental health hospitals or who are under guardianship under the Mental Health (NI) Order 1986 and the offender is a member of staff or in management of the facility.

2.88 The Mental Capacity Act (NI) 2016 also clarifies that if the offence is committed by a **body corporate** (e.g. private healthcare company, HSC trust), any director, manager, secretary, or other similar officer of that body is also guilty of the offence if it was done with their consent; they connived in the offence; or the offence can be attributed to neglect on their part. Such persons can have proceedings issued against them in addition to those which may be issued against the body corporate.

2.89 There is no equivalent specific offence, in Northern Ireland, in relation to those being cared for with capacity.

Legislation in other parts of the UK

2.90 Offences of ill-treatment and wilful neglect of people who lack capacity are already operational in England and Wales under the Mental Capacity Act 2005, and in Scotland, under the Adults with Incapacity Act (Scotland) 2000.

Similar offences are also set out in their separate mental health legislation in respect of people being treated for mental disorder.

2.91 Other parts of the UK have legislated further in respect of the ill-treatment or wilful neglect of those with mental capacity, to recognise the particular vulnerabilities of those receiving health and social care as well as the level of trust placed in those providing that care. The Criminal Justice and Courts Act 2015 (in England and Wales) and the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 introduced two new offences known as -

'Care worker offence'

2.92 In all three jurisdictions, it is an offence for an individual who has the care of another individual by virtue of being a 'care worker' to ill-treat or wilfully neglect that individual. "Care worker" generally means an individual who, as paid work, provides health or social care for an adult. It also includes an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care. Scottish legislation also makes it clear that this includes volunteers.

'Care provider offence'

2.93 In all three jurisdictions, a care provider commits an offence if:

a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,

b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

2.94 'Care provider' generally means a body corporate or unincorporated association which provides or arranges for the provision of health care or social care for an adult; or an individual who provides such care and employs,

or has otherwise made arrangements with, other persons to assist him or her in providing such care.

Key considerations

2.95 Many people receive high quality health and social care from a variety of dedicated professionals across a number of settings in Northern Ireland who work in a manner that respects and protects the dignity and rights of individuals. However, as we know from events at Dunmurry Manor Care Home and Muckamore Abbey Hospital, there can be instances where individuals are deliberately mistreated or neglected by those who have been trusted to look after them.

2.96 There are existing offences of ill treatment and wilful neglect in respect of patients in mental health hospitals and under guardianship, persons who lack capacity who are subject to a deprivation of liberty and, when the Mental Capacity Act (NI) 2016 is fully commenced, this will be widened to include all persons who lack capacity. However, the Department believes that this leaves a gap in the law in relation to people who are being cared for with capacity. We are therefore considering introducing new 'care worker' and 'care provider' offences in Northern Ireland, similar to those already introduced in other parts of the UK.

2.97 Consultees may also wish to note that a Domestic Abuse and Family Proceedings Bill is being considered by the NI Assembly. The Bill will create a new domestic abuse offence for Northern Ireland which will capture patterns of controlling and coercive behaviour, as well as physical abuse, against a partner, former partner or family member.

Consultation questions

14. Do you agree that new offences of ill treatment and wilful neglect should be introduced?

15. Are there any other new offences that should be considered?

Statutory Guidance

2.98 In addition to new legislation, the Independent Review has recommended ***"setting out and consulting on the contents of Statutory Guidance"***.

2.99 The Department recognises that adult protection is complex and agrees that statutory guidance will be necessary to provide further clarity on the specific provisions contained in the Bill and on where the adult protection process sits with wider preventative safeguarding work.

2.100 It is our intention to include a general provision in the Bill to allow the Department of Health to issue statutory guidance, to make the legislation more accessible, so that individuals/organisations are clear on what they must to do comply with the law. Provision would also be included to allow the Department to revise the guidance and to publish any revisions.

Consultation question

16. Are there any other provisions that you would like to see included in the Adult Protection Bill?

3. IMPACT SCREENING

Equality

3.1 In accordance with guidance produced by the Equality Commission for NI and in keeping with Section 75 of the Northern Ireland Act 1998, this consultation on legislative options to inform the development of an Adult Protection Bill has been equality screened and a preliminary decision has been taken that a full equality impact assessment is not required at this stage. The preliminary decision is subject to change following analysis of feedback received during this consultation.

Rural proofing

3.2 Rural proofing is a process that aims to make sure that Government policies are carefully and objectively examined to make sure they treat those in rural areas fairly and to make public services available in a fair way, no matter where people live in NI. Where necessary, policy adjustments might be made to reflect rural needs and in particular to ensure that as far as possible public services are accessible on a fair basis to the rural community. Throughout the consultation process, careful consideration will be given to the needs of rural communities.

Regulatory

3.3 A draft Regulatory Impact Assessment has been developed for these proposals. This draft Regulatory Impact Assessment will be revisited following analysis of feedback received during this consultation.

Data Protection

3.4 This policy has been screened out from the need to undertake a full data protection impact assessment at this time.

4. GET INVOLVED

4.1 A summary of the consultation questions is provided below:

1. Do you agree with the title ‘Adult Protection Bill’?

2. What are your views on a definition of ‘adult at risk and in need of protection’?

3. Do you agree with the list of principles proposed? If no, what would you suggest as an alternative approach?

4. What are your views on principles being set out on the face of legislation or in Statutory Guidance?

5. Do you agree with mandatory reporting? Should there be a new duty to report to the HSC Trust where there is a reasonable cause to suspect that an ‘adult is at risk and in need of protection’?

6. Should a new duty be placed on HSC Trusts to make follow up enquiries?

7. What are your views on a new power of entry to allow a HSC professional access to interview an adult in private? Do you think any additional powers should be available on entry?

8. How many times in the last 12 months, have you been aware of a situation where, had a power of entry existed, it would have been appropriate to use it? What were the circumstances?

9. What are your views on statutory provision for independent advocacy in the context of adult protection?

10. Do you agree that an Independent Adult Protection Board should be established and placed on a statutory footing?

11. Do you agree with the introduction of Serious Case Reviews?

12. Do you agree with the proposal to introduce a duty to cooperate? Are there any aspects of the duty that you would change?

13. Do you think there should be a new power to access an adult’s financial records as part of an adult protection enquiry? If yes, which organisation(s) should be given this power?

14. Do you agree that new offences of ill treatment and wilful neglect should be introduced?

15. Are there any other new offences that should be considered?

16. Finally, are there any other provisions that you would like to see included in the Adult Protection Bill?

HOW TO RESPOND

4.2 This consultation has been launched using Citizen Space. Citizen Space is the Northern Ireland Civil Service (NICS) recommended online Consultation tool and preferred surveying tool.

4.3 You can also share your views on this consultation in a number of other ways.

4.4 In addition a separate questionnaire is available to help you record your comments and views. This can be completed and submitted in the following ways:

- Download and Email us at: AdultSafeguardingUnit@health-ni.gov.uk
- Download, print and post to: Adult Safeguarding Unit,
  Castle Buildings, Stormont,
  Belfast, Northern Ireland, BT4 3SQ

4.5 This document is also available in alternative formats on request. Please contact the Department, at the address above or email, to make your request.

4.6 The consultation closes at 11.59 pm on 8 April 2021.

CONFIDENTIALITY AND ACCESS TO INFORMATION

4.7 In line with the principles within the Fresh Start Agreement to place greater emphasis on innovation, the use of social media, the digital platform and online consultation, this public consultation is being undertaken using Citizen Space. It is accredited for use in Northern Ireland Civil Service.

4.8 The Department may publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be published or disclosed on request in accordance with information legislation; these chiefly being the Freedom of Information Act 2000 (FOIA), the Environmental Information Regulations 2004 (EIR), the Data

Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) (EU) 2016/679. The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

4.9 The FOIA gives the public a right of access to any information held by a public authority, namely, the Department in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

4.10 If you do not wish information about your identity to be made public please include an explanation in your response. Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the DPA and the General Data Protection Regulation (EU) 2016/679. The Department is committed to building trust and confidence in our ability to process personal information. This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. For further information about confidentiality of responses please contact the Information Commissioner's Office on 0303 123 1113 or via https://ico.org.uk/global/contact-us/

4.11 **NB.** Please note that the Department is unable to respond individually to responses; however, a summary of all consultation responses will be published after the close of the consultation period.

Department of Health | An Roinn Sláinte / Männystrie O Poustie

Adult Protection Bill – Draft Final Policy Proposals for Ministerial Consideration (July 2021)

1. Title and purpose of the Bill

- The draft Bill will be called the 'Adult Protection Bill'; it will introduce additional protections to strengthen and underpin the adult protection process.

2. Definition of 'adult at risk and in need of protection'

- The draft Bill will introduce a legal definition of an 'adult at risk and in need of protection' as:

  a) a person aged 18 or over;
  b) whose exposure to harm through abuse, neglect or exploitation may be increased by their personal characteristics and/or life circumstances;
  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.

3. Principles

- The draft Bill will set out Principles which should be adhered to by everyone involved in adult safeguarding and adult protection.

- These Principles are:

  <u>1. Prevention</u>

"Organisations across all sectors should ensure that adults at risk in their care are always as safe as possible and should commit to fostering environments where harm to adults is not tolerated and suspected harm is investigated as quickly as possible."

2. Autonomy

"A presumption that adults have capacity to make their own decisions unless there is evidence to the contrary. This includes the capacity to give or withhold consent and to make what some people would view as unwise decisions."

3. Empowerment

"To support and encourage adults to make informed choices about their lives, avoid unnecessary intervention, take the view views of adults into account and help adults to maximise their opportunities to participate in wider society and keep themselves safe and free from harm."

4. Dignity

"A rights based approach, promoting and respecting the dignity of adults."

5. Proportionality

"Any intervention in an adult's life should be in the best interests of the adult, should not cause the adult any further harm and should be the least restrictive option."

6. Partnership

"Adults at risk, their families, friends, carers and organisations across all sectors all have a part to play in ensuring there is meaningful collaboration in order to prevent, detect and report harm and keep the adult at the centre of decision-making processes."

7. Accountability

"Accountability and transparency with roles and responsibilities clearly understood."

4. Duty to report

- The draft Bill will place a statutory duty on the HSC Trusts, PSNI, HSC Board, Public Health Agency, RQIA and independent providers commissioned or contracted to provide health and social care services to report to the relevant HSC Trust any cases where they believe there is reasonable cause to suspect that an adult meets the criteria of 'an adult at risk and in need of protection'.

5. Duty to make enquiries

- The draft Bill will place a statutory duty on HSC Trusts to make follow up enquiries into all cases where someone who is suspected of being an 'adult at risk and in need of protection' is brought to its attention.

6. Power of entry

- The draft Bill will introduce a new power of entry to interview an adult at risk. The draft Bill will also introduce associated additional powers, equivalent to the Scottish Assessment Order, Removal Order and Banning Order.

- A summary of the power of entry and associated additional powers is as follows:

    - The power of entry would permit a suitably experienced, trained and qualified social worker to enter the home (or other relevant premises) of an adult at risk and in need of protection to interview the adult in private and ascertain if the adult is making decisions freely.

- The Assessment Order would permit a suitably experienced, trained and qualified social worker to take the adult from that premises to a more suitable location to carry out the interview.

- The Removal Order would permit a suitably experienced, trained and qualified social worker to remove the adult from the premises to another location for up to seven days if the adult is likely to be seriously harmed.

- The Banning Order would ban a person from being in a specified location for up to six months if the adult is being or is likely to be seriously harmed by that person.

- The draft Bill will contain the following provisions, restrictions and requirements in relation to the power of entry and associated additional powers:

    - Magistrate approval will be required for use of the power of entry and additional powers on every occasion.

    - There must be a reasonable attempt to seek the consent of the adult at risk when applying to a magistrate to use the additional powers (note – consent will not be required for an application to the magistrate for the initial power of entry). Consent could be sought in person after entering the home, by telephone, or in writing and the application to the magistrate for the Assessment/Removal/Banning Order would indicate whether the adult at risk had consented. Where there is evidence that the adult at risk had not consented but is under duress or subject to coercion, the Magistrate could grant approval anyway, overruling withheld consent.

    - The power of entry and additional powers should be used by a suitably experienced, trained and qualified social worker only (consideration will

be given to creating a new cadre of Social Workers for the purpose of using Adult Protection Bill/Act powers).

- A statutory requirement to take all reasonable steps to support the adult at risk to understand what the power is and why it is being used.

- Anyone who is using the power of entry or additional powers will be able to request PSNI support (but will not be required to).

- An adult at risk will have the right to be supported by a witness rather than be interviewed alone and should be advised of this right.

- There will be the right to appeal the Banning Order only.

- There will be legal consequences to obstructing a social worker who is seeking to apply a power of entry or additional power that has been approved by a magistrate (consideration will be given to issuing fines).

7. Independent advocates

- The draft Bill will introduce a statutory provision of independent advocates who can assist adults at risk to be involved in and influence decisions taken about their care.

- The draft Bill will include a regulatory making power setting out any future requirements in respect of independent advocacy, including eligibility criteria.

8. Independent Adult Protection Board

- The draft Bill will establish the Independent Adult Protection Board (IAPB) and place it on a statutory footing.

- The draft Bill will set out the following core IAPB functions:
    - To publish a strategic plan each year
    - To publish an annual report
    - To make arrangements and have responsibility for Serious Case Reviews (see point 9.)
- The draft Bill will give the IAPB the power to request the supply of information relevant to the exercise of its functions.
- The draft Bill will include a regulatory making power to set out further operational details in relation to the membership and procedures of the IAPB.

9. Serious Case Reviews

- The draft Bill will introduce Serious Case Reviews (SCRs). SCRs are multi-agency reviews that look into the circumstances surrounding the death of, or serious harm to, an adult at risk and in need of protection. The purpose of SCRs is to establish whether there are lessons to be learned from a case about the way in which agencies and professionals work together and to action change as a result.

10. Duty to cooperate

- The draft Bill will place a statutory duty on the HSC Trusts, PSNI, Probation Board for NI, HSC Board, Public Health Agency, RQIA and independent providers commissioned or contracted to provide health and social care services to cooperate with both HSC Trusts and PSNI when those bodies are making enquiries into a case where there is reasonable cause to suspect that an adult meets the criteria of ‘an adult at risk and in need of protection’.

- The draft Bill will include provision that the organisations that are required to cooperate do not have to do so where doing so would conflict with the exercise of their functions.

11. Power to access financial records

- The draft Bill will introduce a new power to access any relevant financial records where there is suspected financial abuse. This includes the financial records of the adult at risk and any other records that are relevant to the enquiry.

- The draft Bill will contain the following provisions, restrictions and requirements in relation to the power to access financial records:

    - Magistrate approval will be required for use of the power to access financial records on every occasion.

    - The power to access financial records will be held by the HSC Trusts and be used by a suitably experienced, trained and qualified social worker only (consideration will be given to creating a new cadre of Social Workers for the purpose of using Adult Protection Bill/Act powers).

    - A statutory requirement to take all reasonable steps to support the adult at risk to understand what the power is and why it is being used.

    - There must be a reasonable attempt to seek the consent of the adult at risk before application to the magistrate to use this power; however if consent is not given, the magistrate will be able to grant permission to access. Consent could be sought in person after entering the home, by telephone, or in writing.

- There will be legal consequences to obstructing a social worker who is seeking to apply a power to access financial records that has been approved by a magistrate (consideration will be given to issuing fines).

12. Offences of ill-treatment and wilful neglect

- The draft Bill will introduce new offences of ill-treatment and wilful neglect.

- The draft Bill will include two tiers of offence of ill-treatment and wilful neglect:

  - Care worker offence – an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully neglect that individual.

    'Care worker' generally means an individual who, as paid work, provides health or social care for an adult. It also includes an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care.

  - Care provider offence – a care provider commits an offence if:

    a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,
    b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and
    c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

‘Care provider’ generally means a body corporate or unincorporated association which provides or arranges for the provision of health care or social care for an adult; or an individual who provides such care and employs, or has otherwise made arrangements with, other persons to assist him or her in providing such care.

13. Statutory Guidance

- The draft Bill will be supported by new Statutory Guidance, the development of which will include a further public consultation. It is intended that the Statutory Guidance will replace the Prevention and Protection in Partnership Policy 2015.

KEEPING SAFE ADULTS

Keeping Adults Safe:
A Shared Responsibility

Standards & Guidance for Adult Safeguarding

VOLUNTEER NOW
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Contents

All adults have the right to live a life **free from abuse and exploitation.**

Ministerial Foreword

As Health Minister I am committed to supporting and protecting those most vulnerable in our society, including those adults who are at risk from harm. Key to this is empowerment, that is, helping people to help themselves, to have and maintain control over their lives and to be able to keep themselves safe.

I welcome the revision and republication of **A Shared Responsibility** by Volunteer Now. The original guidance was commissioned by my Department in 2010. It is important that is kept up to date to ensure that it is keeping pace with new developments. It is particularly good to see new adult safeguarding policy reflected in the guidance.

I am confident that this publication will assist organisations to meet the minimum standards required by the adult safeguarding policy, **Adult Safeguarding: Prevention and Protection in Partnership**, published jointly by my Department and the Department of Justice in July 2015. The intention of the policy is to improve safeguarding outcomes for all adults who are at risk of harm from abuse exploitation or neglect. The policy places a strong emphasis on prevention and early intervention, approaches I have, and will continue to prioritise as health minister alongside robust protection measures.

A Shared Responsibility is targeted at the voluntary, community and independent organisations, which play a crucial role in keeping adults safe. They provide support to adults at risk of harm, in many cases close to home or at home.

In keeping with the aims of the adult safeguarding policy, voluntary, community and independent sector organisations can assist with empowering and enabling adults to keep themselves safe, supporting their right to choose. They are often well placed to intervene early and prevent harm from occurring in the first place. It is important that organisations work to a consistent standard of safeguarding practice and in accordance with robust safeguarding procedures.

A Shared Responsibility helpfully sets the standard and assists organisations to tighten their procedures – that is to be welcomed. Most importantly, it also sends out a very clear message that keeping adults safe is everyone's business – a responsibility that we all share.

Is Mise,

Michelle O'Neill MLA
(2017)

Introduction

In April 2009 the Department of Health commissioned the Our Duty to Care Team in Volunteer Now to develop standards and guidance for good practice in adult safeguarding for voluntary, community and independent organisations. To ensure that the standards and guidance developed was applicable to a wide range of organisations, representing different adult groups, an adult safeguarding Advisory Group was established comprising representatives from key agencies with experience and expertise in their field **(See Appendix 1 Advisory Group).**

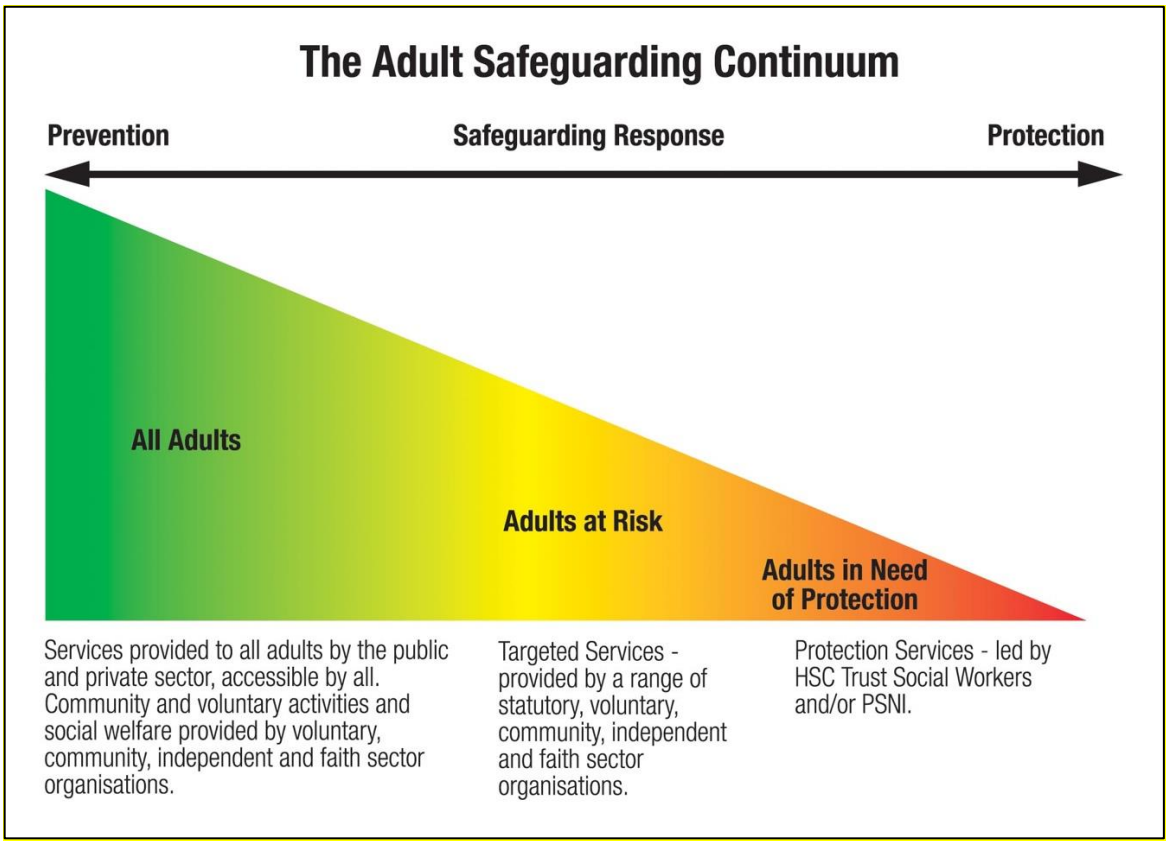
Since the guidance was first published there have been considerable developments in the area of adult safeguarding in Northern Ireland. One of the key developments was the establishment of the Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) in 2010. They were collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland, tasked by the Department of Health (DOH), with support from the Department of Justice (DOJ). The NIASP was the regional body and the five LASPs were located within, and accountable to, their respective Health and Social Care Trusts (HSC Trusts). The partnerships are made up of representatives from the main statutory, voluntary, community and independent sectors involved in adult safeguarding across Northern Ireland and include representation from service providers and users.

Another key development was the launch of the regional adult safeguarding policy "Adult Safeguarding: Prevention and Protection in Partnership", jointly developed and published by the DOH and the DOJ in July 2015. The policy makes it clear that **safeguarding is everyone's business** and whilst it is intended to assist organisations, working with, or providing services to adults, it is also there to assist individuals acting as responsible citizens at home and in their local communities.

The policy outlines the broad continuum of safeguarding activity. It ranges from empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along the 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.

Safeguarding includes activity which **prevents** harm from occurring and activity which **protects** adults at risk where harm from abuse, neglect or exploitation has occurred or is likely to occur without intervention.

Figure 1 outlines the continuum of adult safeguarding.



The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community groups through to larger organisations and statutory services. These organisations provide a range of services and activities. All organisations must uphold the rights of adults and ensure that any service or activity they provide is underpinned by the principles of treating all adults with dignity and respect. The focus must be on the individual receiving the service. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heighted awareness of risk of harm and more robust measures will be required to prevent harm.

Whilst protective safeguarding is led by the HSC Trusts (and the PSNI where a crime is alleged or suspected), voluntary, community and independent organisations are at the forefront of preventative safeguarding. Organisations will be implementing preventative measures by, for example: having robust recruitment and selection procedures in place to screen out unsuitable people; developing a code of behaviour for staff and volunteers to ensure they are clear about acceptable and unacceptable behaviours when working with adults at risk; providing staff and volunteers with appropriate adult safeguarding training and; assessing and managing risks to adults within their organisation and within the wider community.

However, empowerment is essential to the prevention of harm. All adults, including those at risk of harm, must be empowered and enabled to manage their own health and well-being and to keep themselves safe. Many organisations already offer this type of support to adults through the provision of easy-read information leaflets and publications, training programmes and advocacy services, designed specifically for adults at risk of harm. Some examples include travel training and LiveNet e-safety workshops. One key training programme is the 'Keeping You Safe' programme, developed by the Belfast LASP. The training programme looks at the different categories of abuse and what an adult should do if they are experiencing abuse. The programme has been offered out to all organisations working with adults at risk and can be easily adapted to suit the particular needs of participants.

More recently, in response to an independent review commissioned to care failings at Dunmurry Manor Care Home, Minister Swann has undertaken to bring forward a new Adult Protection Bill for Northern Ireland - there has been a consultation undertaken and the findings have been published https://www.health-ni.gov.uk/consultations/legislative-options-inform-development-adult-protection-bill-northern-ireland

The Chief Social Worker, Sean Holland will chair a new Adult Safeguarding Transformation Board. The move to an independent structure will require a statutory footing. The development and commencement of legislation (primary and secondary) and the establishment of the Board is likely to take at least 2 years. With NIASP being stood down, an Adult Protection Board (APB) has been established as an interim measure. The Interim APBNI arrangements will remain in place until the necessary legislation has been passed and commenced. The Board will test new ways of working which will inform the new legislation, and adult protection arrangements will be hosted by the HSCB and Chaired by Brendan Whittle, the Director of Social Care and Children. Board Membership includes representation from PSNI, RQIA, Directors from each of five HSCTs, Patient Client Council, Public Health Agency and NI Social Care Council. Wider membership will include individuals, community and voluntary sector organisations, advocacy groups and HSC representation. LASPs are continuing to operate within the arrangements.

"Adult Safeguarding: Prevention and Protection in Partnership" sets out clear safeguarding expectations for all organisations working with adults, including those at risk. Organisations will find that adherence to the standards and guidance contained within this publication will enable them to meet these expectations, and, if they provide Regulated Services, their adult safeguarding requirements set out in the Minimum Standards published by the DOH and in the Quality Assessment Framework under Supporting People.

However, it is important to note that this guidance outlines **the minimum standards of practice for organisations.**

The guidance is divided into 8 sections. Each section contains:

- **The Standard;**
- **The criteria to meet the Standard;**
- **Supporting information for each criteria; and**
- **Resource material relating to the Standard where referenced in the narrative.**

There are additional generic Appendices at the end of the guidance which contain useful information, reference material and an organisational self-assessment checklist. Organisations can use the self-assessment checklist to identify strengths and weaknesses in their current adult safeguarding policy and practice, with a view to making improvements where necessary.

This guidance will contribute to the range of prevention, support and protection measures needed to meet the needs of adults, their families and carers. Ultimately, our success will be determined by improved safeguarding outcomes for those adults who may be at risk or in need of protection in Northern Ireland.

‘**Good practice** means a commitment to keeping adults **safe from harm and exploitation** and to upholding their rights’.

Section 1

The organisation has a written adult safeguarding policy supported by robust procedures and guidelines.

Section 1

Standard 1

The organisation has a written adult safeguarding policy supported by robust procedures and guidelines.

Criteria:

1. There is a written policy statement of the organisation's intention to keep adults safe from harm.
2. There is an outline of the procedures and guidelines that the organisation will implement to meet this commitment, in line with the minimum standards.
3. The adult safeguarding policy is supported by other organisational policies, procedures and guidelines aimed at promoting safe and healthy working practices.
4. The policy is 'owned' at all levels within the organisation and the person(s) with responsibility for its approval, implementation and review is named.
5. The policy, procedures and guidelines are subject to regular review; at least once every three years.
6. Everyone involved in the organisation is aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.

Section 1

1.1 There is a written policy statement outlining the organisation's intention to keep adults safe from harm.

As an organisation working with adults at risk, 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 adults safe from harm and exploitation and to upholding their rights; that is, always acting in their best interests and with their consent. The most effective way to do this is to have well thought out safeguarding policies, procedures and guidelines in place. All organisations who work with or have potential interfaces with adults at risk, irrespective of size and sector, need to develop a safeguarding policy supported by robust procedures and guidelines to inform and promote good practice in their work.

Who is an adult at risk of harm?

'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'.

Who is an adult in need of protection?

'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 person**s is causing, or is likely to cause, him/her to be harmed'.[1]

[1] These definitions are from the regional adult safeguarding policy for Northern Ireland, "Adult Safeguarding: Prevention and Protection in Partnership", (DOH and DOJ, 2015) available at www.health-ni.gov.uk

Section 1

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 at risk' or an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. Organisations can contact a HSC professional, if the adult is known to the HSC Trust or the Adult Protection Gateway team for advice.

Adult Rights

The rights of adults to live a life free from neglect, exploitation and abuse are protected by the Human Rights Act 1998 – their right to life is protected (under Article 2); 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 and Policy Context

Underpinning Principles

Your organisation's safeguarding policy and practice must be guided by five underpinning principles as outlined below. These principles are contained within the new regional adult safeguarding policy "Adult Safeguarding: Prevention and Protection in Partnership", (DOH and DOJ, 2015).

(1) 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.

(2) 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.

(3) 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.

(4) 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 **(see Resource 1.2 - Consent and Capacity).**

(5) 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.

It may seem obvious that the rights of 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.

Section 1

The way we work with adults at risk, how we behave around them and our attitudes towards them, all contribute to the way they 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 adults at risk are valued and their safety and well-being is paramount.

While such an environment will encourage adults to disclose issues that are worrying them, it will also enable staff and volunteers to observe the demeanour and behaviour of 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 an adult at risk. It is important, therefore, that adults at risk 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 adults at risk; 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.

Adult Safeguarding Policy Statement

An adult safeguarding policy statement appears at the beginning of the safeguarding policy. It should acknowledge the rights of adults and make a clear commitment to uphold these 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 adult 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 procedures and guidelines which all involved with the organisation will follow in order to safeguard adults at risk of harm. It should be clear that the adult safeguarding policy applies to everyone involved with the organisation, including members of the management committee, managers and leaders, staff and volunteers, adults availing of your services or participating in your activities, their carers, advocates and visitors.

See Resource 1.3 – Sample Adult Safeguarding Policy Statement

1.2 There is an outline of the procedures and guidelines that the organisation will implement to meet this commitment, in line with the minimum standards.

Your organisation's 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 and volunteers;

Section 3: Management, support, supervision and training of staff and 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;

Section 8: Code of Behaviour.

1.3 The adult safeguarding policy is supported by other organisational policies, procedures and guidelines aimed at promoting safe and healthy working practice.

In addition to an adult safeguarding 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 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. It is essential these policies are linked and cross referenced to ensure consistent practice in adult safeguarding. Some relevant additional polices are:

- Health and Safety;
- Moving and Handling;
- First Aid;
- Fire Safety;
- Equal Opportunities;
- Handling 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 Improvement Authority (RQIA) will also need to take account of the regulations and associated Minimum Standards for these services.[2]

1.4 The policy is 'owned' at all levels within the organisation and the person(s) with responsibility for its approval, implementation and review is named.

It is essential that your adult safeguarding policy is 'owned' at all levels within your organisation. To demonstrate an organisational commitment to keeping 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. The Adult Safeguarding Champion supports the implementation of the policy throughout the organisation.

The safeguarding policy should be signed off by the Head of the organisation and the person(s) responsible for the review identified, so that everyone is clear about who they can discuss or share their comments with.

[2] Information about Regulated Services can be accessed at www.rqia.org.uk

1.5 The policy, procedures and guidelines are subject to regular review; at least once every three years.

Your organisation's adult safeguarding policy, including all related procedures and guidelines, needs to be reviewed at regular intervals to ensure it remains up to date and continues to be relevant to the work and activities of the organisation. As a minimum, it is recommended that a review is conducted at least once every three years. However, an earlier review may need to take place, particularly in circumstances where there are changes in practice or legislation, or where there is a change in your organisation's operational procedures.

1.6 Everyone involved in the organisation is aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.

The adult 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 of the full safeguarding policy. The Adult Safeguarding Champion has responsibility for ensuring the dissemination of the policy across the organisation.

Adults at risk, carers and advocates

While the safeguarding policy statement should be prominently displayed in the organisation's premises, adults at risk, carers and advocates should have access to the full adult 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 or easy-read versions.

Staff and volunteers

Staff and volunteers, including managers and leaders, should be made aware of the adult safeguarding policy through their initial induction training and adult safeguarding training and should have easy access to a copy. Staff and volunteers should be encouraged to feedback 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.

A Management Committee has ultimate responsibility for all actions carried out by an organisation. It is therefore essential that management committees ensure robust adult safeguarding policy, procedures and guidelines are in place and being implemented across the organisation. 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 and their role.

Section 1

Resource 1.1 Legal and Policy Context

Adults at risk are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against an adult at risk 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 always be consulted about criminal matters.

There are a number of pieces of legislation relating to safeguarding adults at risk which can be accessed through **www.opsi.gov.uk**

Some of the relevant legislation is as follows:

The Criminal Law Act (Northern Ireland) 1967

Section 5 of the Criminal Law Act (Northern Ireland) 1967 creates an obligation on citizens, if they suspect a serious offence has been committed, to provide the police with any information they may have. In particular, anyone who knows or believes that a "relevant" offence has been committed, and has information which is likely to help to secure the arrest, prosecution or conviction of a suspect, is under a duty to give that information to the police within a reasonable period. A "relevant" offence is either an offence for which the penalty is fixed by law, eg life imprisonment, or one for which someone of 21 years upwards can be sentenced to 5 years' imprisonment.

Anyone who fails, without reasonable excuse, to provide information in those circumstances commits an offence under section 5 of the 1967 Act. The maximum custodial punishment for this offence depends on the seriousness of the offence that should have been reported, but the maxima lie between 3 and 10 years.

There is one notable exception. A "relevant" offence does not include an offence under Article 20 of the Sexual Offences (NI) Order 2008. This exception means that it is not unlawful if a person does not report to the police information about sexual activity involving a young person under 16 where the other person is under 18.

The Act also provides for an exception to the "duty to inform" offence for the victim of the "relevant" offence, or someone acting on his behalf, where the victim is reasonably recompensed by the suspect for any loss or injury.

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 DOH 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 him/herself, 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[3] 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 managing a nursing home, a residential care home or a private hospital if they are satisfied that any person within their 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.

[3] 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.

Useful Leaflets published by the Office of Care and Protection can be accessed through **www.courtsni.gov.uk**

The Police and Criminal Evidence (Northern Ireland) Order 1989

Codes of Practice issued under the Police and Criminal Evidence (Northern Ireland) Order 1989 state that a person of any age suspected of being mentally disordered or otherwise mentally vulnerable and detained by police must have the support of an appropriate adult. The appropriate adult can be a parent, relative or guardian or someone experienced in dealing with mentally disordered or mentally vulnerable people. Generally if police can't secure the attendance of a parent or guardian then they will contact the Northern Ireland Appropriate Adult Scheme which will provide a trained person to perform the appropriate adult role. MindWise has been contracted by the Department of Justice to deliver the Northern Ireland Appropriate Adult Scheme. The scheme aims to protect and safeguard the rights of young people and mentally vulnerable adults who are detained by the Police. The role of the Appropriate Adult is to make sure an individual is supported and that they fully understand the process during their period in police detention. The scheme is accessible to every designated PSNI station throughout Northern Ireland.

The Disability Discrimination Act 1995

The Disability Discrimination Act 1995 introduces new laws and measures aimed at ending the discrimination faced by many people with a disability 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 a person with a disability cannot be justified.

Further information on the Disability Discrimination Act 1995 can be obtained from **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**

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 people without disabilities.

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**

The Criminal Evidence (Northern Ireland) Order 1999

The Criminal Evidence (NI) Order 1999 introduced a range of special measures to assist vulnerable and intimidated witnesses to give their best evidence in criminal proceedings.

This includes giving evidence by live link.

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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.

There are 16 basic rights in the Human Rights Act – all taken from the European Convention on Human Rights. The following have particular relevance to adult safeguarding:

- **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 Prohibition of Torture**

  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 4 Prohibition of Slavery and Forced Labour**

  Everyone has an absolute right not to be held in slavery or servitude or to be required to perform forced or compulsory labour. This has relevance in that people who are victims of organised crimes such as human trafficking, prostitution and slavery are adults who are being exploited. There is a positive obligation on public authorities to intervene to stop slavery, servitude or forced or compulsory labour as soon as they become aware of it.

- **Article 5 Right to Liberty and Security**

  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. In terms of safeguarding 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 Trial**

  Everyone has the right to a fair trial and public hearing within a reasonable time by an independent and impartial tribunal established by law. This is relevant in terms of equality of access to justice. It was one of the drivers behind the development of the Criminal Evidence (NI) Order 1999 and the "Protocol for Joint Investigation of Adult Safeguarding Cases".[4]

[4] The protocol can be accessed through www.hscboard.hscni.net

- **Article 8 Right to Respect for 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. 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. Adults at risk 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**

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 DOH, 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 (as amended by the Protection of Freedoms Act 2012)

The Safeguarding Vulnerable Groups (NI) Order 2007 establishes certain safeguarding requirements when organisations are recruiting staff and volunteers to certain positions which involve contact with adults at risk.

Under the Order it is an offence for employers to knowingly recruit barred individuals into 'regulated activity' with adults. Organisations can ensure that they are complying by requesting an Enhanced Disclosure with Barred List Check from AccessNI, before confirming an appointment in regulated activity.

There is also a requirement for organisations to refer to the Disclosure and Barring Service (DBS), any individual who has harmed or poses a risk of harm to adults, and who has been permanently removed (or would have been had they not left the organisation) from regulated activity.

For more information on the requirements visit **www.volunteernow.co.uk** or contact the

Our Duty to Care Team in Volunteer Now on 028 9023 2020.

For further guidance on the DBS referral process visit
www.gov.uk/government/organisations/disclosure-and-barring-service

The Forced Marriage (Civil Protection) Act 2007

A forced marriage is a marriage where one or both people do not or cannot consent to the marriage, this includes where physical force or emotional pressure have been used. This is different from an arranged marriage where families may take a lead role in arranging the marriage but both parties have the free will and choice to accept or decline the arrangement.

The Forced Marriage (Civil Protection) Act 2007 seeks to assist victims of forced marriage, or those threatened with forced marriage. It extends to England and Wales and Northern Ireland. A person threatened with forced marriage can apply to court for a Forced Marriage Protection Order. The Order will contain provisions to prevent the forced marriage from taking place, or to protect a victim of forced marriage from its effects.

Protection measures may include confiscation of passports or restrictions on contact with the victim. A person who violates a Forced Marriage Protection Order may be subject to imprisonment or a fine.

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 are unable to legally consent to sexual activity because of a mental disorder. Articles 47 - 50 provide added protection for those who have capacity to consent but might be at risk of exploitation through inducement, threats or deception.

The Order also sets out clear parameters for people working with adults at risk and sets strong penalties for offenders. Articles 51 – 57 contain new offences for people who are engaged in providing care, assistance or services to adults at risk. 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 adult also fall within the scope of the Order.

The Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015

The Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (NI) 2015 aims to provide Northern Ireland with a more robust legal framework in relation to; the prosecution of traffickers and those subjecting people in Northern Ireland to conditions of slavery; the provision of improved support for victims; and tackling the demand for the services of trafficked victims.

The Act establishes a new offence of slavery, servitude and forced or compulsory labour, a new consolidated offence of human trafficking and clarifies that a victim's consent to any act forming part of these offences is irrelevant. It enhances public protection by increasing the maximum sentence for such offences to life imprisonment; introducing a minimum 2 year sentence for such offences, unless there are exceptional circumstances to warrant a lower sentence; and by introducing slavery and trafficking prevention orders (STPOs) which enable courts to restrict the behaviour of any individual convicted, where necessary. Additionally, the Act makes forced marriage an illegal offence in Northern Ireland.

The Act creates a new offence of paying for sexual services of a person, whilst ensuring that the person who is selling sex is not guilty of aiding and abetting, counselling or procuring this offence, conspiring to commit the offence, or encouraging or assisting the commission of the offence. It also places a duty on the DOH to provide a programme of assistance and support for people who want to leave prostitution.

Under the Act, the Department of Justice is required to provide assistance and support to adult potential victims who are referred to the National Referral Mechanism (NRM). Examples of support which may be provided include safe accommodation; help with living/travel costs; help to access healthcare; sign-posting to immigration advice; sign-posting to independent legal advice and advice on compensation; help to access counselling or other therapeutic services; and interpreter/translation services.

The Act also introduces new measures aimed at protecting victims of human trafficking and slavery-like offences during investigations and criminal proceedings. This includes the introduction of a statutory defence for victims who have been compelled to commit certain offences as a direct consequence of their trafficking or slavery situation. Under the Act, victims of human trafficking and slavery-like offences are protected in respect of avoiding secondary victimisation in police interviews and are automatically eligible for special measures in court when giving evidence.

Section 1

Policy Context

A regional adult safeguarding policy "Adult Safeguarding: Prevention and Protection in Partnership" was launched in July 2015. The policy was jointly developed and published by the Department of Health (DOH) and the Department of Justice (DOJ) on behalf of the Northern Ireland Executive. The aim of the policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. 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 the voluntary, community, independent and faith organisations. A key objective is to reduce the incidence of harm of adults who are at risk; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families.

Organisations should take time to read the new regional policy and associated operational procedures to ensure they are meeting their safeguarding expectations. "Adult safeguarding: Prevention and Protection in Partnership" can be accessed at

www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents

Go back to **Section 1.1**

Section 1

Resource 1.2 Consent and Capacity

Consent

An organisation that provides activities and services for adults should adhere to the underpinning 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 adult and with their consent. Staff and volunteers should always be mindful of the need for the adult to consent to, and to be comfortable with, any proposed activity or service. Consent is a process - it results from understanding through dialogue and the provision of information.

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. As a general rule, the method of obtaining consent is likely to be dictated by the seriousness of what is being proposed. For example, an adult may signal their consent to participate by turning up at the luncheon club voluntarily. However, an adult being asked to agree to transfer from a residential care home to a nursing home where their needs will be better served will require a more formal consideration of consent. Such decisions should involve health and social care professionals. It does not matter so much how an adult gives consent, the important issue is to ensure the consent given is valid.

Consent is only considered to be valid when:

- The adult has the capacity to consent, that is, they can understand and weigh up the information needed to make the decision; **and**
- The adult is appropriately informed, that is, they have been given sufficient information, in an appropriate way, on which to base the decision; **and**
- It has been given voluntarily, that is, free from coercion or negative influence.

If any of these factors is absent, consent cannot be considered to be valid. In cases where the adult lacks capacity, decisions will usually be made on behalf of the adult in accordance with current legal provisions.

Staff and volunteers should remember that no one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this. 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.

Staff and volunteers should:

- Always presume that the adult at the centre of the decision or action is able to give or withhold consent unless it is established otherwise;
- Make every effort to encourage and support the adult to make the decision for themselves and communicate the decision. This includes giving them all the necessary information which is explained or presented in a way which the adult fully understands. If lack of capacity is established, it is still important that you involve them as far as possible in making decisions.
- Be aware that an adult who has capacity has the right to make what others may regard as an unwise decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people, but sometimes a balance needs to be struck between the adult's human rights and the need to intervene to protect others;
- Provide support to an adult where they have withheld consent and this has been overridden; and
- Understand that an adult can change their mind about any choice or decision they have made.

Where there are concerns about consent, for example, doubts about whether it is valid, the staff member or volunteer should bring this to the attention of their Line Manager, who should in turn 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.

In some cases it may be necessary for the withholding of consent to be overridden. This is generally in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected.

Capacity

Mental capacity means the ability to make a decision and take actions. An adult will always be assumed to have capacity to make a decision unless it is suspected otherwise. This means staff and volunteers should always start by believing that the adult can make their own decisions unless they can prove otherwise. It does not matter what the adult looks like, how they behave, what age they are or if they have a disability or illness.

Staff and volunteers must be aware that capacity can fluctuate, and it is both issue and time specific, therefore it should be kept under regular review.

If a member of staff or volunteer has any doubts about the capacity of an adult to make a decision or series of decisions, they should inform their Line Manager or Adult Safeguarding Champion, who should seek professional advice from the local HSC Trust. It may be necessary for a HSC professional to conduct a capacity assessment.

Any decisions made or actions taken on behalf of an adult who lacks capacity must be done in their best interests, after considering their preferences. The person/agencies making the decision must consider whether it is possible to do this in a way that would interfere less with the freedoms and rights of the adult. Where appropriate, relevant family members or carers will be consulted regarding what action to take.

Advocacy

An adult who lacks capacity to make a decision may have the potential to benefit from advocacy services. Advocacy helps people to:

• Access information and services;

• Be involved in decisions about their lives;

• Explore choice and options;

• Defend and promote their rights; and

• Speak out about issues that matter to them.

Advocacy helps to ensure that the adult at risk remains central to the decision making process.

An advocate should not make decisions on behalf of the adult, but always work in partnership with them.

Go back to **Section 1.1**

Go back to **Section 8.8**

Section 1

Resource 1.3 Sample Adult Safeguarding Policy Statement

A sample adult safeguarding policy statement is a statement of your intention to keep 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 adults and safeguard them from harm.

Staff and volunteers in our organisation accept and recognise our responsibilities to develop awareness of the issues that cause 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 the adults we work with and care for by:

- Adhering to our adult safeguarding 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 adults at risk and their carers 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
- Implementing a code of behaviour for staff and volunteers.

We will review our policy, procedures, code of behaviour and practice at regular intervals, at least once every three years.

Author:	
Publication date:	
Approved by:	
Effective from:	
For attention of and action by:	Members of the Senior Management Team, Management Committee/Group; managers and leaders; staff and volunteers; service users; and advocates; and visitors.
Review date:	
Adult Safeguarding Champion:	(Name and contact details)

Go back to **Section 1.1**

Go back to **Section 5.2**

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 form requesting information on previous convictions which are not protected, and investigations, if any.
5. A consent form for an AccessNI disclosure check is completed, if required.
6. There is an interview process suitable to the post/role and task.
7. Written references are sought (and followed up when necessary).
8. If a professional qualification is a requirement of the post, a registration
9. check is made with the appropriate Professional Regulatory Body.
10. Where required, an appropriate AccessNI disclosure check is carried out.
11. The post is approved by management.

Section 2

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 in place to minimise the opportunity for unsuitable people to work or volunteer with adults who may be at risk. The same procedures must be applied consistently with paid staff (full time and part time) and volunteers alike, even those who live locally and are known to the organisation or those with a lot of experience.

This section sets out the procedures that should be followed to ensure good practice. The actual degree of formality applied to the procedures will vary from one organisation to another but should be developed in line with these standards.

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 activity under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, as amended by the Protection of Freedoms Act 2012. If a post does fall within the scope of regulated activity, any individual included on the Adult's Barred List, is prohibited by law from applying for the job or role. Organisations are also prohibited from employing/involving a Barred individual in regulated activity.

See Resource 2.1 – Disclosure and Barring Arrangements

2.2 There is an open recruitment process.

In addition to the job or role description and personnel or 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 job or 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 or role description and personnel or 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

Section 2

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;
- 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 form requesting information on previous convictions which are not protected, and investigations, if any.

All applicants should be asked to sign a declaration form which gives them the opportunity to declare criminal history information, in line with legal requirements. The extent of the declaration of criminal history will depend on the nature of the post. The reason for this is to ensure that the information provided by the applicant concurs with the information that appears on any subsequent Disclosure Certificate.

Sometimes details of an individual's criminal record will not appear on their disclosure certificate. They are 'filtered' from Standard and Enhanced checks because they are old and/or minor. The individual does not have to tell a perspective employer/organisation about these convictions and/or cautions. Therefore, where organisations are processing these levels of checks they may only ask applicants for details of convictions and information that is 'not subject to filtering'.

The applicant should also be asked to provide any information on any investigation carried out in relation to 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 not used unfairly to disadvantage the applicant. The declaration form should be returned to the organisation in a sealed envelope marked 'confidential' and only opened when the preferred applicant has been identified.

2.5 A consent form for an AccessNI disclosure check is completed, if required.

Where an AccessNI disclosure check will be carried out, the applicant should be provided with a consent form which outlines the level of AccessNI check to be sought, and asking the applicant's written consent to the check.

Organisations should make it clear that where consent to an AccessNI disclosure check is not provided, the recruitment process will not proceed and the applicant will no longer be considered eligible for the post.

See Resource 2.4 – Sample Declaration and Consent Form

Note:

Regulated activity - the declaration and consent form should include questions 1 - 4.

Section 2

Non-regulated activity eligible for an Enhanced Disclosure without Barred List Check

- the declaration and consent form should include questions 2 - 4.

See Resource 2.5 – AccessNI Information

2.6 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 job or role. You should take this opportunity to gauge the candidate's understanding of adult safeguarding to ensure that they are 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.

Based on the interview/meeting, it should be possible to identify a preferred candidate and make a conditional offer of the job or role, subject to satisfactory references and the result of an AccessNI check (where relevant).

2.7 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 adults at risk. 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 adults at risk.

See Resource 2.6 – Sample Employee Reference Request Form

See Resource 2.7 – Sample Volunteer Reference Request Form

2.8 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 2 – Professional Regulatory Bodies

Section 2

2.9 Where required, an appropriate AccessNI disclosure check is carried out.

Under the Safeguarding Vulnerable Groups (NI) Order 2007, as amended by the Protection of Freedoms Act 2012, it is an offence for organisations to knowingly recruit Barred individuals into 'regulated activity' with adults. Organisations can ensure they are complying by requesting an Enhanced Disclosure with Barred List Check, before confirming an appointment in regulated activity. This check will be carried out by AccessNI, either through a Registered Body or an Umbrella Body.

A Barred individual is legally prohibited from working or volunteering in regulated activity and is committing an offence by applying for or offering to undertake such work.

If the post meets the former definition of regulated activity (i.e. pre 2012 definition) the organisation can choose to request an Enhanced Disclosure without Barred List Check on the preferred applicant.

If the post does not meet either of the above definitions, there is no eligibility to undertake AccessNI checking at enhanced level. Organisations may decide to request a Basic Check.

See Resource 2.1 - Disclosure and Barring Arrangements

See Resource 2.5 - AccessNI Information

Information obtained through an AccessNI check will ensure that decisions about appointments are made based on all available information. Once the Disclosure Certificate has been received by the applicant and forwarded to the organisation, it should be cross referenced with the applicant's self-declaration form. At this point the organisation will be able to make a final recruitment decision. Where the organisation is satisfied, the conditional offer of employment/volunteering should now be confirmed with the preferred candidate.

Discretion needs to be applied when a Disclosure Certificate reveals criminal history information. A number of factors should be considered including the nature of the information or conviction, any frequency or pattern of offending, and care needs to be taken to consider this information alongside the requirements of the post.

2.10 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 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 by your organisation. The make-up of your staff and volunteers should be responsive to the needs of the adults with whom you work or who are in your care.

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 and volunteers;
- Attempting to attain, as far as possible, staff and volunteers who are reflective of any minority cultural or linguistic groups represented in your organisation's user groups.

Section 2

Resource 2.1 Disclosure and Barring Arrangements

Organisations delivering services and activities to adults at risk must ensure they comply with disclosure and barring arrangements which are in place through law and/or best practice. The following information should be read in conjunction with **Resource 2.5 AccessNI Information**.

Disclosure arrangements

The Safeguarding Vulnerable Groups (NI) Order 2007, as amended by the Protection of Freedoms Act 2012 defines 'regulated activity' with children and adults. Regulated activity is work which a Barred person must not undertake. It is a criminal offence for a Barred person to seek or undertake work from which they are Barred, and it is an offence for organisations to 'knowingly employ' a staff member or involve a volunteer in regulated activity if they are Barred. Organisations can ensure they are complying by requesting an Enhanced Disclosure with Barred List Check, before confirming an appointment in regulated activity.

What is regulated activity?

The following categories of people (and anyone who provides day to day management or supervision of those people) fall within the definition of regulated activity:

1. **Providing health care** - any health care professional providing health care to an adult or anyone providing health care to an adult under the direction or supervision of a health care professional.

   A **health care professional** is a person who is regulated by one of the following professional regulators:

   • General Medical Council,
   • General Dental Council
   • General Optical Council
   • General Osteopathic Council
   • General Chiropractic Council
   • Pharmaceutical Society of Northern Ireland
   • Nursing and Midwifery Council
   • Health Professions Council.

   Health care includes all forms of health care provided for adults, whether relating to physical or mental health, and includes palliative care. This includes diagnostic tests and investigative procedures. Health care also includes procedures that are similar to forms of medical or surgical care that are not provided in connection with a medical condition. An example of this is taking blood from a blood donor or cosmetic surgery.

   The provision of psychotherapy and counselling (including over the telephone) to an adult which is related to health care the adult is receiving from, or under the direction or supervision of, a health care professional, is regulated activity. Life coaching is excluded.

   First aid, when any person administering the first aid is doing so on behalf of an organisation established for the purpose of providing first aid (for example, St John Ambulance Service), is regulated activity. This includes first aid given by First Responders. However, a worker employed for another purpose who volunteers, or is designated, to be that organisation's first aider is not in regulated activity.

Members of peer support groups, staff in community pharmacies, opticians, GP surgeries and dental practices who do not provide health care are not in regulated activity.

2. **Providing personal care** - Anyone providing physical assistance, prompts and supervision, training, guidance or instructions to an adult with eating, drinking, toileting, washing, bathing, dressing, oral care or care of the skin, hair or nails because of the adult's age, illness or disability.

   Excluded from regulated activity is any physical assistance provided to an adult in relation to the care of their hair when that assistance relates only to the cutting of the adult's hair. Hairdressers who cut the hair of patients and residents in hospitals and care homes are not engaging in regulated activity.

   Illustrative examples:

a) A care assistant in a care home who cuts and files an adult's nails to keep the nails short and safe, because the adult cannot do it themselves, because, for example, they cannot see well enough, is engaging in regulated activity.

b) A beauty therapist who attends a day care centre once a week and provides manicures for anyone who would like one, instead of for people who need them because of their age, illness or disability, is not engaging in regulated activity.

c) A volunteer who prepares and serves a meal to an adult in their own home (but does not feed the adult) is not engaging in regulated activity. To be engaged in regulated activity you must provide physical assistance to the person, for example spoon feeding that person, or you must be prompting and supervising (for example, prompting and supervising a person with dementia, because without it they would not eat), or you must be training or instructing (for example, teaching a person who has suffered a stroke to eat using adapted cutlery).

3. **Providing social work** - A social care worker providing social work in connection with any health or social services, including assessing or reviewing the need for these services, and providing ongoing support to clients.

4. **Assistance with general household matters** - Anyone providing day to day assistance to an adult because of their age, illness or disability, where that assistance includes managing the person's cash, paying the person's bills and/or shopping on their behalf.

   Illustrative examples:

a) A volunteer who collects shopping lists and the cash to pay for the shopping from older adults' homes, who then does the shopping on their behalf, is engaging in regulated activity.

b) A befriender who helps a disabled person compile their weekly shopping list is not in regulated activity.

5. **Assistance in the conduct of a person's own affairs** - Anyone who provides assistance in the conduct of a person's own affairs by virtue of:

- The Enduring Powers of Attorney (NI) Order 1987;
- An order or direction in relation to a person's property and affairs of the High Court under the Mental Health (NI) Order 1986;
- Being appointed a controller by the High Court under the Mental Health (Northern Ireland) Order 1986; and/or

- Receiving payments on behalf of that person under the Social Security Administration (Northern Ireland) Act 1992.

6. **Conveying** - Anyone who transports an adult, who requires it because of their age, illness or disability, to or from a place where they have received or will receive health care, personal care or social care (health care, personal care or social care are outlined above).

   Hospital porters, Patient Transport Service drivers and assistants, employees of the Northern Ireland Ambulance Service Health and Social Care Trust and staff within an emergency department who transport an adult because of their age, illness or disability to or from places where they have received, or will be receiving, health care, personal care or social work are also included in regulated activity.

   Conveying does not include licensed trips taken for purposes other than to receive health care, personal care or social work (for example, trips for pleasure are excluded).

   Illustrative examples:

a) A person who volunteers to take an adult to and from their GP appointment on behalf of a community group is in regulated activity. It would not matter if that person knows, or is friends with, the adult they were taking to the appointment if the conveying is on behalf of the group.

b) A friend who takes their neighbour to a hospital appointment would not be in regulated activity, as this is a personal relationship.

   Regulated activity continues to exclude any activity carried out in the course of family relationships, and personal, non-commercial relationships.

Barring arrangements

The Disclosure and Barring Service (DBS) is responsible for maintaining the list of individuals barred from engaging in regulated activity with children and/or adults across England, Wales and Northern Ireland. Organisations who have permanently removed an individual from regulated activity (or would have done had the employee/volunteer not left) because of harm or risk of harm to an adult, are required by law to refer the individual to the DBS who will then consider inclusion on a Barred list.

Guidance on how to refer and in what circumstances is available from the DBD website **www.gov.uk/government/organisations/disclosure-and-barring-service**

Individuals who have been convicted or cautioned for very serious offences against children or adults at risk will be automatically barred. A list of relevant offences is available on the DBS website listed above.

Go back to **Section 2.1**

Go back to **Section 2.9**

Section 2

Resource 2.2 Sample Employment Application Form

Application Form

Candidate Reference Number	
JOB TITLE	Return to

PERSONAL DETAILS (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 ☐ No ☐			
Email Address			
Where did you see the vacancy advertised?			

CURRENT OR MOST RECENT EMPLOYER			
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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PREVIOUS EMPLOYMENT Please give details of employment (paid or unpaid) over the last 10 years. **Please give your most recent first.**				
Name & Address of Employer and Nature of Business	Date of Employment		Position Held	Reason for leaving
	From	To		

EDUCATION Please give details of all qualifications obtained, along with grade and date achieved. **Please give your most recent first.**				
Level: Secondary/Further/Higher	Dates		Course details and Exam Results	Date obtained
	From	To		

Professional Qualifications (Held or working towards)				
Professional Body/ College/University	Dates		Course details and Exam Results	Date obtained
	From	To		

Section 2

SPECIALISED TRAINING OR COURSE ATTENDED			
Course Taken	Organised By	Location	Date

MEMBERSHIP OF PROFESSIONAL BODIES 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

SUPPORTING INFORMATION (Please ensure when completing this section that you demonstrate that you meet the shortlisting criteria)			
Experience			
Knowledge			

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Ability
Qualifications

REFERENCES Please give details of two referees; one must be your current or most recent Line Manager. References from family or friends are NOT acceptable.			
REFERENCE 1		**REFERENCE 2**	
Name		Name	
Job Title		Job Title	
Organisation		Organisation	
Address		Address	
Postcode		Postcode	
Tel No		Tel No	
Email Address		Email Address	

DECLARATION OF CONVICTIONS
See attached – Declaration and Consent Form

Section 2

DECLARATIONS Please ensure you sign and date this declaration before returning your application form

DATA PROTECTION DECLARATION - The information on the application form will be held and processed in accordance with the requirements of Data Protection Legislation.

I understand that the information is being used to:

• Process my application for employment;

• Form the basis of a computerised record on the recruitment system for processing and monitoring purposes;

• Form the basis of a manual job file with other application forms and will be used for processing;

• If appointed, form the basis of a manual and computerised employment record.

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.

Signature _____

Date _____

Please note:
All information received will be dealt with in confidence, consistent with our commitment to safeguard adults.

Go back to **Section 2.3**

Section 2

Resource 2.3 Sample Volunteer Application Form

Volunteer Application Form

Name of Organisation:			
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?			
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)?

Section 2

What previous work experience, including voluntary work, do you have?

Do you have any hobbies or interests relevant to the post?

What skills, knowledge and experience do you feel you could bring to a voluntary role in our organisation?

Are there reasonable adjustments that we could make as part of your recruitment process that would enable you to enjoy equality of opportunity in seeking 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.)			
1. Name:		**2.** Name:	
Address:		Address:	
Postcode:		Postcode:	
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 adults.

Go back to **Section 2.3**

Section 2

Resource 2.4 Declaration and Consent Form

We are committed to safeguarding 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, as amended by the Protection of Freedoms Act 2012. This post is not open to anyone who is included on the Adult's Barred List.

OR

You have applied for a position that is eligible for an Enhanced Disclosure Check under the Safeguarding Vulnerable Groups (NI) Order 2007, as amended by the Protection of Freedoms Act 2012.

(Select as appropriate)

It also falls within the position 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', which are not subject to filtering*. 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 about your criminal record history (and, if the post is regulated activity, if your name has been included in a Barred List). It is to make sure that individuals who are considered a risk to adults 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 Check 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.

Applicants can also submit a separate statement of disclosure if they wish. This may include details such as the particular circumstances around the conviction(s); how circumstances may have changed; and what has been learnt from the experience. Applicants can contact the Northern Ireland Association for the Care and Rehabilitation of Offenders (NIACRO) for more information.

Guidance notes on filtering*

Filtering is the term given to the non-disclosure of information, which is considered to be old and minor, on disclosure certificates. You do not need to give us details of any criminal history information that may be subject to filtering. Filtering rules are summarized below. However, if you need additional guidance on what you should disclose, you should seek advice from NIACRO.

Disposal	Aged 18 or over at time of issue/conviction	Aged under 18 at time of issue/conviction
Conviction for non-specified offences	Filtered after 11 years	Filtered after 5 ½ years
Cautions for non-specified offence	Filtered after 6 years	Filtered after 2 years
Informed warnings for non-specified offence	Filtered after 1 year	Filtered after 1 year
Diversionary Youth Conferences	n/a	Filtered after 2 years

AccessNI does not filter the following:

- a conviction or caution, diversionary youth conference or informed warning for a specified offence
- a conviction resulting in a custodial sentence (including a suspended sentence)
- a conviction for trying to commit a specified offence
- a conviction for encouraging or helping someone else commit a specified offence

'Specified offences' include serious, sexual or violent offences or those relevant to safeguarding. A full list of 'specified offences' is available from the Department of Justice website: www.dojni.gov.uk

Section 2

Declaration of Criminal Convictions, Cautions & Bind-Over Orders

In Confidence

1. Are you included in the Adult's Barred List? (if yes, please give details)	**YES** ☐	**NO** ☐

2. Do you have any cases pending? (if yes, please give details)	**YES** ☐	**NO** ☐

3. Do you have any convictions, cautions, warnings, diversionary conferences or bind-over orders that are not subject to 'filtering' (as defined by the Rehabilitation of Offenders (Exceptions) Order (NI) 1979, as amended in 2014)?

YES ☐ **NO** ☐

If yes, please provide details below, giving 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.

4. Have you ever been the subject of an Adult Abuse investigation which alleged that you were the perpetrator?

YES ☐ **NO** ☐

If yes, please provide details below, giving 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.

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. I consent to the appropriate AccessNI check being made and I agree to enquiries relevant to this declaration.

Signature: Date:

Print name:

Any surname previously known by:

Position applied for

Section 2

Resource 2.5 AccessNI Information

AccessNI is the system for the disclosure of an individual's criminal history to help organisations make safer recruitment decisions. It was established in April 2008 by the Northern Ireland Office as a result of the introduction in Northern Ireland of Part V of the Police Act 1997. Since then, AccessNI has moved under Department of Justice. Registered bodies can process applications for standard and enhanced disclosure checks. Typically, a Registered Body will be an employer seeking disclosures as part of the recruitment process. Registered Bodies must submit over 20 applications a year to maintain their status. Organisations who are not Registered Bodies can use the services of an organisation which has already registered with AccessNI and can deliver all of the necessary services on their behalf - an Umbrella Body. Full details of Umbrella Bodies and any costs are available on the AccessNI website.

Age of applicants

AccessNI will not accept applications for Basic, Standard or Enhanced checks where the individual is not aged 16 or over on the day the application was submitted. The only exception to this is where the applicant is seeking an Enhanced check and they are a member of a family, where an adult in that family is a registered childminder or is seeking to foster or adopt a child; or is living or working at the same premises where the childminding, fostering or adoption is to take place. In such circumstances, applications will continue to be processed provided the applicant is over 10 years of age.

Types of AccessNI checks

There are different levels of disclosure certificates available through AccessNI, each returning different levels of information. Individuals can apply directly to AccessNI using the appropriate application form to obtain a Basic Disclosure. Standard and Enhanced Disclosures can only be accessed through Registered/Umbrella Bodies.

Further information on the process and associated costs can be found at https://www.volunteernow.co.uk/app/uploads/2021/06/AccessNI-What-you-need-to-know.pdf

Go back to **Section 2.5**

Go back to **Section 2.9**

Section 2

Resource 2.6 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 as relevant to the post: Be as specific as possible • Applicant's main strengths
• Areas for improvement
• Applicant's ability to meet the competencies and skills of the post (see job description)
8 Please detail any concerns about any aspects of their work, where relevant to the post

Section 2

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 ☐ No ☐
11 Has the applicant had a satisfactory attendance record? Yes ☐ No ☐
If no, please give details
12 Do you have any concerns about the applicant's suitability to work with adults at risk? Yes ☐ No ☐
If yes, please give details

Under Data Protection Legislation, 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.

Go back to **Section 2.7**

Section 2

Resource 2.7 Sample Volunteer Reference Request Form

Volunteer Reference Form

In Confidence

_____ Has expressed an interest in becoming a volunteer, and has given your name as a referee.

1 How long have you known this person?

2 In what capacity?

3 What attributes does this person have that would make them a suitable volunteer?

4 Please rate this person on each of the following? (please tick one)					
	Poor	Average	Good	V/Good	Excellent
Responsibility					
Self motivation					
Can motivate others					
Commitment					
Trustworthiness					
Reliability					

5 Do you have any concerns about the applicant's suitability to work with adults at risk? 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 Legislation I am aware that this reference may be made available to the applicant, if requested.

Signature Date

Tel No

Email Address

Go back to **Section 2.7**

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 for staff and volunteers.
2. There is a probationary period for staff and a 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 for all staff and volunteers, 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/reviews.

Section 3

3.1 There is an induction process for staff and volunteers.

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 and responsibilities are. A thorough induction process is integral to good organisational practice. It ensures that staff and volunteers are properly prepared for their work and reduces anxieties associated with starting a new job or role. Organisations should ensure they have an induction process in place for staff and 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, relevant managers and senior staff;
- 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 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.[5]

Induction will ideally be done over a few days as new staff and 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 and volunteers should be asked to acknowledge that they have completed induction training and have read and understood the organisation's policies, procedures and guidelines, and agree to abide by them.

With the increasing number of people entering the workforce from outside Northern Ireland, organisations should take account of cultural sensitivities. Some cultural awareness raising may be required by organisations and existing staff and volunteers to minimise misunderstandings. Awareness raising for staff and 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 Bryson Intercultural (formerly the Multicultural Resource Centre).

See Appendix 3 – 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 and volunteers for reference.

See Resource 3.1 – Sample Induction Checklist

[5] 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

Section 3

3.2 There is a probationary period for staff and a trial period for volunteers.

All appointments of staff and volunteers should be conditional on the completion of a satisfactory period of work i.e. a probationary period for staff 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 their attitude to and aptitude for working with adults at risk. 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 the job or 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 with the member of staff/volunteer.

3.3 Relevant training is provided, appropriate to the post/role.

In addition to induction, all staff and volunteers (including Adult Safeguarding Champions and Management Committee Members) should receive adult safeguarding training relevant to their job or role and the nature of the contact they will have with adults at risk. 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.

Adult safeguarding training should include an awareness and understanding of the factors which increase the risk of harm in adulthood; the possible signs of 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 and 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 in line with the organisation's reporting procedures **(see Section 4).**

A training needs analysis is useful to determine the nature and level of training that staff and volunteers should receive. Organisations should ensure that any adult safeguarding training provided for their staff and volunteers meets the required learning outcomes in the Northern Ireland Adult Safeguarding Partnership (NIASP) Training Strategy and Framework available at www.volunteernow.co.uk/publications/?category=7&type=0&Search.x=26&Search.y=12

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 adults, such as understanding dementia. The type of training required will depend very much on the profile of the adults with whom you work.

It is best practice to keep a record of training needs, training provided, date provided and how useful staff and volunteers found it. For organisations providing Regulated Services, this will be mandatory.

Section 3

All organisations should have a Code of Behaviour for staff and volunteers outlining the behaviours expected and behaviours to be avoided when working with adults at risk of harm. Staff and 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 2 – Professional Regulatory Bodies

3.4 There is a robust structure and process for support and supervision for all staff and volunteers, 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 and 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 their work, and support and supervision issues at regular intervals. 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 and 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 and volunteers, to meetings with a group of staff and 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 and 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 3.2 – Support/Supervision/Appraisal Checklist

3.6 Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals/reviews.

It is best practice for written records to be kept of all training completed by staff and volunteers, support and supervision meetings held and all annual appraisals/reviews. Both parties should agree the content of the records and each should have a copy. These records should be stored confidentially and in line with the organisation's data protection policy.

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 within the organisation.

See Resource 3.3 – Employees and Volunteers – Definitions

Section 3

Resource 3.1 Sample Induction Checklist

What	Who	Date
About the Organisation • aims, philosophy and ethos • people we work/volunteer with • work/volunteering we do • limitations of the organisation • structure: departments/teams • management		
The Building • toilets, cloakrooms, parking, etc. • where to get tea/coffee/lunch • health and safety rules		
The Job/Role • worker's/volunteer's area of responsibility • line management • days/hours of work/volunteering and breaks • relevant organisational policies and procedures, including the safeguarding policy • code of behaviour		
The Support System • who will supervise worker/volunteer, where and when to find them • support available • supervision/support meetings • resources, facilities, equipment, • training • complaints procedure • reasonable adjustments, if required		
Fellow Workers/Volunteers • who and what they do • team meetings • working/volunteering with others		
Other Information • settling in – probationary/trial period • claiming expenses • key stakeholders and their roles		
Employee/Volunteer: I confirm that I have completed all items in the induction checklist and, where indicated, read and understood policies and procedures. Signature_____ Date _____ **Line Manager:** 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. Signature_____ Date _____		

Go back to **Section 3.1**

Section 3

Resource 3.2 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. Adult Safeguarding

Are there any adult safeguarding issues you would like to raise that we have not yet discussed?

Go back to **Section 3.5**

Section 3

Resource 3.3 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 (or in addition to) one's immediate family. It is unpaid and undertaken freely and by choice.'

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 2013) available from www.volunteernow.co.uk

Go Back to **Section 3.6**

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.

Section 4

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. The policy outlines what constitutes adult abuse, where abuse can occur and who abuses.
2. There is a written procedure outlining how staff and volunteers respond to, record and report adult safeguarding concerns.
3. There is a system to communicate the reporting procedure to staff and volunteers to ensure they are familiar with it.
4. There is an Adult Safeguarding Champion or appointed person who has responsibility for dealing with adult safeguarding concerns which come to light within the organisation.
5. There is a procedure for the Adult Safeguarding Champion or appointed person to report adult safeguarding concerns to the appropriate authorities.
6. There is a written procedure outlining how staff and volunteers respond to and report allegations made against staff and volunteers.
7. There is a whistleblowing policy and procedure.

Section 4

4.1 The policy outlines what constitutes adult abuse, where abuse can occur and who abuses.

Good safeguarding practice means that organisations must ensure that all staff and volunteers understand how to recognise abuse, and how to pass any safeguarding concerns to the relevant people within the organisation. This does not mean that staff and volunteers are responsible for deciding whether or not abuse has occurred, but they do have a responsibility to be alert to the physical signs, actions and/or behaviour by adults, staff or volunteers that suggests something may be wrong.

An adult may be at risk of harm because of their personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect themselves 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.

In most situations HSC Trusts will make decisions regarding the degree of risk and level of harm an adult may be facing and decide on the most appropriate action to take. 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.

What is abuse?

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'. [6]

Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

"Adult Safeguarding: Prevention and Protection in Partnership" (DOH and DOJ, July 2015) outlines the main forms of 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. Female Genital Mutilation (FGM) is considered a form of physical AND sexual abuse.

Sexual violence and abuse is 'any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability). [7]

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

[6] Action on Elder Abuse: definition of abuse 1993 which can be accessed at www.elderabuse.org.uk/Mainpages/Abuse/abuse.html This was later adopted by the World Health Organisation: www.who.int/ageing/projects/elder_abuse/en/

[7] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' are from "Stopping Domestic and Sexual Violence and Abuse in Northern Ireland, A seven year strategy" (DOH and DOJ, March 2016) available at www.health-ni.gov.uk

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 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 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 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 happen in any organisation, within and outside Health and Social Care (HSC) provision. 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.

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 where the person lacks the capacity to assess risk.

"Adult Safeguarding: Prevention and Protection in Partnership" does not include self-harm or self-neglect within the definition of an 'adult in need of protection'. Each case will require a professional 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, they may very well be experiencing harm in other ways.

Section 4

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 is 'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member'. 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.

The response to any adult facing this situation will usually require a referral to specialist services such as Women's Aid or the Men's Advisory Project. In high risk cases a referral will also be made to the Multi-Agency Risk Assessment (MARAC) process. Specialist services will then decide if the case needs to be referred to a HSC Trust for action under the safeguarding procedures. If in doubt anyone with a concern can contact the Domestic and Sexual Violence helpline (0808 802 1414) to receive advice and guidance about how best to proceed.

Human trafficking/Modern Slavery 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/modern slavery 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 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.

The response to adults at risk experiencing hate crime will usually be to report the incident to the Police Service.

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; or
- In public places.

Who can abuse?

Staff and volunteers should be aware that abusers come from all sections of society, all professions and all races and can be male or female.

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An abuser can be anyone who has contact with the adult including someone who is physically and/or emotionally close to the adult at risk, and on whom they may depend and trust. It could be a:

- Partner;
- Spouse;
- Child;
- Relative;
- Friend;
- Informal carer;
- Healthcare, social care or other worker;
- Peer; or less commonly a
- Stranger.

Professional abuse – the misuse of power and trust by professionals; the failure of professionals to act on suspected abuse/crimes; poor care practice or neglect in services; or resource shortfalls or service pressures that lead to service failure and culpability as a result of poor management systems.

Peer abuse – the abuse of one adult by another within a care setting. It can occur in group or communal settings such as day centres, clubs, residential care homes, nursing homes or other institutional settings.

Stranger abuse – the abuse of an adult by someone they don't know such as a stranger, a member of the public or a person who deliberately targets adults at risk.

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are stressful experiences occurring during childhood that directly harm a child or affect the environment in which they live (Bellis et al 2016). ACEs can include abuse; neglect; domestic violence; mental ill health; alcohol or drug misuse, parental separation; a household member in prison; homelessness; adversities associated with living in care; chronic ill health or serious illness; the death of a parent or sibling; and the impact of the conflict in our region. This is not an exhaustive list, there are many other adversities which children and young people experience.

ACEs can create levels of stress that are dangerous to the child's brain development, behaviour, health, and learning. Individuals who have experienced multiple ACEs are more likely to have poor physical and mental health in adulthood. They are also more likely to engage in health harming behaviours. Staff and volunteers working with adults should be mindful that such behaviours can signify trauma and they should adopt a trauma sensitive approach in their work to reflect and explore why an individual may be behaving in the way that they are, what their needs might be, and what support they may require.

Further information can be found at https://www.safeguardingni.org/aces-and-trauma-informed-practice. Free e-learning programmes can be accessed at https://www.ascert.biz/specialist-courses/

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4.2 There is a written procedure outlining how staff and volunteers respond to, record and report adult safeguarding concerns.

Organisations must ensure that there is a written procedure which tells all staff and volunteers how to record and report any adult safeguarding concerns, and the procedure for dealing with an allegation made against them. This should be covered at induction and through ongoing safeguarding training and contained in the organisation's adult safeguarding policy.

Where there are concerns raised about an adult at risk, or where a disclosure or allegation is made, people often feel anxious about passing on the information. Often staff and volunteers can feel afraid that their concerns may be wrong and because of this, they may delay in passing on vital information regarding an adult at risk. Staff and volunteers who have concerns do not need any evidence of wrongdoing, nor are they responsible for conducting an investigation, they simply need to pass on their concerns through the organisation's reporting procedures, as soon as possible.

It is important to remember that it is not the responsibility of one person in an organisation to evaluate information regarding the adult at risk and any safeguarding concerns. It is unlikely that one person will hold all the information relevant to the adult as often important information may be held by several people and more than one organisation but each piece of information may add to the overall jigsaw, which can show a fuller picture of an adult's situation. Sharing information is one of the most important ways to prevent and detect adult abuse.

How can you be alerted to signs of abuse or neglect?

There are a variety of ways that you could be alerted that an adult is suffering harm:

- They may disclose to you;
- Someone else may tell you of their concerns or something that causes you concern;
- They may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
- Their demeanour/behaviour may lead you to suspect abuse or neglect;
- The behaviour of a person close to them 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 abuse plays a major role in ensuring that adults are safeguarded, and it is important that all concerns about possible abuse are taken seriously and appropriate action is taken.

What if an adult at risk discloses abuse?

In cases where an 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 attentively;
- Express concern and sympathy and acknowledge what is being said;
- Reassure the person – tell the person that they did the right thing in telling you;

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- Let the person know that the information will be taken seriously and provide details about what will happen next, including the limits and boundaries of confidentiality;
- If urgent medical/police help is required, call the emergency services;
- Ensure the immediate safety of the person;
- If you think a crime has occurred be aware that medical and forensic evidence might be needed. Consider the need for a timely referral to the police service and make sure nothing you do will contaminate it;
- Let the person know that they will be kept involved at every stage;
- Record in writing (date and sign your report) and report as per your organisation's procedures 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 person to have caused the harm;
- Attempt to investigate yourself;
- Leave details of your concerns on a voicemail or by email;
- Delay.

It is important for everyone to be aware that the person who first encounters a case of alleged or suspected abuse is not responsible for deciding whether or not abuse has occurred. That is a task for statutory authorities. The primary responsibility for the person who first suspects or is told of abuse is to report it in line with the organisation's reporting procedures and to ensure that their concern is taken seriously.

The Line Manager or person in charge will take any immediate action required to ensure the adult at risk of harm is safe and make a decision as to when it is appropriate to speak with the adult at risk of harm about the concerns and any proposed actions. They must then report the concerns and any action taken to the appointed person or Adult Safeguarding Champion.

Under no circumstances should any individual member of staff or volunteer or the organisation itself attempt to deal with the problem of abuse alone or investigate the situation. They should not ask questions that relate to the detail, or circumstances of the alleged abuse, beyond initial listening, expressing concern and checking out.

Reporting and recording

All concerns, disclosures and allegations should be recorded on pro formas provided by the organisation. 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. If there is a disclosure it is important to record what was said as soon as possible in the adult's own words.

The record should be clear and factual, since any information 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.

See Resource 4.1 – Sample Form for Recording and Reporting Concerns, Disclosures and Allegations or Suspicions of Abuse

It is also good practice for staff and volunteers to record the fact that they made a report, on what date and to whom the report was made.

Confidentiality

When a staff member or volunteer has a concern about an adult they are working with, that concern needs to be recorded and reported on a 'need to know' basis. Staff and volunteers should be clear that information relating to a concern, disclosure, allegation or suspicion should only be passed on to the relevant people whose task it is to decide what action to take. It is essential that the organisation has robust systems in place for the maintenance of all records, including records of alleged or suspected abuse **(see Section 7).**

4.3 There is a system to communicate the reporting procedure to staff and volunteers to ensure they are familiar with it.

All staff and volunteers should be made aware of the procedure for recording and reporting adult safeguarding concerns. This should be covered at induction and through ongoing training. Staff and volunteers should also have a copy of the organisation's adult safeguarding policy which outlines the recording and reporting procedure.

What if a staff member's/volunteer's concerns are not taken seriously?

If a staff member/volunteer raises a safeguarding concern but the Line Manager, Adult Safeguarding Champion or appointed person is reluctant to pass it on, the staff member should contact the Head of the organisation. Where this fails, the staff member or volunteer should contact the local HSC Trust Adult Protection Gateway Service, the PSNI, or RQIA if it is a Regulated Service. Contact details should be included in the safeguarding policy.

4.4 There is an Adult Safeguarding Champion or appointed person who has responsibility for dealing with adult safeguarding concerns which come to light within the organisation.

Organisations, even small ones, should nominate at least one person with responsibility for dealing with adult safeguarding concerns, disclosures or allegations about actual or suspected abuse.

Organisations which have staff or volunteers subject to any level of vetting under the Safeguarding Vulnerable Groups (NI) Order 2007 must nominate an **Adult Safeguarding Champion (ASC).**

Organisations which do not have staff or volunteers subject to vetting, are not required to nominate an ASC. Although the organisation may wish to do so, to adhere to good practice.

The role of the ASC set out in "Adult Safeguarding: Prevention and Protection in Partnership", has both strategic and operational components. In larger organisations the ASC may delegate the operational day to day responsibility for safeguarding to an appointed person(s) within their organisation. For example, a provider with a number of Nursing Homes throughout Northern Ireland

may choose to delegate some of the tasks of an ASC to a member of staff in each facility. They will then report to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Organisations who delegate operational tasks to appointed person(s) must have sufficient numbers to ensure they are accessible to all service areas in the organisation as a source of advice and guidance.

In smaller organisations the ASC may be responsible for all actions relating to adult safeguarding situations, including working with the adult at risk and making referrals to PSNI and/or HSC Trusts.

Organisations which are not required to nominate an ASC, can contact the HSC Trust Adult Protection Gateway Service directly for advice and guidance on adult safeguarding concerns.

It is essential that everyone in the organisation knows who they have to report adult safeguarding concerns to and how to contact them. The relevant name(s) and contact details should be included in the adult safeguarding policy, be widely available and 'out of hours' contact included.

See Resource 4.2 – Role and Responsibilities of an Adult Safeguarding Champion (ASC)

What support is available for an ASC?

The HSC Trust Adult Protection Gateway Team is available to advise and support each ASC on operational issues such as necessary, particularly if the ASC is unsure whether or not a referral is required.

The HSC Trust Adult Safeguarding Specialist is available to offer advice and support on strategic issues such as local developments in adult safeguarding, regional policy or strategic direction, and prevention initiatives in the area.

4.5 There is a procedure for the Adult Safeguarding Champion or appointed person to report adult safeguarding concerns to the appropriate authorities.

All organisations should have procedures in place to report adult safeguarding concerns to the appropriate authorities. This important role needs to 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 and volunteers and externally with the appropriate authorities.

If your organisation is required to have an ASC, it will be their responsibility to provide advice to staff and volunteers who have concerns about the signs of harm and ensure a report is made to the HSC Trust where there is a safeguarding concern.

When an alert is raised within an organisation in relation to an adult safeguarding concern or disclosure, the ASC, or appointed person where the tasks have been delegated, will ensure the following actions occur:

- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided whilst being careful not to stray into the realm of investigation;
- **Where immediate danger exists or the situation warrants immediate action,** ensure any medical assistance has been sought and refer to the HSC Trust Adult Protection Gateway Service or PSNI;
- Support staff to ensure that any actions take account of the adult's wishes;

- Where it has been deemed that it is not a safeguarding issue, other alternative responses should be considered such as monitoring, support or advice to staff and volunteers. A record should be made of the concern and the details kept on file, including any action taken; the reasons for not referring; and the situation monitored on an ongoing basis;
- If it is decided that it is a safeguarding issue, the situation will be reported to the HSC Key Worker where known. If unaware of HSC Key Worker contact details, a referral will be made to the HSC Trust Adult Protection Gateway Service. The HSC Trust will then conduct a risk assessment and decide what response is appropriate;
- If a crime is suspected or alleged, contact the HSC Trust Adult Protection Gateway Service directly;
- If the concern involves a regulated facility, the RQIA will be informed;
- Act as the liaison point for any investigative activity which is required and will ensure easy access to relevant case records or staff;
- Ensure accurate and timely records and any adult safeguarding forms required have been completed.

Where there is any doubt or uncertainty about whether there is a safeguarding issue this should be discussed with the HSC Key Worker (if known) or HSC Trust Adult Protection Gateway Service.

Consent and Capacity

Adults should be central to decisions regarding any actions to prevent or protect them from harm; their wishes are of paramount importance in all cases of alleged or suspected abuse. If an adult does not want a referral made to the HSC Trust or PSNI, the ASC or appointed person must consider the following:

- Do they have capacity to make this decision?*
- Have they been given full and accurate information in a way which they understand?
- Are they experiencing undue influence or coercion?
- Is the person causing harm a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service?
- Is anyone else at risk from the person causing harm?
- Is a crime suspected or alleged?

*There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance, unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, the HSC Trust Designated Adult Protection Officer (DAPO) should ensure a capacity assessment is completed.

The above factors will influence whether or not a referral without consent needs to be made.

If in doubt, the ASC or appointed person should contact the HSC Trust Adult Protection Gateway Service for advice and guidance.

If it is determined that the concerns do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and the reasons for not referring to the HSC Trust.

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The ASC will ensure that records of reported concerns are compiled and analysed to determine whether a number of low-level concerns are accumulating to become significant. If the organisation is regulated by RQIA or other bodies, the ASC will make records available to them for inspection.

Where the ASC or appointed person 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.

HSC Trust Decision Pathway

On receipt of the adult at risk referral the Key Worker will discuss the concern with their Line Manager and/or DAPO in core services to establish the facts of the concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses.

Where the decision is that the adult is potentially at risk of harm, the Key Worker and their Line Manager will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm. The consent of the adult at risk will be sought and the assessment will include the wishes and views of the adult at risk and, where appropriate, their family and carers. The Key Worker will inform the referrer of the outcome of the assessment and care plan.

Where the Line Manager determines that the threshold for an adult in need of protection is met, the Key Worker will refer the concern to the HSC Trust Adult Protection Gateway Service. The Key Worker will advise the adult in need of protection of the decision to refer.

See Resource 4.3 – Reporting Procedures

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 adult at risk and their 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 their location.

See Resource 4.5 – HSC Trust APP1(a) Referral Form and Body Map

Contact can be made with the HSC Trust by phone in the first instance but should be confirmed in writing under confidential cover within two working days. Organisations should expect to receive an acknowledgement from the HSC Trust within two working days of the referral.

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4.6 There is a written procedure outlining how staff and volunteers respond to and report allegations made against staff and volunteers

One of the most difficult situations for an organisation to deal with is an allegation of abuse against a member of staff or volunteer. In many cases the person may be a close colleague, friend or neighbour. Nevertheless, the response from the organisations to allegations of abuse must at all times be consistent, regardless of relationships as the primary interest must always be the safety and well-being of adults.

When responding to an allegation that has been made against a member of staff or volunteer, the organisation has a dual responsibility; firstly, to the adult at risk, and, secondly, to the staff member or volunteer.

Organisations should have procedures for dealing with an allegation made against a member of staff or volunteer which, in the case of a concern about an adult at risk, should run parallel to the procedure for reporting an adult safeguarding concern.

In the first instance the details of the allegation should be fully recorded by the ASC or appointed person and passed on (depending how the organisation is constituted) to the Line Manager of the individual whom the allegation has been made against 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 the organisation's ASC or appointed person, consult with the HSC Trust and/or PSNI to ensure that any subsequent action taken by the organisation 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 them and provide them with an opportunity to respond to the allegation. Their response should be recorded fully;
- Through the organisation's ASC or appointed person, consult with the HSC Key Worker (if known) or the HSC Trust Adult Protection Gateway Service (if Key Worker is not known) to agree the most appropriate way forward;
- Take protective measures which may involve transferring the staff member/volunteer to another post without contact with adults at risk, or suspension. It should be noted that suspension is a neutral act to allow the investigation to proceed and to remove the staff member/volunteer from the possibility of any further allegation. If it is necessary to suspend a staff member or volunteer, the allegation 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 and/or PSNI so as not to prejudice any investigation. It is recommended that the ASC or appointed person is not the person who carries out the disciplinary procedure.

See Resource 4.6 – Allegations of abuse against staff and volunteers

Possible Outcomes of Investigation

As a result of the investigation, there are 4 possible outcomes which organisations should consider, and plan for, and outline in the adult safeguarding policy.

- **Allegation of harm/risk of harm substantiated – the individual is removed from regulated activity.**

  If the investigation finds that the allegation is substantiated, that is harm or risk of harm to an adult has occurred, and the individual is removed from regulated activity, the organisation will be under a statutory duty to refer to the Disclosure and Barring Service (DBS) under the SVG (NI) Order 2007, as amended by the Protection of Freedoms Act 2012. Referral to the DBS should be at the point that the organisation determines that harm/risk of harm has occurred and there has been a decision made to permanently remove the staff member or volunteer from regulated activity. This may happen at any stage during the disciplinary process and not necessarily when the process concludes.

  If the staff member or volunteer resigns or retires at any point during the investigation process, the investigation should still be concluded and a referral made to the DBS if it is found that harm or risk of harm to an adult has occurred.

- **Allegation of harm/risk of harm substantiated – the individual is reinstated to regulated activity.**

  It is possible that the investigation finds that the allegation is substantiated, but the circumstances of the case are such that the individual can be reinstated to their job/role subject to appropriate disciplinary sanctions, training and support and supervision arrangements being implemented. Despite the finding that harm/risk of harm has occurred, the decision to return the individual to the job/role means that a referral to the DBS is not required.

- **Allegation of harm/risk of harm unsubstantiated – but there are ongoing concerns.**

  In a situation where the investigation concludes that the allegation is unsubstantiated and that the individual has not harmed an adult or placed them at risk of harm, but the organisation has ongoing concerns about the conduct of the staff member of volunteer, the organisation may conclude that the individual can be reinstated with additional support, supervision and training/retraining.

- **Allegation of harm/risk of harm unsubstantiated – there are no ongoing concerns.**

  In an instance where the internal investigation finds that the allegation is unsubstantiated, that is that the individual has not harmed or placed at risk of harm an adult, the staff member or volunteer may be reinstated and provided with support to reintegrate back into the organisation. Training and supervision may be necessary depending on the nature of the allegation and findings of the investigation.

  Regardless of the outcome of an investigation, dealing with allegations made against staff and volunteers can be traumatic and unsettling for any organisation. It is therefore vital that all staff and volunteers have a clear understanding of how allegations will be handled and how the organisation's disciplinary procedure will 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 the investigation is handled sensitively from initiation to conclusion while ensuring that anxieties expressed or demonstrated by adults at risk, carers, advocates or any other member of staff or volunteer are acknowledged and addressed.

  Following the investigation and regardless of the outcome, there will be issues for everyone involved in the organisation, including staff, volunteers, adults, carers and advocates. Clearly this will be a sensitive issue for the whole organisation. Through training and staff discussion, organisation should explore strategies for addressing a range of issues such as:

- Possible reactions of other members of staff and volunteers within your organisation of anger, disbelief, doubt, fear, guilt, shock, anxiety;

- The effects of internal proceedings, an official safeguarding investigation or criminal investigation on the individual against whom the allegation has been made;
- The reactions of staff, volunteers and other adults involved in the organisation towards an adult who has been abused or whose allegation is being investigated;
- The reactions of carers, advocates or other family members; and
- The reputation of the organisation and reaction within the wider community.

It is extremely valuable to have a discussion with staff and volunteers about what could happen and how people might feel if an allegation of abuse is made or a suspicion is reported. Rehearsing the issues will give everyone concerned the confidence to face what will inevitably be a very difficult situation.

There may be situations in which suspicions or allegations turn out to be unfounded. Nevertheless, it is important that everyone in the organisation knows that if they raise a concern it will be taken seriously.

4.7 There is a whistleblowing policy and procedure.

Whistleblowing occurs when a member of staff or 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 risk of harm to others or are abusive, discriminatory or exploitative. This will include situations where a staff member's or volunteer's concerns are not acted upon by the Adult Safeguarding Champion or appointed person, or Head of the organisation.

Your organisation should have a whistleblowing policy and procedure in place which makes it clear that:

- The organisation is committed to the highest possible standards of conduct, openness, honesty and accountability;
- The organisation takes poor or malpractice seriously, giving examples of the types of concerns to be raised, to endure that a whistleblowing 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 through the whistleblowing procedure; and
- It is a disciplinary matter both to victimise a bona fide whistleblower and for someone to maliciously make a false allegation.

There may be situations in which concerns or allegations turn out to be unfounded. It is important that everyone in the organisation knows that if they raise a concern which, through the process of investigation, is not validated, they have not in any way been wrong in their initial action. Responsible action needs to be encouraged in the organisation and whistleblowers should be confident of support. The whistleblowing policy needs regularly reviewed to ensure the procedures work in practice. It is everyone's duty to be vigilant in preventing abusive practice.

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Resource 4.1 Sample Form for Recording and Reporting Concerns, Disclosures and Allegations or Suspicions of Abuse

Adult Abuse Report Form

Please answer all relevant questions as fully as you can.

Work location
Name of adult
Age/Date of Birth
Gender
Names of carers (if known)
Home address (if known)
Please complete those sections below that are relevant
1. Disclosure by adult at risk
When was the disclosure made (dates and times)?
Who did the adult make the disclosure to?
What did the adult actually say?

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2. Indicators
Describe any signs or indicators of abuse (with times and dates)
Has the adult alleged that any particular person is the abuser (if so, please record details and the relationship, if any, to the adult below)
3. Concerns expressed by another person about an adult at risk
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
4. Details of any immediate action taken, e.g. first aid, etc

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5. Has the adult expressed any reservations about you talking to your Line Manager/Adult Safeguarding Champion/appointed person about the matter?
6. Does the adult have any particular needs, e.g. communication, etc?
Signatures
To be signed by the person reporting the concern
Name
Job title
Signed
Date
Date received and actioned by Line Manager
Name
Signed
Date
Date received and actioned by Adult Safeguarding Champion/appointed person
Name
Signed
Date
Action taken by Line Manager/Adult Safeguarding Champion/appointed person
Signed Date

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Resource 4.2. Role and Responsibilities of an Adult Safeguarding Champion (ASC)

What is an Adult Safeguarding Champion (ASC)?

The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement.

The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

- Recognising that adult harm is wrong and should not be tolerated;
- Being aware of the signs of harm from abuse, exploitation and neglect;
- Reducing opportunities for harm, abuse, exploitation and neglect to occur; and
- Knowing how and when to report adult safeguarding concerns to HSC Trusts and/or the PSNI.

What are the key responsibilities of an ASC?

"Adult Safeguarding: Prevention and Protection in Partnership" summarises the key responsibilities for the ASC as follows:

- To provide information, support and advice for staff and volunteers 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 a report is made to HSC Trusts where there is a safeguarding concern;
- 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 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), 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 more significant; and make records available for inspection.

What sort of information should an ASC monitor?

Most ASC's will already have daily access to a great deal of information that will assist the organisation or group improve the services it provides to adults at risk or in need of protection. To meet the governance requirements set out in the Policy, the ASC should compile an annual Adult Safeguarding Position Report using the following core data:

- Number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;

- Number of adult safeguarding discussions where the decision taken was to not refer to HSC Trust;
- Any untoward event that triggered an adult protection investigation;
- Adult safeguarding training opportunities provided and uptake across staff groups; and
- Any action that your organisation plans to take to ensure it is compliant with "Adult Safeguarding: Prevention and Protection in Partnership" and to implement the organisation's own adult safeguarding policy.

What does the ASC do with the Adult Safeguarding Position Report?

The Position Report is an important overview and governance tool for all organisations and groups supporting adults at risk or in need of protection. As such, it contains significant information for your organisation's Senior Management Team and/or Trustees. It should be scrutinised by them on an annual basis.

It would also be appropriate to provide core information from the Position Report in any organisational annual reports or updates.

The Position Reports should also be made available for any external audit purposes, for example any audits undertaken by the Local Adult Safeguarding Partnership, and to demonstrate compliance with policies as specified within any contracts with HSC Trusts.

Services that are externally regulated e.g. by RQIA, CJINI, or other relevant bodies may also be subject to inspection on adult safeguarding arrangements. The Position Report will be key in demonstrating that the organisation is complying with the requirements of the regional policy.

If the service or group you represent is contracted to provide services by the HSC Trust, as part of your normal contract monitoring process you should provide confirmation to the relevant Trust(s) that the Safeguarding Position Report is available for scrutiny.

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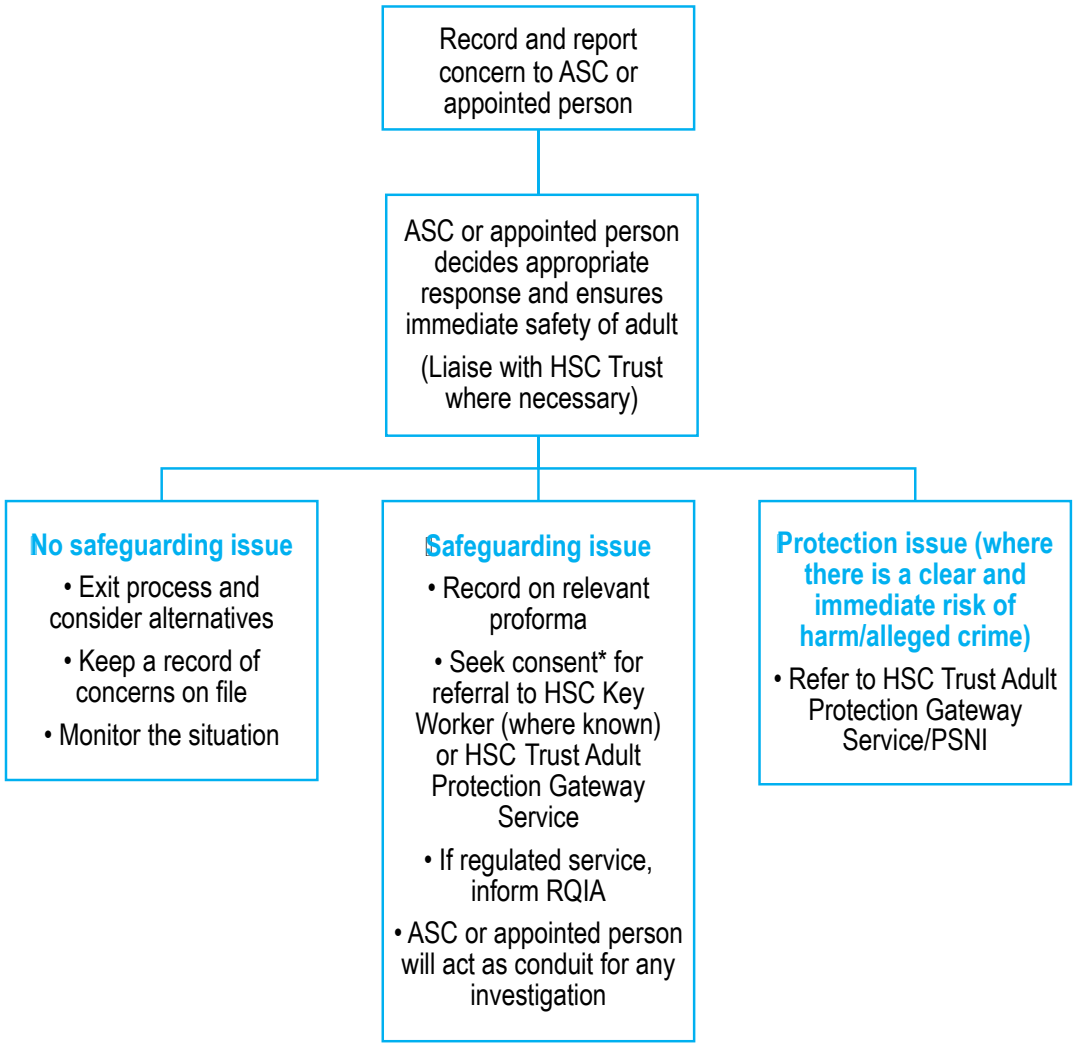
Resource 4.3 Reporting Procedure – Flow Chart



*See Section 4.5 Consent and Capacity for guidance.

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Resource 4.4 HSC Trust, PSNI and RQIA Contact Numbers

HSC Trusts

	Normal working hours (9am to 5pm)	Regional Out of Hours*
Belfast	(028) 9504 1744	(028) 9504 9999
Northern	(028) 9441 3659	(028) 9504 9999
South Eastern	(028) 9250 1227	(028) 9504 9999
Southern	(028) 3756 4423	(028) 9504 9999
Western	(028) 7161 1366	(028) 9504 9999

***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

	Normal working hours (9am to 5pm)
Belfast	(028) 9051 7500
Omagh	(028) 8224 5828

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Resource 4.5 HSC Trust APP1(a) Referral Form and Body Map

N.B This form should be completed by the Adult Safeguarding Champion or appointed person.
It can be found in the regional adult safeguarding operational procedures.

Regional Adult Protection Procedures
APP1(a) Referral / Screening Information

APP1 FORM

(For completion by HSC staff and contracted providers)

Please ensure Sections 1 & 2 are fully completed before referral to Trust DAPO

Name:	**Date of Birth:** (if not known, please give approximate age)	**Date of referral:**
Address: **Postcode:**	**Gender: M** ☐ **F** ☐	**Service/Client Group**
Telephone Number:	**Is the person known to the Trust?** **Yes** ☐ **No** ☐	**Reference No:**

SECTION ONE (Completed by Referrer)

Source of Referral			
☐ **Carer**	☐ **Other Trust**	☐ **RQIA**	☐ **Regulated Care Home**
☐ **GP**	☐ **Other Health Professional**	☐ **Adult Mental Health Unit**	☐ **Other Regulated Facility** (Specify)
☐ **Hospital Staff**	☐ **Anonymous**	☐ **Self**	☐ **Learning Disability Hospital**
☐ **PSNI**	☐ **Social Worker**	☐ **MARAC**	☐ **Other** (Specify)
☐ **DHSS**	☐ **Care Manager/ Care or Homecare Worker**	☐ **Adult Safeguarding Champion**	
☐ **Vol. Organisation**	☐ **Housing Association**	☐ **Acute General Hospital**	

Section 4

Details of Referral (the person who brings the concerns to the attention of the agency)	
Name:	**Relationship to Adult at Risk of Harm:**
Job Title & Agency	**Contact Number:**

Who was the first person to note concern?		
Name:	**Relationship to Adult at Risk of Harm:**	**Contact Number:**

Key Contacts			
	Name:	**Address:**	**Contact Number:**
Key Worker			
Care Manager			
GP			
Family/Carer			
Significant Other			
Other			

What is the main form of suspected, admitted or known abuse?			
☐ **Physical**	☐ **Sexual**	☐ **Institutional Abuse**	☐ **Human Trafficking**
☐ **Financial**	☐ **Neglect**	☐ **Psychological**	☐ **Domestic Violence**
☐ **Discrimination**	☐ **Exploitation**		

Incident Report

Background Information: (To include factors precipitating referral, home circumstances, support available, including issues of capacity)

Incident Report - Location / Date / Time of Incident (Please give exact details of what has been reported and if appropriate include names of any witnesses and note injuries on the attached body chart)

Details of any witnesses

Name:	**Name:**
Address:	**Address:**
Contact No:	**Contact No:**

Section 4

APP1 Form

Describe the impact of the incident on the adult at risk of harm

_____

_____

_____

The adult at risk of harm usual living arrangements

Does the adult at risk of harm live alone? **Yes** ☐ **No** ☐

Does the person who is suspected to have caused harm live with the adult at risk of harm? **Yes** ☐ **No** ☐

Is the adult at risk of harm present location different from home address **Yes** ☐ **No** ☐

If Yes, give present location:

_____

_____

_____

Have you taken any action due to emergency situation to avoid immediate serious risk?

Was immediate protection needed for adult at risk of harm? **Yes** ☐ **No** ☐

If Yes, give details:

_____

_____

Are there any children or other adults at risk? **Yes** ☐ **No** ☐

If Yes, give details:

_____

_____

Was immediate protection required? **Yes** ☐ **No** ☐

If Yes, give details:

_____

_____

Adult at risk of harm's knowledge of referral

Does the adult at risk of harm know that a referral may be made? **Yes** ☐ **No** ☐

Is the adult at risk of harm able to give informed consent? **Yes** ☐ **No** ☐ **N/K** ☐

Has the adult at risk of harm consented to a referral? **Yes** ☐ **No** ☐

Section 4

Details of person/persons suspected of causing harm

Name **Date of Birth** **M** ☐ **F** ☐

Address

Does the person/persons suspected of causing harm know that an allegation has been made against them? **Yes** ☐ **No** ☐ **N/K** ☐

Is the person/persons suspected of causing harm known to the adult at risk of harm? **Yes** ☐ **No** ☐ **N/K** ☐

If yes, please specify below:

☐ **Family member** ☐ **Another service user** ☐ **Paid carer**

☐ **Trust employee** ☐ **Other (specify)** _____

Any additional information relevant to the referral
(Please note the views of others you have consulted and note any difference of opinion)

Signature: **Date:**

Section 4

SECTION TWO (completed by Appointed Person)

Have 'Alerts' been checked to establish if previous APP1s are recorded? Yes ☐ No ☐ N/K ☐

Have previous APP1 alerts been recorded? Yes ☐ No ☐ N/K ☐

If yes, give summary of previous APP1s

_____

_____

_____

_____

Actions agreed by Appointed Other

Further information required prior to decision being made and and if yes, what information is required and who will action. Yes ☐ No ☐

_____

Answer EITHER

(a. HSC Trust Line Manager)

Consultation with core team DAPO re adult at risk of harm Yes ☐ No ☐

OR

(a. Adult Safeguarding Champion managers)

Consultation with key worker, if known / or Adult Protection Gateway service re adult at risk of harm Yes ☐ No ☐

Referral of adult in need of protection to Trust Adult Protection Gateway Services Yes ☐ No ☐

No further action under Adult Protection Procedures Yes ☐ No ☐

Is there a need to refer or notify?

☐ **Professional Community Assessment** ☐ **Quality Assurance Team**

☐ **Care Management** ☐ **Contracts** ☐ **Human Resources**

☐ **Adverse Incident Team** ☐ **RQIA** ☐ **PSNI**

Is there a need to consider any immediate Human Rights issues? Yes ☐ No ☐

(Please refer to drop down of Convention Human Rights or manual form)

Details of decision making

This should prioritise issues of risk/harm/possible criminal offence

_____

_____

Signature: **Date:**

Section 4

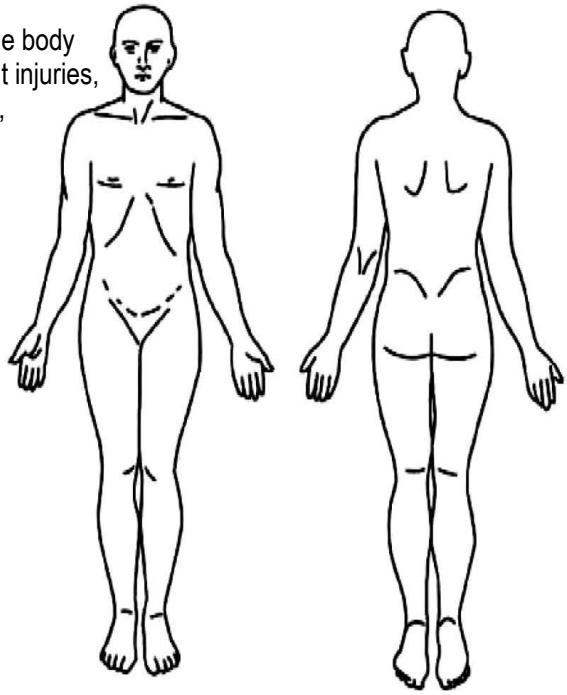
Adult Protection Procedures REFERRAL FORM – BODY MAP

APP1 Body Map

Name	**Date of Birth**
Health & Social Care Number (if known)	

APP1(a) Body Map is to be used in conjunction with the APP1 Referral Form by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care. Where used, the completed APP1(a) Body Map should be submitted with the APP1 Referral Form.

Please mark with numbers drawn on the body map in black ink to indicate the different injuries, and provide brief details for each injury, e.g. measurements of would, colour of bruise, etc., using arrows (a ruler is provided to assist with measurement).

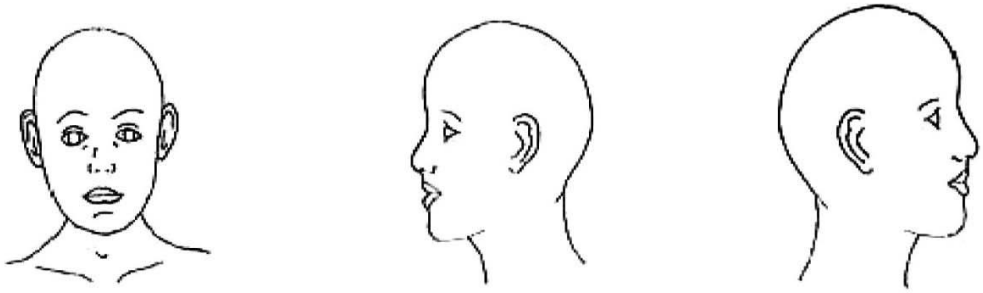


No	Site	Size	Bruise/cut/ burn/pressure ulcer/other	Colour	Comments
1					
2					
3					
4					
5					
6					

Section 4

Body Map notes:

Note any other details, such as anything the adult discloses on examination (verbatim), or information received from any other source regarding injuries.



No	Site	Size	Bruise/cut/burn/pressure ulcer/other	Colour	Comments

Time of injury:	
Date when injury happened (if known)	
Date injuries above were observed (if this is different to the original date)	

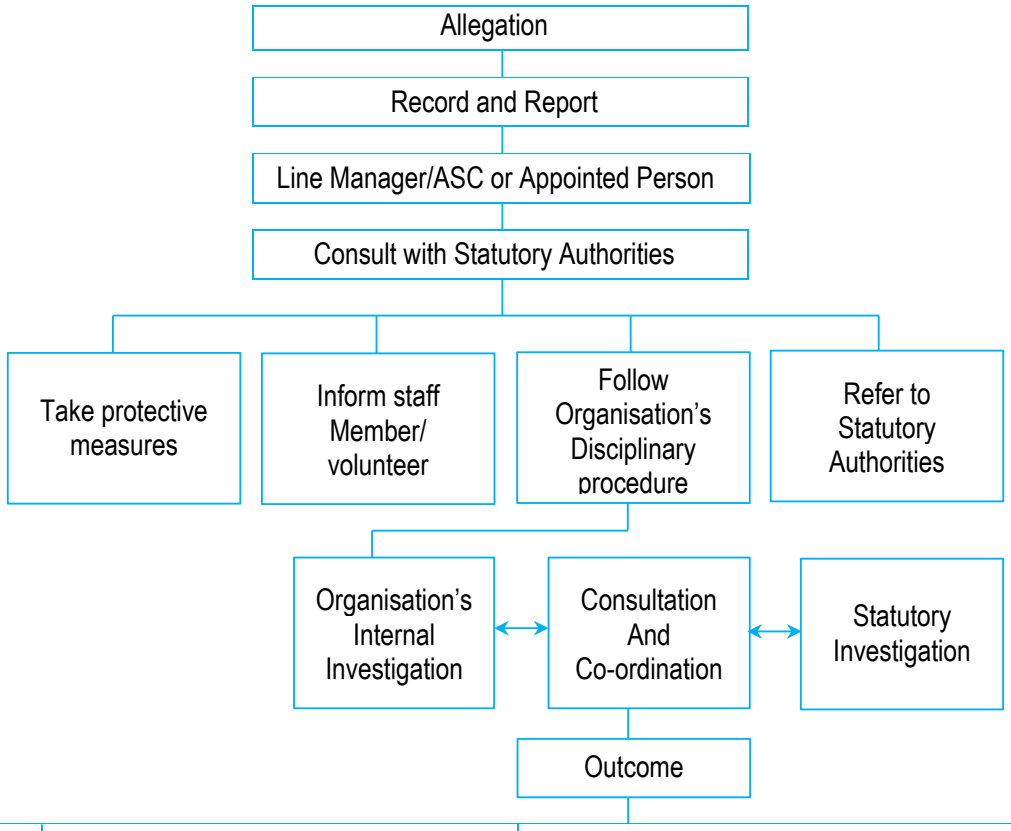
Completed by:	
Printed name/designation of person completing Body Map form	
Signature of person completing Body Map form	
Contact details of person completing Body Map form	
Date/time of completion	
(NB. When used, completed APP1 Body Map form should be attached to completed APP1 Referral form)	

Go back to **Section 4.5**

Go back to **Resource 4.3**

Section 4

Resource 4.6 Allegations of abuse against staff and volunteers – Flow Chart



1 **OR**	Allegation of harm/risk of harm substantiated - individual removed from regulated activity.	Refer the individual to the DBS and if relevant, inform appropriate professional body.
2 **OR**	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 **OR**	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.

Go back to **Section 3.3** | Go back to **Section 4.6** | Go back to **Section 6.2**
Go back to **Section 6.3** | Go back to **Section 7.1** | Go back to **Section 7.4**

Section 5

The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding adults.

Section 5

Standard 5

The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding adults.

Criteria:

1. A risk assessment is carried out to identify and evaluate risks to adults using services or participating in activities.
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 all 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 adults using services or participating in activities.

Assessing and managing risks to service users 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 adults, staff, volunteers or others in the context of the activities and services your organisation provides; in the interactions with and between individuals; 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 an adult to be safeguarded; the duty of care owed to the adults served by the organisation; the duty of care owed by the organisation to its staff and volunteers; the legal duties of statutory bodies and service providers; and the right of 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.

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.

Section 5

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:

- The assessment and management of risk should promote the independence, real choices and social inclusion of adults;
- Risks change as circumstances change;
- Risk can be minimised, but not eliminated;
- Information relating to 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 adults who use services, 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 and 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 adults is known to be greater when:

- The 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.

Section 5

When care services are provided, abuse is more likely to occur if staff and 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 undergo a 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 and 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.

Determining the level of risks

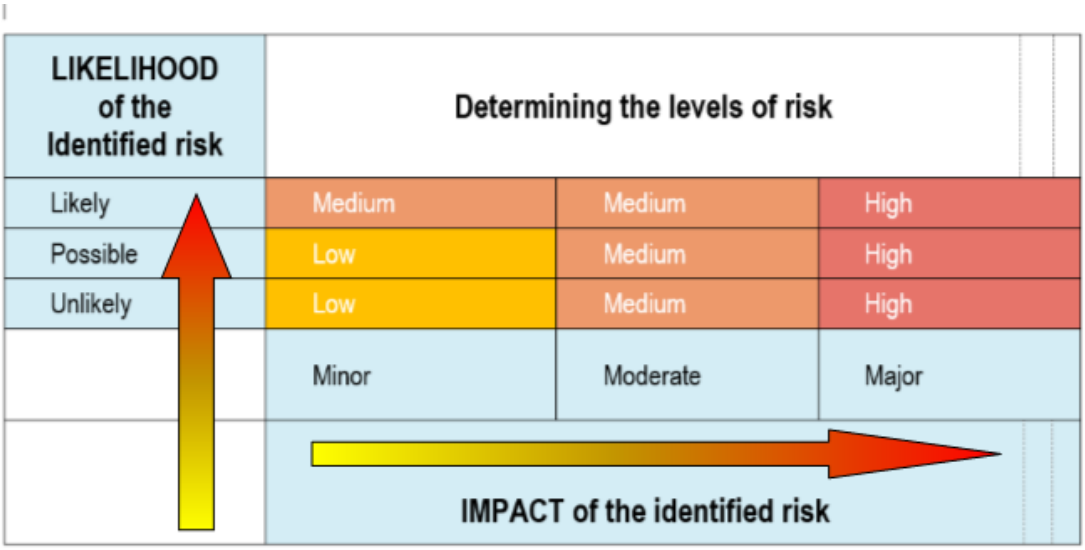
You need to be able to determine the level of risk (e.g. high, medium or low) associated with the risks identified. The purpose of determining the level of risk is to establish which risks warrant most attention. While an organisation will want to be mindful of all risk, those which have been determined 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 an 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.

Section 5



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 they will be named in the organisation's risk log/register (see Section 5.3), alongside the risk(s) for which they are responsible.

For the organisation, the primary aim of the Safeguarding Policy (see Section 1) is to manage the risk of abuse to adults by establishing an organisational culture in which the rights of 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 risk of harm in adulthood, 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 adults at risk;
- 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 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.

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 and volunteer training required to reduce risk and harm.

Finance the risk

It is important to provide resources to meet the liabilities caused by the risks when they are identified.

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 them.

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 adult that may accrue from positive risk taking **(see Section 5.4).**

Section 5

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. Organisations working with adults at risk should 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

Go back to **Section 5.2**

5.4 The organisation should recognise that all 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 for an individual or group, this needs to be offset against the benefits which they 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 – adults using services, carers and 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 service users; 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 Adult Safeguarding Champion for appropriate action.

See Resource 5.2 – Sample Accident/Incident/Near Miss Record Form

Section 5

Resource 5.1 Sample Risk Register

Identify **MAIN RISKS** 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 Unlikely Possible Likely	**Impact of it happening** Minor Moderate Major	**Combination of likelihood and impact** Low Medium High		**Stop the Activity** Action Needed	**Reduce the Risk** Action Needed	**Finance the Risk** Action Needed	**Transfer the Liability** Action Needed			**How** and **when** will you review the risks in this area?
A)											
B)											

Go back to **Section 5.3**

Section 5

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: *(person involved/injured)* *If more than one person has been involved please use separate forms for each person.*	Date:	Time:
Status: Service User ☐ Employee ☐ Volunteer ☐ Visitor ☐ Other ☐		
If other, please specify:		
Details of Accident/Incident/Near Miss: *(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).*		
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: *(What action is to be carried out to prevent the Accident/Incident/Near Miss happening again).*	
Is a risk assessment (or support plan) review required as a result of this Accident/Incident/Near Miss?	YES ☐ NO ☐
Action to be carried out by: *(name)*	By Date:
Line Manager Section Reviewed by: *(name)*	Date:
RIDDOR[8] Report confirmed by: *(name)*	Date:

Go back to **Section 5.5**

Go back to **Section 7.2**

[8]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 everyone involved in the organisation.
2. There are appropriate procedures in place to share concerns or make complaints about the organisation.
3. Complaints procedures are communicated appropriately to everyone involved in the organisation.

Section 6

6.1 The organisation has an ethos of inclusion, transparency and openness which is communicated to everyone involved in the organisation.

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 service users, 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 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 adults who use your services and staff/volunteers who discuss matters affecting their interests;
- Maintaining a record of matters and suggestions made by service users and their representatives and actions taken;
- Involvement of service users 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 adults who are involved in your organisation. Carers and advocates will have a wealth of knowledge about the emotional, physical and cultural needs of the 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. 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 service users can complete anonymously.

6.2 There are appropriate procedures in place to share concerns or make complaints about the organisation.

Where an individual has a concern or complaint about some aspect of the organisation, they should have access to the organisation's complaints procedure.

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 an adult at risk, 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 nature of the complaint;
- 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.

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 everyone involved in the organisation.

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).**

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. Adults involved with the organisation should have access to information held about them.

Section 7

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 adults with whom they work or who are in their care and their families should not be the subject of gossip. They should also know that information cannot be passed on to others without good cause or reason and we all have a fundamental right to privacy of information and confidentiality. 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 adult.

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, in line with the organisation's reporting procedures **(see Section 4).**

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 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.

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 Legislation.

The Information Commission's Office (ICO) has published a statutory Data Sharing Code of Practice to assist organisations to comply with The General Data Protection Regulation (GDPR) 2018. 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. The Data Sharing Code of Practice can be accessed at www.ico.org.uk

Data protection principles

Six Principles for Processing of Personal Data

Data protection principles underpin the new GDPR. These principles set out obligations for businesses and organisations that collect, process and store individuals' personal data. These principles relate to:

1. Lawfulness, fairness and transparency - you must process personal data lawfully, fairly and in a transparent manner in relation to the data subject.
2. Purpose limitation - you must only collect personal data for a specific, explicit and legitimate purpose. You must clearly state what this purpose is, and only collect data for as long as necessary to complete that purpose.
3. Data minimisation - you must ensure that personal data you process is adequate, relevant and limited to what is necessary in relation to your processing purpose.
4. Accuracy - you must take every reasonable step to update or remove data that is inaccurate or incomplete. Individuals have the right to request that you erase or rectify erroneous data that relates to them, and you must do so within a month.

5. Storage limitation - You must delete personal data when you no longer need it. The timescales in most cases aren't set. They will depend on your business' circumstances and the reasons why you collect this data.
6. Integrity and confidentiality - You must keep personal data safe and protected against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

GDPR provides the following rights for individuals:

1. The right to be informed – fair processing information, transparency over how their data will be used, e.g. privacy statement.
2. The right of access – access to personal data and how it is being used and processed, e.g. subject access request.
3. The right to rectification – personal data can be rectified if inaccurate or incomplete. This should be rectified within one month of being advised and third parties may also need advised if data has been shared.
4. The right to erasure – the right to request personal data be deleted, except where there is a compelling reason for continued processing, e.g. legal obligation, public interest, statistical analysis.
5. The right to restrict processing – to permit the storage of personal data, but block or restrict processing, e.g. when accuracy of data is contested. Third parties may also need advised if data has been shared.
6. The right to data portability – individuals can obtain and reuse their personal data across different services without hindrance to usability.
7. The right to object – objection to direct marketing, processing for legitimate reasons, e.g. public interest, statistical research.
8. Rights in relation to automated decision making and profiling – can only be carried out when: fulfilling a contract with the individual, authorised by law or the individual has given consent.

Many organisations hold information about their volunteers in paper and computer-based records i.e. personal details, equality monitoring data. Compliance with the legal obligations in respect of the handling of personal data is the responsibility of the 'data controller'. That is the title given to the person (individual, company or organisation) who decides why personal data is held and the way in which such data is dealt with. A Privacy Policy outlining how you will hold volunteers' information is an important document to be shared with volunteers. An important concept to consider is consent.

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 adults for whom they provide services or activities.

Essential joining information should include:

- The name, address and contact number of all adults and where appropriate their carers, advocates or next of kin name(s) and contact details;
- Any medical and health issues or particular requirements;
- Contact with other professionals/agencies, if any.

It is useful to have a standard registration form for this information. This should be completed before the adult accesses any service from your organisation so that reasonable adjustments can be made if appropriate. Careful consideration needs to be given to the storage of, and access to, this information. Adults have the right to know why information is required and how it will be used.

Section 7

See Resource 7.1 – Sample Service User Health Form

Note: Organisations providing Regulated Services will also need to take account of the regulations and associated Minimum Standards for these services.

Organisations should also keep records which reflect the 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

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 General Data Protection Regulation (GDPR) 2018. It contains guidance in factors to consider when deciding whether or not to share personal data.

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 local HSC Trust in accordance with procedures (see Section 4).

Adults, carers & advocates

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 information needs to be shared, for example, in cases of emergency or in the case of suspected abuse, the 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 adult to further risk of harm.

External agencies

While information 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.

Good record keeping of decision making is essential in cases where information sharing is being considered. Organisations should maintain records of the information gathered which explains and justifies their decisions.

Section 7

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.

This agreement should outline how organisations have agreed to share information and ensure compliance with legal requirements. It should stipulate when information may be shared without the adult's consent.

7.5 Adults involved with the organisation should have access to information held about them.

Adults at risk 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 adult, and, with their consent to another person acting on their 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. 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 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 staff and volunteers;
- Help with research, but only with the 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.

Section 7

Resource 7.1 Sample Service User Health Form

SERVICE USER HEALTH FORM

IN CONFIDENCE

Name (organisation)	
Activity	
PERSONAL DETAILS	
Name (adult)	
Address	
Tel No	
Medical card number	
Are you taking any medication/treatment? YES ☐ NO ☐ Please detail:	
CONTACTS FOR EMERGENCIES Should be in a position to collect you if necessary.	
CONTACT 1	**CONTACT 2**
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

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DOCTOR'S CONTACT DETAILS
Name
Address
Tel No
MEDICAL DETAILS
Do you have any medical conditions? YES ☐ NO ☐
Please detail
Do you have any allergies, including allergies to foods and medication? YES ☐ NO ☐
Please detail
Do you have hearing loss? YES ☐ NO ☐ Are you visually impaired? YES ☐ NO ☐
Please detail
Are there any issues related to your: Physical health YES ☐ NO ☐
Please detail
Mental health and emotional well-being YES ☐ NO ☐
Please detail

Section 7

Awareness and decision-making skills	YES ☐	NO ☐
Please detail		
Personal care & daily tasks	YES ☐	NO ☐
Please detail		
Administration of medicines	YES ☐	NO ☐
Please detail		
Walking & movement	YES ☐	NO ☐
Please detail		
Communication & sensory functioning	YES ☐	NO ☐
Please detail		
Any other relevant information:		
Please detail		

Section 7

CONSENT ☐ 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. ☐ 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
IF SIGNED BY SOMEONE OTHER THAN THE ADULT
What is your relationship to the adult?
On what grounds do you have the authority to sign on their behalf?[9]

Go back to **Section 4.2**

Go back to **Section 7.2**

[9]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 of Behaviour which outlines the behaviour expected of all involved in the organisation.

Section 8

Standard 8

There is a written Code of Behaviour which outlines the behaviour expected of all involved in the organisation.

Criteria:

1. The Code of Behaviour (the Code) contains positive statements about how staff and volunteers are expected to behave in their work with adults.
2. 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 money.
8. The Code contains guidelines on the use of technology, including photography.
9. The Code outlines sanctions in the case of staff and volunteers breaching the Code
10. The Code sets out an expectation that everyone involved in the organisation should relate to each other in a mutually respectful way.
11. The Code is tailored to organisational activities or services.

Section 8

8.1 The Code of Behaviour (the Code) contains positive statements about how staff and volunteers are expected to behave in their work with adults.

Having a Code of Behaviour for your organisation will minimise the opportunity for adults to suffer harm. It will also help to protect staff and 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 and volunteers, adults at risk and their 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.

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 adults at risk. It should be a positive document encouraging staff and volunteers to take a rights-based approach. However, the Code should also highlight behaviours to be avoided and those which are unacceptable.

Staff and volunteers must:

- Promote and protect the human rights of all adults in every aspect of their work;
- Treat all adults with dignity and respect;
- Be patient and listen;
- Communicate clearly, in whichever way best suits the individual and check their understanding;
- Adopt a person-centred approach;
- Treat all adults fairly and equally;
- Promote independence and choice;
- Encourage participation;
- Help all adults to fulfil their ability and potential;
- Involve all adults in decision making to the fullest extent.

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 2 – Professional Regulatory Bodies

The NISCC Standards of Conduct and 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.

Section 8

Social care workers must:

1. Protect the rights and promote the interests of adults at risk and carers;
2. Strive to establish and maintain the trust and confidence of adults at risk and carers;
3. Promote the autonomy of adults at risk while safeguarding them as far as possible from danger or harm;
4. Respect the rights of adults at risk 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 when working with adults at risk. These refer to behaviours that staff and 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 abuse being made. For example:

Staff and volunteers should not:

• Spend excessive amounts of time alone with an adult at risk;

• Take an adult at risk to your own home;

• Take an adult at risk 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 all those involved in the organisation.

Staff and volunteers should never engage in any of the following behaviours with adults at risk:

• Abuse, neglect or harm an adult, or place them at risk of harm, whether by omission or commission;

• Engage in rough physical games including horseplay;

• Engage in sexually provocative games e.g. spin the bottle, strip poker;

• Make sexually suggestive comments;

• Form inappropriate relationships;

• Gossip about personal and sensitive information; or

• Make/accept loans or gifts of money.

Section 8

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 care plan, where required;
- When providing intimate care, it is done sensitively and with respect for the individual's dignity and privacy;
- They involve the individual as far as possible in their own intimate care;
- If they are concerned about anything during intimate care, they report it 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 individual 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.

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 individuals and their families;
- Ask how an individual'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 individuals and their families who have different cultural backgrounds and beliefs from their own;
- Use the procedures outlined in this Guidance to report any discrimination.

Section 8

8.7 The Code contains guidelines on the handling of money.

Staff and volunteers should:

- Maintain records of personal allowances, receipts and expenditure in line with organisational policy;
- Never deny an adult access to their money;
- Never gain in any way when using the adult's money on their behalf or guiding them in the use of their own money;
- Never borrow money from, or lend money to, an adult you are working with or caring for;
- 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 adults at risk.

Staff and volunteers should:

- Not photograph/video an adult, even by mobile phone, without the adult's valid consent;
- Ensure that any photographs/videos taken are appropriate;
- Report any inappropriate use of images;
- Report any inappropriate or dangerous behaviour on the internet that involves an adult at risk.

It is important that adults at risk 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 and volunteers breaching the Code.

Staff 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, PSNI, DBS and regulatory bodies, as appropriate.

8.10 The Code sets out an expectation that everyone involved in the organisation 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 everyone involved in the organisation, including adults using services or participating in activities. The Code may cover behaviours such as having respect for each other, staff and volunteers and avoiding the use of offensive language; guidelines on the use of alcohol, particularly on day trips and sleeping arrangements for residentials.

The Code should be drawn up in consultation with staff and volunteers, service user groups, carers and advocates, with the understanding that its breach could lead to their exclusion, or where the behaviour constitutes abuse, e.g. of a peer, referral to the local HSC Trust or PSNI for further investigation and action.

Everyone involved in the organisation, including visitors, should 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 organisational activities or services

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 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

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
Eilís McDaniel	Department of Health
Pat Newe	Department of Health
Dee Kelly	Volunteer Now
Rosie Oakes	Volunteer Now
Carol Twycross	Volunteer Now

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Go back to **Introduction**

Appendix 2

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.

Professional Regulatory Bodies	Contact
General Chiropractic Council	www.gcc-uk.org
General Dental Council	www.gdc-uk.org
General Medical Council	www.gmc-uk.org
General Optical Council	www.optical.org
General Osteopathic Council	www.osteopathy.org.uk
General Teaching Council for Northern Ireland	www.gtcni.org.uk
Health and Care Professions Council	www.hcpc-uk.co.uk
Northern Ireland Social Care Council (NISCC)	www.niscc.info
Nursing and Midwifery Council	www.nmc.org.uk
Pharmaceutical Society of Northern Ireland	www.psni.org.uk

Go back to **Section 2.8** | Go back to **Section 3.3** | Go back to **Section 8.1**

Appendix 3

Useful Contacts

Statutory Bodies	Contact
Department of Health	www.health-ni.gov.uk
Health & Social Care Board	www.hscboard.hscni.net
Public Health Agency	www.publichealth.hscni.net
Health & Social Care Trusts	www.belfasttrust.hscni.net www.northerntrust.hscni.net www.setrust.hscni.net www.southerntrust.hscni.net www.westerntrust.hscni.net
Patient and Client Council	www.patientclientcouncil.hscni.net
Health & Safety Executive	www.hseni.gov.uk
Northern Ireland Housing Executive	www.nihe.gov.uk
Regulation and Quality Improvement Authority	www.rqia.org.uk
Police Service of Northern Ireland	www.psni.police.uk
Advocates/Commissioners	
Commissioner for Older People for Northern Ireland	www.copni.org
Voluntary Organisations & Service Providers	
Action on Elder Abuse	www.elderabuse.org.uk
Age NI	www.ageuk.org.uk/northern-ireland
Alzheimer's Society	www.alzheimers.org.uk
Apex Housing Association	www.apex.org.uk
Autism Initiatives	www.autisminitiatives.org
Autism NI	www.autismni.org
Bryson Intercultural (formerly Multi-Cultural Resource Centre)	www.brysonintercultural.org
Carers NI	www.carersuk.org/northernireland
Extern	www.extern.org
Independent Age	www.independentage.org

Independent Health and Care Providers	www.ihcp.co.uk
Mencap	www.mencap.org.uk
Mindwise	www.mindwisenv.org
NIAMH	www.niamhwellbeing.org
Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO)	www.niacro.co.uk
Northern Ireland Women's Aid Federation	www.womensaidni.org
Praxis Care	www.praxisprovides.com
Public Concern at Work	www.pcaw.org.uk
Simon Community	www.simoncommunity.org
United Kingdom Homecare Association	www.ukhca.co.uk
Volunteer Now	www.volunteernow.co.uk
Others	
AccessNI	www.nidirect.gov.uk/accessni
DBS	https://www.gov.uk/government/organisations/disclosure-and-barring-service
nidirect Government Services for Northern Ireland	www.nidirect.gov.uk
The Care Tribunal for Northern Ireland	www.courtsni.gov.uk/en-GB/Tribunals/CareTribunal
The Adult Safeguarding Hub (SAaRIH)	www.saarih.com
Helplines	
AccessNI	0300 200 7888
DBS	03000 200 190
Domestic and Sexual Violence	0808 802 1414
Elder Abuse	0808 808 8141
Lifeline	0808 808 8000
NIACRO (Belfast)	028 903 20157
Northern Ireland Housing Executive	03448 920 900

Go back to **Section 3.1**

Appendix 4

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 Keeping Adults Safe: 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.volunteernow.co.uk which organisations can use as a tool.

Standard 1 – The organisation has a written adult safeguarding policy supported by robust procedures and guidelines.

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date:
			What?	By whom?	By when?	
1. There is a written policy statement of the organisation's intention to keep adults safe from harm.						
2. There is an outline of the procedures and guidelines that the organisation will implement to meet this commitment, in line with the minimum standards.						
3. The adult safeguarding policy is supported by other organisational policies, procedures and guidelines aimed at promoting safe and healthy working practices.						
4. The policy is 'owned' at all levels within the organisation and the person(s) with responsibility for its approval, implementation and review is named.						
5. Everyone involved in the organisation is aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.						

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?	
1. There is a clear job description for staff and role description for volunteers and 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 form requesting information on previous convictions which are not protected, and investigations, if any.						
5. A consent form for an AccessNI disclosure check is completed, if required.						
6. There is an interview process appropriate to the post/role and task.						
7. Written references are sought (and followed up when necessary).						
8. If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.						
9. Where required, an appropriate AccessNI disclosure check is carried out.						
10. 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?	
1. There is an induction process for staff and volunteers.						
2. There is a probationary period for staff and a 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 for all staff and volunteers, 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/reviews.						

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?	
1. The policy outlines what constitutes adult abuse, where abuse can occur and who abuses.						
2. There is a written procedure outlining how staff and volunteers respond to, record and report adult safeguarding concerns.						
3. There is a system to communicate the reporting procedure to staff and volunteers to ensure they are familiar with it.						
4. There is an Adult Safeguarding Champion or appointed person who has responsibility for dealing with adult safeguarding concerns which come to light within the organisation.						
5. There is a procedure for the Adult Safeguarding Champion or appointed person to report adult safeguarding concerns to the appropriate authorities.						
6. There is a written procedure outlining how staff and volunteers respond to and report allegations made against staff and volunteers.						
7. There is a whistleblowing policy and procedure.						

Standard 5 – The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding adults.

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date:
			What?	By whom?	By when?	
1. A risk assessment is carried out to identify and evaluate risks to adults using services or participating in activities.						
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 all 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.						

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?	
1. The organisation has an ethos of inclusion, transparency and openness which is communicated to all involved in the organisation.						
2. There are appropriate procedures in place to share concerns or make complaints about the organisation.						
3. All identified risks and risk-reducing measures are recorded Complaints procedures are communicated appropriately to everyone involved in the organisation.						

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?	
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. Adults involved with the organisation should have access to information held about them.						

Standard 8 – There is a written Code of Behaviour which outlines the behaviour expected of all involved in the organisation.

Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date:
			What?	By whom?	By when?	
1. The Code of Behaviour (Code) contains positive statements about how staff and volunteers are expected to behave in their work with 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 money.						
8. The Code contains guidelines on the use of technology, including photography.						
9. The Code outlines sanctions in the case of staff and volunteers breaching the Code.						
10. The Code sets out an expectation that everyone involved in the organisation should relate to each other in a mutually respectful way						
11. The Code is tailored to organisational activities or services.						

“A Shared Responsibility helpfully sets the standard and assists organisations to tighten their procedures – that is to be welcomed.”

Michelle O’Neill MLA