

Islington Safeguarding Adults Partnership

Islington appendices to London safeguarding adults policy and procedure

Appendix A: Local contact details.....	2
Appendix B: Contact details of local and national support organisations	5
Appendix C: Quick guide for alerters	7
Appendix D: Establishment concerns process.....	9
Appendix E: Recognising abuse.....	12
Appendix F: Interviewing adults at risk (and their possible reactions)	15
Appendix G: Guidance on consent relating to sexual activity.....	17
Appendix H: The legislative framework.....	19
Appendix I: Protocol for inter-authority safeguarding adults investigations	50
Appendix J (containing sub-appendices 1-6) Serious Case Review Protocol	53

Please also refer to Islington's inter-agency information sharing policy and procedure, which can be found on Islington Council's website.

Appendix A: Local contact details

This appendix only includes contact numbers relevant to the reporting and investigating of abuse. Many more organisations have a role to play in protecting adults.

1. Social Services	
Address	Tel/Fax/Email
Information and Access Team: 57 Calshot Street N1 9XH This is the first point of contact. This team takes initial details and refers on to the most appropriate team.	020 7527 2299
	Safe-Haven Fax: 020 7527 5114 The fax can receive Alerts from outside Social Services
	access.service@islington.gov.uk
Emergency Duty SW Team 5pm – 9am weekdays, 24 hours at weekends and Bank Holidays	020 7226 0992
Archway Community Care Centre North Locality Adults 4 Vorley Road N19 5JH	020 7527 7500 020 7527 7507 (fax)
Calshot Community Care Centre South Locality Adults 57 Calshot Street N1 9XH	020 7527 6400 020 7527 6407(fax)
Canonbury Community Care Centre Mental Health Services 68 Halliford Street N1 3RH	020 3317 4850 020 7527 8207(fax) CMHT only accepts referrals from GPs
Drayton Park & Archway Community Mental Health Team 1 Lowther Road N7 8US	020 3317 6370 020 7690 3519 (fax – Drayton Park CMHT) 020 7690 3516 (fax – Archway CMHT) CMHT only accepts referrals from GPs
Elthorne Community Care Centre Mental Health Services 17-23 Beaumont Rise N19 3AX	020 7527 7300 020 7527 7307(fax) CMHT only accepts referrals from GPs
Learning Disabilities Service Islington Learning Disabilities Partnership 52 ^d Drayton Park N5 1NS	020 7527 6600 020 7527 6607(fax)

Sensory Team & BSL interpreting team 23-26 St Albans Place N1 0NX	020 7527 4443 020 7527 3279 (fax) 020 7527 3282 (minicom)
Whittington Hospital Social Work Team Ward MB3 Highgate Hill N19 5NF	020 7288 5260 020 7288 5262(fax)
2. Children's Social Services	
Referral and Advice Team (Monday to Friday 9am to 5pm)	020 7527 7400
Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays)	020 7226 0992
3. Police	
Islington Police Station 2 Tolpuddle Street, N1 0YY	0300 123 1212 Central Switchboard
Community Safety Team / Officer	020 7421 0174
http://cms.met.police.uk/met/boroughs/islington/06advice and support/community safety unit csu http://www.met.police.uk/reporting_crime/index.htm	
4. Inspection	
Care Quality Commission Finsbury Tower 103 – 105 Bunhill Row London EC1Y 8TG	Helpline 03000 616161
5. Independent Safeguarding Authority	
PO Box 181 Darlington DL3 9FA (for referrals to the Employment Barring list)	Helpline: 0300 123 1111 info@vbs-info.org.uk
6. For Advice	
Head of Safeguarding Adults	020 7527 8160

Islington Council/NHS Islington 338-346 Goswell Road, London EC1V 7LQ	020 7527 8162
Safeguarding Training Courses Rachel Adelson-Kettle	020 7527 8883

Appendix B: Contact details of local and national support organisations

Local

Islington Victim Support www.vslondon.org 1 Highbury Crescent London N5 1RN	Helpline: 0845 303 0990 (24 hours) or 020 7700 6014 vs.islington@vslondon.org
Independent Mental Capacity Advocate (IMCA) Advocacy Partners	0845 0175198

Local (domestic violence)

Home Safe (children & families)	020 7527 5778
Independent Domestic Violence Advocacy Service (for professionals only 10-4 Mon –Fri)	020 7281 9284
Women’s Aid advice and support following violence	020 8269 2121
Single Homeless Project	referral line: 020 7520 8660 client support line: 0800 783 8993
Criminal Injuries Compensation Authority (CICA) www.cica.gov.uk	(claims) 020 7842 6800
Women’s Therapy Centre (individual & group psychotherapy)	020 7263 6200
Women’s Alcohol Centre	020 7272 8214

National (for victims)

Voice UK (for people with learning disabilities)	0845 1228695
Criminal Injuries Compensation Authority	0800 358 3601
Domestic Violence (24 hour)	0808 2000247
Men’s Advice Line & Enquiries	0845 0646800
Women’s Aid Federation (24 hour)	0808 2000247
Rights of Women	0116 255 6234

(legal advice on relationship breakdown)

Samaritans www.samaritans.org

0845 790 9090

National (for agencies)

Resource Information Service

(hostel advice to agencies)

020 7939 0641

Forced Marriage Unit British Nationals

020 7008 0151

National (for people causing harm)

Respect

Help for perpetrators of domestic violence

0845 122 8609

Respond

For victims or perpetrators of sexual abuse & other trauma, who have learning disabilities.

Helpline: 0808 808 0700

Appendix C: Quick guide for alerters

What is 'safeguarding adults'?

'Safeguarding Adults' means making sure that adults at risk live free from abuse and neglect. This used to be called 'Adult Protection'. Everyone working in public services has a responsibility to report suspicions or allegations of abuse of adults at risk and children.

Who is an adult at risk?

An 'adult at risk' is someone who is 18 years or over who may be in need of community care. As a result of their mental or other disability, age or illness, they will find it difficult to protect themselves from abuse. Children can also be at particular risk of abuse and neglect.

What is abuse?

There are many different types of abuse; some examples are:

- Physical
- Sexual
- Emotional/psychological
- Financial/material
- Neglect/acts of omission
- Discriminatory
- Institutional

Lots of different people may abuse adults at risk; some examples are:

- People who deliberately target adults at risk
- Members of the adult at risk's own family and friends
- People who are employed to care for adults at risk

Sometimes people are not actually aware that they are abusing someone. Carers of adults at risk may become abusive because they are stressed and tired. It is still important that you report these situations, as Social Services can help to reduce pressure on stressed carers.

What are the signs of abuse?

There are many signs of abuse – ask if you are not sure! Some examples are:

- The person looks dirty or is not dressed properly
- The person never seems to have money
- The person has an injury that is difficult to explain
- The person seems frightened

There may be other explanations but these are often signs of abuse.

What should I do if I suspect abuse?

- If there is a risk of immediate harm to the adult and/or others:
 - Take yourself out of danger
 - Call 999
- If there is no immediate risk but you think abuse or neglect may be a problem:
 - Call the Social Services Access Service on Tel: 020 7527 2299
- If you think another colleague or professional person is abusing an adult at risk:
 - Report this to your line manager.
 - If you are unhappy with their response or do not feel you can approach them then call the Social Services Access Service (Tel: 020 7527 2299).
 - You might feel worried about reporting your colleagues. Remember that it is difficult for adults at risk to report abuse and they rely on you to help them.
- If you think a child is at risk, and it is an emergency, call 999.
- If you think a child is at risk, but it is not an emergency, call the Referral and Advice Team (Monday to Friday 9am to 5pm) on 020 7527 7400, or the Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays) on 020 7226 0992.

What happens next?

We will look into your concern.

Depending on what we find, we may take action to safeguard the adult at risk from harm.

Do you suspect abuse? Tell us now.

Islington Adult Social Services Access Service

Tel: 020 7527 2299 | Email: access.service@islington.gov.uk | Fax: 020 7527 5114

Appendix D: Establishment concerns process

Background information

The Establishment Concerns Process (ECP) is invoked to address serious concerns within an establishment. The threshold for an ECP is likely to be the occurrence of more than one serious incident involving more than one service user and/or more than one staff member within an establishment.

For the purposes of this process, an 'establishment' is defined as a provider of care to adults at risk. This can be a care home, hospital, supported accommodation or provider of care in the community

The definition of a 'serious incident' is an adult safeguarding incident where a service user or service users have suffered actual harm or sustained physical or psychological injury or financial or material loss which, on the basis of evidence has been caused by neglect or abuse.

Key stages

Stage 1: Decision to invoke the ECP

The decision to invoke the ECP will be taken by the Development Manager, Safeguarding Adults and the appropriate Assistant Director within Strategy and Commissioning.

The incidents affecting service users will be individually investigated in the usual way via the Safeguarding Adults procedures. This would include inviting the service user or their advocate/family member to attend a safeguarding meeting following the individual investigation, to determine actions required if abuse/neglect is substantiated. The findings (with a statement of probability as to what occurred in each case) must be fed back within an Establishment Concerns meeting.

Stage 2: Initial strategy meeting and notification

Once it has been agreed to invoke the ECP, a meeting will be called with relevant parties.

The establishment about which the concern has been raised will be notified in writing that the ECP has been invoked. They will be informed of the allegations at the earliest possible opportunity. If there is a Police investigation, they will be informed in accordance with Police advice.

The Development Manager Safeguarding Adults will inform the Care Quality Commission (CQC) that the ECP has been invoked, and the CQC will be invited to participate.

The initial strategy meeting will clarify roles and responsibilities, particularly:

- The chair (who will be responsible for coordinating all pieces of work within the process).
- The administrative support.
- The link worker for user/carer/relatives
- The lead responsible for drawing up terms of reference for the external investigation (if appropriate).
- Date of next and any subsequent meeting of the ECP.

Stage 3: Service user involvement

Service users or their advocates/family members will be invited to attend a safeguarding meeting following the individual investigation (see Stage 1 above) to determine what action is required once suspicion of abuse or neglect has been substantiated. Service users, their advocates/family members would not be invited to attend ECP meetings which will by nature involve discussion of potentially sensitive details about more than one individual service user or staff member. Accordingly it is important that information which relates to or identifies other service users is only shared on a 'need to know' basis using the Caldicott Principles as follows:

- Justify the purpose
- Do not use personally identifiable information unless it is absolutely necessary
- Use the minimum personally identifiable information
- Access to personally identifiable information on strict need to know basis
- Everyone should be aware of their responsibilities
- Understand and comply with the law.

Stage 4: Central file

One central shared file will be set up for each ECP investigation. This file will only be accessible by Council and NHS Islington staff involved in the specific ECP, with password protection shared only with participants. All minutes will record key decisions and agreed actions to be followed up at the next meeting.

Stage 5: Investigation and report

The ECP would be informed by the outcome of the individual Safeguarding Adults investigation or investigations (see guidance on the Safeguarding Adults investigation process), unless there are exceptional reasons for a further investigation to be undertaken. This minimises the repeated questioning of the adults at risk and witnesses (as per the National Framework for good practice and Outcomes in Adult Protection Work published by the ADSS).

Once the investigation report (or reports in the case of more than once investigation) is written, it will be presented to the ECP meeting and will form the basis of the discussion to agree an action plan to minimise the risks of future abuse or neglect within the establishment.

The ECP may need to take decisions or make recommendations for an action plan in advance of completion of investigations in order to address urgent concerns about adults at risk.

Should the ECP conclude that there is no cause for concern then this decision will be recorded and the establishment and CQC informed.

Stage 6: Implementation of the Action Plan in cases where abuse/neglect are established

Where there are issues to be addressed, the action plan will be agreed with involved parties/agencies (see Stage 5 above). The action plan will be monitored over an agreed period of time, with a final concluding statement issued that will record the progress of the establishment to reach the required standard, or the need for any alternative actions that have been undertaken. This statement should be taken to Housing and Adult Social Services Senior Management Team or NHS Islington Senior Management Team for sign-off.

Stage 7: Concluding Statement

At the point of writing the concluding statement (see Stage 6 above) at the end of an ECP the group will review actions that have been taken and lessons learnt that will be included in a Summary Report to the Quality, Audit and Assurance sub group of the Islington Safeguarding Adults Partnership Board and the appropriate Senior Management Team.

Appendix E: Recognising abuse

<p>1. Physical Abuse is the use of force which results in pain or injury or a change in the person's natural physical state</p>	
<p>Examples: Punching Slapping Hitting Shaking Pinching Burning/scalding Enforced sedation Forced feeding The use of excessive restraint Catheterisation for ease of "management"</p>	<p>Possible Indicators: Black eyes Welt marks Fractures Sprains Dislocations Drowsiness Lacerations Pressure sores Unexplained injuries Scalds/cigarette burns Bruises (especially in well protected areas) Confusion due to over sedation Delays in seeking medical attention Anxiety or fear more evident in the presence of a possible abuser</p>
<p>2. Sexual Abuse is the involvement of an adult at risk in sexual activities or relationships which</p> <ul style="list-style-type: none"> i. They do not want and have not consented to; or ii. They cannot understand and are not able to consent to <p>(Please see Appendix 1 for further guidance on consent) Every person has a right to engage in sexual activities that are lawful and wanted and understood without being exposed to exploitation or sexual violence Sexual activity between employed staff and an adult at risk is never acceptable and will always be regarded as sexual abuse</p>	
<p>Examples: Enforced sexual contact Harassment Serious teasing or innuendo Sex for reward Pornographic photography Enforced witnessing of sexual acts or sexual media Penetration or attempted penetration of vagina, anus, mouth, with or by penis, fingers, other objects</p>	<p>Possible Indicators: Changes in behaviour (e.g. more withdrawn, depressed, confused, fearful, agitated) Difficulty in walking or sitting Torn, bloody or stained underclothes Pain or itching in the genital area Bruising or bleeding in external genitalia, vaginal or anal areas Venereal disease Sexualised behaviour</p>

<p>3. Psychological Abuse is behaviour that has a harmful effect on an adult at risk's emotional health and development</p>	
<p>Examples: Absence of warm support or human contact Swearing Insults Humiliation Shouting Threats Intimidation Ignoring Racist abuse Lack of stimulation Enforced isolation Confining or locking someone in Depriving an individual of the right to choice, information and privacy, respect Preventing access of other people in the home</p>	<p>Possible Indicators: Fear Passivity Confusion Wandering Depression Withdrawal Running away Mental anguish/anxiety Loss of independence Low self-esteem Behaviour which is out of character Uncontrolled/unprovoked crying Unusual weight loss or gain A lock on the outside of room Disturbed sleep pattern A physical environment that does not allow access to other parts of the home</p>
<p>4. Financial & Material Abuse is the use of an adult at risk's property, assets, income without their informed consent or making financial transactions which they do not comprehend (unless this is legally sanctioned)</p>	
<p>Examples: Deprivation of money/benefit Taking possessions Fraud, Stealing or misappropriating money Using pressure to obtain rights to property or to give money away, including in Wills Financial transaction between staff and service user without explicit written consent of a service manager Inducing a person to pay for goods or services from or on behalf of the recipient where this is not a reasonable expectation or where the sums paid would be considered excessive</p>	<p>Possible Indicators: A "disappearing" pension Homelessness Hypothermia Malnutrition Inadequate clothing Insufficient money to purchase basic necessities Inadequate money to pay bills etc Inadequate heating/lighting Sudden and/or large withdrawal from bank etc Legal documents requiring signature</p>

<p>5. Institutional Abuse is the regimentation of residents/users of a service</p>	
<p>Examples: (also see above categories) Undue restraint due to staff shortages (low seated chairs, cot sides, harness, use of sedatives / other drugs, withholding drugs, etc. Lack of choice about bed times, meals etc. Lack of respect for a person's environment such as smoking in a person's home, or playing music/watching TV that reflects staff interest rather than that of the service user Denial of privacy such as absence of screens, leaving toilet doors open etc. Lack of supervision resulting in intentional/accidental harm, poor safety, pressure sores Lack of stimulus or recreational activity Lack of consideration of a person's language, cultural or dietary needs Punishment for perceived "bad" behaviour Lack of promised care Personal possessions or money used for someone else</p>	<p>Possible Indicators: Poor management of life in the living environment Poor standards of cleanliness Low staffing levels over a long period of time Low staff morale High staff turnover Lack of knowledge about care guidelines; staff factions: Lack of positive communication with residents Punitive treatment of residents/patients Staff ordering residents around Low level/absence of staff training</p>
<p>6. Discriminatory Abuse is slurs or similar treatment that is based upon a person's race, gender, sexual orientation, disability, age, religious or other beliefs and other forms of harassment</p>	
<p>Examples: Isolation from religious or cultural activities or antipathy to a religion or cultural activity Racial harassment Refusal to accept support from services Remarks or actions or being treated unfairly because of a person's disability or sexual orientation.</p>	<p>Possible Indicators: Unable to eat culturally acceptable foods Religious observances not encouraged or anticipated Isolation due to language barrier</p>
<p>7. Neglect And Acts Of Omission is behaviour which results in the adult at risk's basic needs not being met</p>	
<p>Examples: Failure to provide adequate health care Failure to provide adequate food/drink Failure to provide a safe and adequately heated environment, Failure to assist with appropriate levels of hygiene</p>	<p>Possible Indicators: Dehydration Malnutrition Infections Hypothermia Inadequate clothing Pressure sores Unexplained failure to respond to prescribed medication</p>

Appendix F: Interviewing adults at risk (and their possible reactions)

1. This practice note gives some guidance on interviewing adults at risk and some of the common reactions to abuse. Interviewing is often a complex task requiring careful planning beforehand. In many cases an adult at risk will have limited communication and understanding.
2. Points to note before interviewing:-
 - Avoid reaching conclusions about the suspected abuse before the facts are known
 - Consult with an IMCA if appointed.
 - Ensure that any communication difficulties are recognised prior to the interview.
 - The location of the interview must ensure privacy, safety and lack of interruption
 - Allow time, remain calm, unhurried and non-accusatory
 - Be clear about confidentiality and explain that information will only be shared on a "need to know" basis explaining also what that means
 - Be aware of making stereotypical judgements about race, gender sexuality and disability
 - Informing the interviewee of purpose of interview - think beforehand about how you will explain why you are there. It is important not to alarm the interviewee and to establish rapport first. You may initially want to indicate general concern, rather than explain an allegation of abuse has been made
 - Encourage the person to talk (free narrative). If you need specific information use open-ended questions (i.e. What? How?) without leading the person towards a particular response. This should invite more detailed, spontaneous responses.
 - Take account of background information: family history and dynamics, assessment of level of dependency, assessment of needs of carers, what services are being provided, physical and material environment.
 - When closing the interview, summarise what you understand they have said and invite them to ask you questions. Ensure that they are thanked for this, and you can recognise it may have been a difficult experience for them. Let them know what will happen next and who they can contact if concerned about something later on.
3. Victims of abuse do not always react in the same way. However, some of the more common reactions are as follows:
 - Denial that anything is wrong and even an emphasis that all is extremely well
 - Acceptance or resignation of their situation as part of being old and/or disabled
 - Withdrawal from normal activities through a continuum to a total lack of communication
 - Depression which can either happen very suddenly or gradually emerge

- A dramatic change of behaviour/personality: this can happen very suddenly and unexpectedly and is often associated with fear. This may indicate an attempt at self-protection
- Physical or verbal outbursts or displays of anger that are out of character
- Confusion: this can be characterised by a sudden onset or a marked deterioration in a previously confused person
- Seeking help from numerous sources/people. This may be a direct request for help or attention seeking behaviour.

Appendix G: Guidance on consent relating to sexual activity

1. Consent is the crucial issue in determining whether a particular act, relationship or situation is abusive of an adult at risk.
2. The two pertinent questions are:
 - Whether the adult at risk did give her/his consent? **And**
 - Whether the person could give her/his consent?
3. Abuse occurs when:
 - The adult at risk withholds consent; or
 - The person is unable to give her/his consent because the severity of her/his learning disability/mental illness significantly undermines her/his understanding of the basic elements of sexual behaviour; and/or
 - The individual is subject to a degree of pressure which prevents the individual making a free personal choice. If the person is unable to think "about" or "through" sexual behaviour in any of the following ways, then s/he is not in a position to consent to sexual activity:
 - Making sense of what has been done to her/him and/or construing the sequence of behaviours as a sexual act
 - Appreciating the appropriateness or inappropriateness of particular behaviour
 - Appreciating the value accorded to sexual acts
 - Appreciating the possible consequences of sexual acts
4. Even where a person is able to make such judgements, there may be other factors, which mitigate against freely given consent. They are:
 - The presence of a parental or familial relationship between the persons involved (excluding husband and wife); this may involve the offence of incest
 - The presence of a custodial or care-taking relationship between the persons involved; sexual activity between employed care staff and adults at risk should always be viewed as abusive
 - The use of a weapon, threat of injury, or use of force
 - The presence of a power imbalance between them which precludes consent by the weaker person
5. The criminal law is applicable in some of these situations.
6. Where there are concerns about the mutuality of the relationship and/or consent of one of the individuals the same process of determining whether there is consent should be worked through.
7. Factors, which may indicate mutuality, are:
 - Both parties seeking each other out
 - Spending spare time together
 - Sharing leisure activities
 - Sharing resources equally

- Restricting activities with other potential partners

Appendix H: The legislative framework

- Procedures for responding to suspected abuse of adults at risk is not underpinned by a specific legislative framework as they are for children. Nevertheless a range of legislation does exist which may be applicable to the protection of adult at risk. Adult abuse can be dealt with under the criminal law. The application of which requires a joint approach by the police, Islington Housing & Adult Social Services and other relevant agencies. In cases of domestic violence, criminal and civil remedies exist.
- The NHS and Community Care Act 1990 - Section 47, which requires Local Authorities to carry out assessments where it appears that people are in need of services, provides the general legislative framework for protecting adults at risk. Adults at risk who are abused or at risk should be regarded as having a high priority under this Act.
- Other legislation, including the Mental Health Act 1983, which specifically deals with adults at risk who are mentally disordered, is more interventionist. This legislation should, as a rule, only be used as a last resort in cases of abuse and then only after multi-agency discussion.
- The Mental Capacity Act implemented in April 2007 introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks, or is believed to lack, mental capacity. At an early stage, if it appears that the adult at risk may lack capacity to make any decision related to or arising as a result of the suspected abuse, there will be a need to consider whether to appoint an Independent Mental Capacity Advocate (IMCA). An IMCA should be appointed where the adult at risk is un-befriended – which in this context would mean there is no friend or family who can speak on their behalf. Where all potential friends/family are either suspected or potential abusers or compromised by their connection to the suspected abuse(s), the adult at risk is likely to be regarded as un-befriended and an IMCA appointed.
- The Safeguarding Vulnerable Groups Act 2006 introduced a new ‘Vetting and Barring Scheme’, to vet staff and volunteers, prior to them working with vulnerable groups. The Scheme is administered by the Independent Safeguarding Authority (ISA) and began in October 2009 but more information is required as the rollout of this scheme has been delayed by national government¹. It replaces the Protection of Vulnerable Adults (POVA) list.
 - Under the scheme regulated activity providers are under a duty to make referrals to the ISA of the names of staff and volunteers who have been found to have harmed or put at risk of harm a child or a “vulnerable” adult. The ISA will make a judgement on the evidence whether the person should be barred from any future employment

¹ The Coalition Government has announced a delay to the introduction of the new Vetting and Barring Scheme in its current format, Registrations for new employees was expected to start from July 2010. It is expected that there will be changes to scale back the scheme, please see the link to the Independent Safeguarding authority website for more information, <http://www.isa-gov.org.uk/>

or activity with vulnerable adults. Professional regulators and local authorities also have a duty to refer as leads in safeguarding adults.²

- Mechanisms introduced by the General Social Care Council will further complement and strengthen safeguards for the protection of adults at risk.
 - Responsibility for making a referral to the ISA and/or to relevant professional bodies such as the General Medical Council, Nursing and Midwifery Council and General Social Care Council, rests with the employer. Professional regulators including the CQC and local authorities also have a duty to refer as leads in safeguarding adults where the regulated activity provider is the subject of the referral or where they have failed to make the appropriate referral.
- The proper and wise use of legislation should not be avoided, as in some instances abuse may constitute a criminal offence.
 - The relevant legislation and guidance are summarised in Appendix 1. It is important for the actual legislation to be consulted directly in relation to individual situations. Guidance can be sought from the Local Authority's Legal Section and/or the police, where necessary. If intervention under the Mental Health Act appears appropriate, an Approved Mental Health Professional must be involved at an early stage.

1. Safeguarding the welfare of adults at risk

1.1 People with a mental disorder – the Mental Health Act 1983

1.1.1 Current Situation

The Mental Health Act (1983) deals with the reception, care and treatment of mentally disordered patients, the management of their property and other related matters. There are four categories which come within the definition of "mental disorder". Three of the categories are "mental impairment", "severe mental impairment" and "psychopathic disorder". For any of these definitions to apply, the conditions must be associated with "abnormally aggressive or seriously irresponsible conduct" on the part of the persons concerned. The fourth category of "mental disorder" is mental illness.

In considering whether it is appropriate to use the Mental Health Act 1983 in situations of alleged abuse, regard should be taken of the mental health needs of the alleged perpetrator as well as the alleged victim, as sometimes abuse may be due to the mental disorder of the alleged perpetrator.

² Independent Safeguarding Authority Vetting and Barring Scheme www.isa.gov.org.uk

The most relevant parts of the Mental Health Act for the purpose of these guidelines are likely to be:

- Sections 2, 3 and 4 – deal with the compulsory admission to hospital, for assessment or treatment, of a person who is suffering from a mental disorder of a nature or degree which warrants detention in the interests of her/his health or safety or for the protection of others. Applications under these parts of the Act can be made either by the person's nearest relative or by an Approved Mental Health Professional (AMHP), and supported by two doctors. A person suffering from a psychopathic disorder can only be detained for treatment if treatment is likely to alleviate or prevent a deterioration of their condition (known as the "treatability" test).
- Section 115 – under this section, an ASW/AMHP can enter and inspect any premises where a mentally disordered person is living if s/he has reasonable cause to believe that the patient is not under proper care. This Section does not give an ASW/AMHP power to enforce an entry, although a person refusing her/him entry may commit an offence under Section 129.
- Section 135 – under this section, an application can be made by an ASW/AMHP to a magistrate to enter premises with a police constable to remove a person believed to be suffering from a mental disorder to hospital or an alternative place of safety for up to 72 hours, where there is reasonable cause to suspect that the person believed to be suffering from a mental disorder has been ill-treated or neglected or kept otherwise than under proper control or is unable to care for her/himself and is living alone.
- Section 7 (Guardianship) - a person, aged 16 or over, may be received into guardianship provided s/he suffers from a mental disorder of a nature or degree which warrants guardianship and guardianship is necessary for the welfare of the patient or the protection of others.

An application for guardianship can be made by an AMHP or the person's nearest relative and supported by two doctors.

Guardianship initially lasts for six months but may be renewed for a further six months and annually thereafter.

The guardian may be either the Social Services Department or a person who is acceptable to the Department. Once appointed, the guardian has the power to require the patient to live at a specified place, to attend at places and times specified for the purpose of medical treatment, occupation, education or training. They can require access to be given for example to doctors, or ASW/AMHPs, at any place where the person is living,

The Code of Practice of Mental Health Act (1983) sets out the purpose of guardianship as being to "enable patients to receive community care where it cannot be provided without the use of compulsory powers". It enables the establishment of an authoritative framework for working with a patient with the minimum of constraint to achieve as independent a life as possible within the community. Where it is used, it must be part of the patient's overall care and treatment plan. The code also outlines the essential components of effective guardianship.

- Section 117 – this sets out a duty owed to persons who have been compulsorily detained under the Act and have been discharged, for provision of aftercare services by the PCT or Health Authority and the local social services authority.

Other related legislation is:

- Mental Health (Patients in the Community) Act 1996
- Mental Health (After Care under Supervision) Regulations 1996. This Act provides a new framework for the supervision of patients aged 16 and over detained for treatment, under Section 117 of the Mental Health Act 1993.

1.1.2 Mental Health Act Code and 2007 Act amendments to the 1983 Mental Health Act

The Mental Health Act 2007 amends the Mental Health Act 1983 and took effect from the 3rd November 2008. The Mental Health Act 2007 does not abolish the Mental Health Act 1983; the old Act continues to exist but has key amendments brought in by the new Act. The new Code of Practice has been published on the Department of Health's website on <http://www.dh.gov.uk/publications>.

There are 9 key changes to the amended Act and 5 guiding principles that guide practitioners in how to apply the Act and Code in individual situations. Please see the key changes listed below.

These are the main changes to the 1983 Act made by the 2007 Act, as stated by the Care Services Improvement Partnership on their website:- (<http://www.mhact.csip.org.uk/news/latest-news/summary-of-the-amendments.html>):

- Definition of Mental Disorder: it changes the way the 1983 Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder. These amendments complement the changes to the criteria for detention.
- Criteria for Detention: it introduces a new "appropriate medical treatment" test which will apply to all the longer-term powers of detention. As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient At the

same time, the so-called “treatability test” will be abolished.

- Professional Roles: it is broadening the group of practitioners who can take on the functions currently performed by the Approved Mental Health Professional and Responsible Medical Officer (RMO).
- Nearest Relative (NR): it gives to patients the right to make an application to displace their NR and enables County Courts to displace a NR where there are reasonable grounds for doing so. The provisions for determining the NR will be amended to include civil partners amongst the list of relatives.
- Supervised Community Treatment (SCT): it introduces SCT for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again - the so-called “revolving door”.
- Mental Health Review Tribunal (MHRT): it introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England, the one in Wales remaining in being.
- Age Appropriate Services: it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
- Advocacy: it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.
- Electro-convulsive Therapy: it introduces new safeguards for patients.

In addition to the changes listed, the 2007 Act makes changes to the Mental Capacity Act (MCA) providing for procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent. (See section 1.2 *Persons Who Lack Capacity*, below).

1.2 People Who Lack Capacity - The Mental Capacity Act 2005

1.2.1 Introduction

The Mental Capacity Act 2005 (“MCA”) provides a statutory framework to protect people who lack capacity to make certain decisions. The MCA also works to protect carers and professionals when making decisions on behalf of persons who lack capacity. It makes it clear who can take decisions on behalf of a person who lacks capacity, in which situations and how they should go about this. The Act starts from the fundamental point that a person has capacity and that all practical steps must be taken to help the person make a decision. The Act was fully implemented from October 2007 and must now be complied with.

1.2.2 Key principles

The key principles of the MCA are:

- Presumption of capacity: A person must be assumed to have capacity unless it is established that he or she lacks capacity.
- Maximising decision-making capacity: A person is not to be treated as unable to make a decision unless all practical steps have him/her to do so have been taken without success.
- Unwise decisions: A person is not to be treated as unable to make a decision because s/he makes an unwise decision.
- Best Interests: An act done, or a decision made, on behalf of a person who lacks capacity to decide for him/herself must be done or made in his/her best interests.
- Least restrictive alternative: When an act is done, or a decision made, on behalf of someone who lacks capacity to do so him/herself, regard must be had to what is the least restrictive of the person's rights and freedom of action.

1.2.3 When will a person lack capacity?

Capacity is decision specific. The MCA makes it clear that you cannot refer to someone as lacking capacity generally, but rather, you must look at whether a person lacks the capacity to make the specific decision in question.

Assessing capacity

Anyone assessing capacity should use the two-stage test of capacity:

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their brain works?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Stage 1 of the test is known as a "diagnostic threshold". The Code of Practice for the MCA gives the following examples of where a person may have an impairment in or disturbance of the function of the mind or brain:

- Conditions associated with some forms of mental illness;
- Dementia
- Significant learning disabilities;
- Long-term effects of brain damage;
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness;
- Delirium;
- Symptoms related to head injury;
- Symptoms of alcohol or drug use.

Stage 2 of the test, is the inability to make the decision in question. The MCA provides that people are unable to make a decision for themselves if they cannot:

- Understand information about the decision to be made;
- Retain the information for long enough to use it to make the decision;
- Use or weigh the information as part of the decision making process; or
- Communicate their decision (this can include non-verbal forms of communication).

Some people will experience fluctuations in their capacity to make specific decisions. An assessment of a person's capacity to make a decision should be done when the decision is to be made and where at all possible, making a decision for a person who temporarily lacks capacity should be put off until capacity is regained.

1.2.4 Assessment of Capacity

Who makes an assessment of a person's capacity will depend on the decision to be made. For most day- to- day decisions, (for example, when to get up, what to eat), the carer most directly involved with the person's care at the time the decision has to be made should assess the person's capacity to make the decision. Where a legal transaction is involved, such as making a will or a Lasting Power of Attorney, the solicitor handling the transaction must decide whether the person has the required capacity, and may ask for the opinion of a doctor. Where consent to medical treatment or examination is required, the doctor proposing the treatment must decide whether the patient has the capacity to consent to or refuse treatment.

The more complicated or serious the decision is, the greater the degree of professional expertise required to assess whether a person has the capacity to make it. An assessment from a psychiatrist or other mental health professional will not always be needed to assess a person's capacity to make a specific decision. Where an expert's opinion is sought, it does not substitute for the decision of the person or agency required to make the decision ("the decision maker"); it is used to inform the decision maker only.

A formal expert's assessment of capacity must be obtained where:

- A person's capacity to sign a legal document could be challenged;
- Where it must be established that a person who is or is likely to be involved in litigation requires the assistance of the Official Solicitor or other litigation friend;
- Where the Court of Protection or other court is required to make a decision as to whether a person has or lacks capacity about a particular matter;
- Where there may be legal consequences of a finding of capacity.

A lack of capacity cannot be established merely by reference to a person's age, appearance, a condition they have, or an aspect of

behaviour which might lead others to make unjustified assumptions about his capacity. This applies to people with a mental illness or disorder who are detained for treatment under section 3 of the Mental Health Act 1983; for example, it cannot be assumed that such persons lack capacity to make **all** decisions, including decisions regarding medical treatment outside of treatment given under s3 Mental Health Act 1983.

When assessing a person's capacity to make a specific decision, the following steps must be taken:

- All practicable steps to maximise a persons capacity including, for example, the use of simple language or visual aids in order to help the person understand the decision in question. The assessor must permit, encourage and improve the person's ability to participate;
- Consider whether the person can retain the information for long enough even if it is only a short period;
- Consider whether the person will regain capacity to decide at some point and if so, when that will be?
- Make sure the person has all the information or sufficient information in order to make the particular decision.
- Make sure that the information is explained or presented in a way that is easiest for the person to understand.
- Take into account whether there are particular times of the day when the person's understanding is better or locations where they feel more at ease. Consider postponing the decision to another occasion if that would be better.
- Consider whether the person can be helped or supported to make choices or express a view, by someone else, such as a relative or an independent advocate. If so, arrange for that to happen.
- Reach a decision based on the balance of probabilities; it is more likely than not that the person lacks capacity, but remembering that there is a presumption of capacity.

The graver the consequences of the decision the greater the level of competence is required to make the decision. A legal case, *RET, (an Adult) (Consent to Medical Treatment) [1993]* gives some background to this and if there is any doubt, contact should be made with legal services.

1.2.5 Best Interests checklist

Someone who makes a decision on behalf of a person who lacks capacity to make it themselves must only do so in the best interests of that person, and it must be the least restrictive of their basic freedoms. The decision maker must consider the following:

- Whether it is likely that the person will at some time have capacity for the decision in question and if so, when?
- So far as is reasonably practicable, encourage the person to participate as fully as possible in any decision.
- If the decision relates to life-sustaining treatment he must not be motivated by a desire to bring about death.
- Consider past and present wishes and feelings however expressed, any written statement made when he had capacity, the

beliefs and values that would be likely to influence his decision if he had capacity, the other factors he would consider if he had capacity.

- He must consult anyone named by the person as someone to be so consulted.
- Anyone caring for the patient or interested in his welfare, any person appointed under a Lasting Power of Attorney.
- Any Deputy appointed by a Court.
- The views of an Independent Mental Capacity Advocate (IMCA), if one has been engaged
- Any close friends or relatives interested in his welfare

NOTE: No-one can consent on behalf of patient to sexual relations, marriage, divorce, adoption or to vote.

The Court of Protection now has jurisdiction to make declarations as to what is in the best interests of a person who lacks capacity. The MCA has also brought in:

- the ability for people to appoint others, under a Lasting Power of Attorney (“LPA”), to make welfare decisions for them when they lose capacity;
- the ability for the Court of Protection to appoint a Deputy who can make ongoing welfare decisions for a person.

Persons acting as a Deputy or a donee under a LPA must follow the principles of the MCA and act in the best interests of the person who lacks capacity.

Agencies must act in the best interests of persons who are unable to make decisions themselves. If there is a conflict between what an agency believes and what a person appointed under an LPA or a Deputy believes is in a person’s best interests, the matter should be resolved by the Court of Protection. It may also be appropriate to refer the matter to the Court of Protection in other disputes about best interests of a person lacking capacity, between agencies and other persons, most often friends and relatives of the person lacking capacity.

The consequences of taking decisions for people who lack capacity under the MCA, with the reasonable belief that the decision taken is in the persons best interests, is that carers/professionals will be protected from liability.

1.2.6 Independent Mental Capacity Advocates

The MCA creates a role for special advocates, the Independent Mental Capacity Advocates (IMCAs). The role of an IMCA is to support and represent the person who lacks capacity.

An IMCA **must** be instructed where:

- A local authority proposes to provide a person who lacks capacity with residential accommodation (under s21 National Assistance Act 1948 or under s117 Mental Health Act 1983), or make a change to the person's residential accommodation, for longer than eight weeks and there is no person whom it would be appropriate person to consult with about the person's best interests;
- An NHS body proposes to provide a person who lacks capacity with accommodation (in a hospital for longer than 28 days, or in a care home for longer than eight weeks), or change the person's accommodation to another hospital or care home (for the same length of time as above) and there is no person whom it would be appropriate to consult;
- An NHS body proposes to provide serious medical treatment to a person who lacks capacity and there is no appropriate person to consult.

There is a power to instruct an IMCA where:

- A local authority or an NHS body are to conduct a care review and there is no person whom it would be appropriate to consult;
- In adult protection cases (where adult protection procedures have been initiated), whether or not there are family, friends or others could be consulted.

See sections 35-41 MCA, Code of Practice for the MCA and Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (Expansion of Role) Regulations 2006.

1.2.7 Code of Practice

A Code of Practice has been produced by the Department of Health. Persons making best interests decisions for people who lack capacity must be aware of the Code and have regard to it when acting and making decisions. There are also guides for people who require assistance, informal carers and professionals which can be downloaded from: -

www.dca.gov.uk/legal-policy/mental-capacity/mca-guide-for-professionals.pdf

1.2.8 Deprivation of liberty

The MCA defines restraint as the use of threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if:

1. The person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity

2. The restraint used is proportionate to the likelihood and the seriousness of the harm

So while reasonable restraint is permitted, detention of a person's liberty is not permitted. The issue of deprivation of a person's liberty, where they lack capacity to make decisions about their living and care arrangements, is a problem that was highlighted in the famous case of HL v UK (2005) EHRR 32, also known as the *Bournewood* case. Sometimes where the decision made on behalf of a person lacking capacity is for them to remain in a care home or a hospital, it will cross into a deprivation of liberty. In the *Bournewood* case, the court said that the difference between *mere restriction* and *deprivation* of liberty is one of "degree and intensity", not one of "nature and substance". Factors which may relate to the degree and/or intensity of the placement include:

- a. the type of care involved;
- b. how long the situation lasts;
- c. the effects of the situation on the person;
- d. how the situation came about and how the care is implemented;
- e. whether the person is 'free to leave' at all.

There are times when the local authority, or other person/agency responsible for the person who lacks capacity's care, will decide that it is in the person's best interests to remain under certain care arrangements which amount to a deprivation of liberty. At the moment, only the Court of Protection can authorise such a deprivation of liberty in a person's best interests. Before proceeding with an application to the Court of Protection, it is advisable to consider whether guardianship under the Mental Health Act 1983 is applicable for requiring a person to live at a certain place.

The Mental Health Act 2007 amends the MCA and creates a procedure to authorise deprivations of liberty in the best interests of a person who lacks capacity to make decisions about where they should live and their care or treatment. These are known as the 'deprivation of liberty safeguards' and came into effect on 1 April 2009. Under the procedure, where a hospital or care home identifies that a person is, or is at risk of, being deprived of their liberty, they must refer the matter to the 'supervisory body'. Where the person is in a care home, the supervisory body will be the local authority. Where a person is a patient in hospital, the supervisory body will be the Primary Care Trust (PCT). Department of Health guidance states that, "The deprivation of liberty safeguards do not introduce a new system for determining whether a person who lacks capacity to decide the matter for themselves should receive care or treatment. Nor do they provide any new power to take and convey people to hospitals or care homes. They are solely about ensuring that there are appropriate safeguards in place when it is deemed that a person who lacks the capacity to decide the matter for themselves needs to receive care or treatment, in their best interests, in a hospital or care home, in circumstances that deprive them of their liberty".

(see: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080718).

When a supervisory body receives a request for authorisation of deprivation of liberty they must obtain 6 assessments:

1. Age Assessment – the person in question is aged 18 or over
2. Mental Health Assessment – they are suffering from a mental disorder
3. Mental Capacity Assessment – they lack capacity to decide whether to be admitted to or remain in a hospital or care home
4. Eligibility Assessment - the person is eligible unless they are:
 - detained under the Mental Health Act 1983;
 - subject to a requirement under the Mental Health Act 1983 that conflicts with the authorisation sought e.g. a guardianship order requiring them to live somewhere else;
 - subject to powers of recall under the Mental Health Act 1983; or
 - unless the application is to enable mental health treatment in hospital and they object to being in hospital or to the treatment in question. In deciding whether a person objects, their past and present behaviour, wishes, feelings, views, beliefs and values should be considered where relevant.
5. Best Interests Assessment – the proposed course of action would constitute a deprivation of liberty and it is:
 - in the best interests of the person to be subject to the authorisation; and
 - necessary in order to prevent harm to them; and
 - a proportionate response to the likelihood of suffering harm and the seriousness of that harm.
6. No Refusals Assessment – the authorisation sought does not conflict with a valid decision by a donee of a Lasting Power of Attorney or by a Deputy appointed for the person by the Court of Protection, and is not for the purpose of giving treatment that would conflict with a valid and applicable advance decision made by the person.

The department of health has published a Code of Practice for the deprivation of liberty safeguards, and has also published transitional arrangements for the implementation. Both can be found on the department of health's website: www.dh.gov.uk.

1.3 Removal from home of certain adults at risk Section 47 of the National Assistance Act 1948

This Act allows the removal to suitable premises of persons in need of care and attention. Application must be made by the Local Authority to a Magistrates Court based on the certification to be provided for an application under Section 1 of the National Assistance (Amendment) Act 1951 is to be provided by a proper officer of the Local Authority or a District Community Physician and secondly, by a registered medical practitioner (usually the GP).

The grounds are that:

- The person is suffering from grave chronic disease or, being aged,

infirm or physically incapacitated, is living in unsanitary conditions, and

- The person is unable to devote to her/himself and is not receiving from other persons proper care and attention, and
- The community physician certifies in writing that they are satisfied that her/his removal from home is necessary either in her/his own interests or for preventing injury to the health of, or serious nuisance to, other persons.

The Court may order that an officer of the Local Authority remove the person to a suitable hospital or other place. The Order lasts for an initial period of three months with the Court having power to extend it for further periods of up to three months.

The Local Authority must give seven days' notice to the person in respect of whom the application has been made, or to the person in charge of him before a Section 47 application can be considered by the Court.

In an emergency situation, where it is necessary to remove the person from her/his home without delay, it is possible to make an application without notice. This order lasts for three weeks. It must be based on certificates from the Consultant in Communicable Disease Control and another Doctor (usually the GP) including that it is in the interests of the person to be removed without delay.

In practice these powers are used rarely and should only be considered when all other alternatives have been exhausted.

Section 47 is inappropriate where:

- There is evidence of mental impairment which inhibits the person from making valid judgements about her/his situation and this mental impairment is not secondary to acute physical illness;
- Public health hazards and unhygienic conditions can be dealt with under the public health acts;
- Additional community resources would alleviate the situation.

It should be noted that if a person is in need of medical treatment a doctor could arrange admission to hospital under the common law duty of care.

A decision to use Section 47 should only be made after a formal multi-agency meeting. The meeting must be convinced that removal from home would lead to a substantial improvement in the person's health.

Every effort should be made to ensure that the person subject to a Section 47 application has legal representation.

1.4 Entering and Cleaning Homes Public Health Act (1936)

Local authorities have powers under public health legislation to enter and cleanse premises constituting a public health risk. A Magistrates' warrant is normally required, e.g. to inspect premises under Section 287 of the Public Health Act 1936. While these powers were not designed with the protection of adults at risk in mind, they can sometimes be helpful in conjunction with, or even instead of, the use of other statutory powers.

1.5 The Family Law Act 1996

Under this Act the High Court, County Court or Magistrates Court may make Occupation Orders which may provide who shall occupy the home and the Court may direct another party to leave. Factors to be considered and the exact nature of the Order vary according to who is legally entitled to occupy the property and the relationship between the parties. Non-Molestation Orders prohibit the respondent from the molesting of a person with whom he or she is associated.

1.6 Provision of Services by the Local Authority

- 1.6.1 Residential Accommodation – *Section 21 National Assistance Act (1948)*
Local authorities are under a duty to provide residential accommodation for persons who, by reason of age, illness, disability or any other circumstances, are in need of care and attention which is not otherwise available to them.
- 1.6.2 Domiciliary and Day Care Services - *Chronically sick and Disabled Persons Act 1970 S2(1), Health Services and Public Health Act 1968 S13(1,) Residential Homes Act 1989 S(8)*
Including duties and powers to provide practical assistance in the home, provision of adaptations, holidays, meals on wheels, telephone installation or recreational facilities.
- 1.6.3 *Disabled Persons (Services, Consultation, and Representation Act) 1986*
As its title indicates, the act provides disabled people and their carers with a range of rights covering services.

1.7 Legislation for Carers

On occasions it may be that an adult may be at risk of harm from their family or informal carer, as a result of the stress caused through their caring role. Actions taken under the following legislation may be used in a protection plan to alleviate stress and reduce the risk, or a re-occurrence, of an adult at risk suffering harm.

- 1.7.1 *The Carers (Recognition and Services) Act 1995*
This Act places a **duty** on local authorities to assess carers (who are not employed under a contract of employment or as volunteers for a voluntary organisation), upon the carer's request, who provide, or intend to provide, a substantial amount of care on a regular basis to:
- A person who is being assessed under Section 47 of the NHS and Community Care Act, 1990; or
 - A disabled child who is being assessed under the Children Act 1989.
- 1.7.2 *The Carers and Disabled Children Act 2000*
This Act has extended local authorities responsibilities towards carers:

- Carers now have a right to an Assessment even in circumstances where **the cared for person has refused a Community Care Assessment**;
- Parent carers of disabled children have a right to their own assessment;
- Councils have the **power** to provide services directly to carers to support the carer in their caring role or to maintain their own health and well being;
- Councils have the **power** to make direct payments to carers to meet their own assessed needs. This includes 16 or 17 year old carers in certain circumstances;
- Councils have the **power** to make direct payments to parent carers to meet the assessed needs of the disabled child and the
- Councils have the **power** to make direct payments to 16 and 17 year old people with disabilities.

1.7.3 *The Carers (Equal Opportunities) Act 2004*

This Act states that:

- local authorities are given a **duty** to inform carers of their entitlement to an assessment under the 1995 Act, who must be informed about their right to a carer's assessment.
- carers assessment must consider the wishes of the carer in relation to leisure, education, training and desire to return to work;
- there should be co-operation between local authority and other public authorities, including housing, education, health, in the planning and provision of services to carers to support them in their caring role.

1.8 Race and Sex Discrimination

1.8.3 *Race Relations Act 1976*

Where abuse or neglect appears to have its origins in racist behaviour (including some discrimination on the grounds of religious beliefs in some circumstances), this Act may apply. The Act deals with unlawful discrimination on racial grounds in the fields of employment, provision of goods and services, education and exercise of functions by public bodies, and the ability to take legal action in cases of unlawful discrimination.

1.8.2 *Race Relations (Amendment) Act 2000*

This extends protection against racial discrimination and places a new, enforceable positive duty on public authorities. Local authorities must publish a race equality scheme.

1.8.3 *The Sex Discrimination Act 1975*

This Act renders discrimination on the grounds of marriage unlawful. The Act was amended by the Sex Discrimination Act 1986, removing certain restrictions applying to the working hours and other working conditions of women.

1.8.4 *The Equality Act 2010*

The Act is a consolidating act which replaces in respect of discrimination, the Race Relations Act 1976, Sex Discrimination Act 1975 and Disability Discrimination Act 1995. The Act prohibits discrimination on the basis of any 'protected characteristics' set out in the act. These include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

1.9 **Housing** **The Housing Act 1985 Part 111 (Homelessness)**

Section 66: Local authorities have a preventative duty to take reasonable steps to ensure that accommodation does not cease to become available for applicants threatened with homelessness.

1.10 **Duty of care to adults at risk** **X & Y v LB Hounslow (2008)**

The case of X & Y v Hounslow is the first example of a local authority being held to have been negligent to an adult at risk.

The tort of negligence will only be made out if the authority owes a duty of care to a person(s), that it has breached that duty and that the breach of duty caused the claimant to suffer loss or damage.

In this case, X and Y had learning difficulties. They lived in a council flat on an estate with their children. Various departments of the defendant local authority (teams in the Housing and Social Services departments) received information that they were being exploited by youths on the estate, including that the youths were using the couple's flat to store allegedly stolen goods and were using it as a place to have sex. There were also threats of violence and actual violence against Y. They suffered a terrible ordeal of physical abuse by those youths one weekend, in which they had been imprisoned in their own home, and repeatedly assaulted and abused, often in the presence of their children.

X and Y brought proceedings against the local authority in negligence. They contended that the authority owed them a duty of care, specifically to move them into some sort of alternative accommodation at some stage before the relevant weekend, and that it could have done so under its emergency system for transferring tenants to temporary accommodation in extreme cases involving severe violence or harassment.

The authority replied that X and Y had no right of action in negligence because they were effectively challenging a failure to re-house them, which could only be challenged by way of judicial review.

An argument was made by the local authority that the acts/omissions by Social Services and Housing Departments should be considered separately. The main issue for the court was whether the authority was under a duty of care to the claimants and whether there had been a

breach of any such duty such that the local authority were liable in negligence to X and Y.

The court held that:

- the authority should be considered as a single entity. Each of the sections and departments was under a duty to communicate with the others and amongst its own members of staff the information that it had received. The authority was, in law, a single entity, and was sued as such. Each relevant department and section knew that the others were involved with X and Y or their children, and they had communicated with each other from time to time. Also, moving the family from their flat might require input from both of the departments in question.
- A duty of care existed on the evidence, for the following reasons, applying the principles of negligence law:
 - it was *reasonably foreseeable* that either or both X and Y would suffer a serious physical attack from local youths in their flat;
 - the relationship between the authority and X and Y was of *sufficient proximity* (closeness) to give rise to a duty of care as the authority was their landlord and provided social services for them;
 - it was fair, just and reasonable to impose a narrow duty of care to move the claimants out of the flat in response to the particular, unusual, but highly dangerous, situation that had developed. The extension of a duty of care to the claimants would involve a small step in extending the law in which duties of care had been found to be owed by local authorities to children, rather than a giant leap, which the case law says should be avoided. X and Y functioned in many ways like children. Previous cases also demonstrated a greater willingness to find the existence of duties of care subsequent to the passing of the Human Rights Act 2003.
- The authority could have invoked its emergency system to move the claimants, it should have done so, and had it done so, alternative accommodation would have been found. This was a situation of severe violence and harassment, and therefore satisfied the authority's own test for the invocation of that system. The authority had a procedure that it could have used before the relevant weekend. The claim was not based on the action and inaction of both Housing and Social Services in response to information received by them about X and Y's situation and the danger posed to them. In all the circumstances, that breach of duty had *caused* the claimants' injury and loss.

2. Safeguarding the finance and property of adults at risk

2.1 Local Authority duty to protect property

S48 National Assistance Act 1948

A local authority must take reasonable steps to prevent or mitigate the loss or damage to movable property of a person where the person:

1. Is admitted as a patient to a hospital
2. Is admitted to accommodation which is provided under Part 3 of the National Assistance Act 1948
3. Is removed to any place under an Order made under Subsection 3 of section 47 of this act. (Removal from home - see Legal Appendix)

And it appears that there is danger of loss or damage to any movable property, and no other suitable arrangements can be made.

The Local Authority has the power, in certain circumstances, to force entry to premises and to recover payment.

2.2 Management of money and property

2.2.1 Third party mandate

A person can issue a mandate for someone to have access to their bank or building society account to collect money on their behalf. The presumption is that the person would have sufficient mental capacity to be able to do so.

2.2.2 Agency

A person in receipt of social security benefits can appoint an agent to collect their pension or other state benefits from the Post Office. On a temporary basis this can be done by completing the back of the pension book with the name of the person appointed as agent. A permanent arrangement needs to be made through the local benefits office. The authorisation is to collect money only and the agent has no power to spend the money without specific further authorisation.

2.2.3 Ordinary Power of Attorney

This is a deed (a particular form of legal document) whereby donors can appoint attorney(s), either on a temporary or a longer term basis, to act on their behalf in financial matters, while they are still capable of acting for themselves. The process for doing this was established under the Powers of Attorney Act 1971.

The power of attorney can be limited to a specific transaction or granted as a general power. It is only valid in law whilst the person giving his/her authority is fully mentally capable to make decisions about their property and affairs. If there is any doubt about the capability of a person to sign, it is recommended that the signature be witnessed by an independent person (e.g. doctor).

A power of attorney must be made on the prescribed legal forms. It will become invalid if the donor becomes mentally incapable due to mental disorder.

2.2.4 Lasting Power of Attorney

Enduring Powers of Attorney (EPA) were replaced by Lasting Powers of Attorney (LPA) from the 1 October 2007, under the Mental Capacity Act 2005. Existing EPAs before that date are still valid, but any new appointment is a LPA.

Like the EPA a LPA has to be made when the person has capacity but takes effect by registration with the Court of Protection after the person has lost capacity. The main difference between an EPA and a LPA is that under the new provisions the person can appoint an individual to decide on matters of welfare, not just property and finance.

LPAs must be registered with the Court of Protection after which it will become a valid document.

2.2.5 Appointeeship

The Secretary of State is empowered to appoint someone (“the appointee”) to exercise on behalf of a social security claimant (“the claimant”) when the claimant is incapable of acting. The appointee is able to receive and deal with any social security benefits payable. An appointee can collect, deal with and spend the benefit to pay expenses, for example, food, bills, personal care. An appointee does not have the authority to deal with capital or other income belonging to the incapacitated person. The claimant of benefits must be unable to act for her/himself.

The appointee must complete a form BF56 and apply, in writing, to receive the money due to the claimant. The Benefits Agency must satisfy themselves as to the claimant’s ineligibility to manage her/his affairs and as to the suitability of the proposed appointee.

The appointee can be anyone who knows the claimant well, usually a partner or close adult relative. However, if no suitable person is available, Islington Social Services Department can take responsibility as the Corporate Appointee for appointeeship. (Social Services staff should consult the Community Care Division.)

Where appointeeships are held by residential and nursing home managers, this should be carefully monitored by the placing Authority.

If doubts arise regarding the conduct of an appointee, the matters should be referred to the Benefits Agency who have the power to and will take away the rights of an appointee who is not acting properly or in the best interests of the claimant.

It should be noted that while a power of attorney, enduring power of attorney and appointeeship can be used to protect adults at risk, these powers can also be used to take advantage of them.

The powers invested in an appointeeship are overridden when a Deputy is appointed or if the service user has made an EPA or a LPA while mentally capable.

Where a mentally incapacitated person has assets, which are

substantially over the level of state benefits, an Appointee must instigate an application to the Court of Protection for the appointment of a Deputy.

The Secretary of State can revoke an appointeeship at any time. An Appointee may resign his/her appointeeship by giving one month's notice. An appointeeship ceases automatically as soon as:

- the claimant is able to act for themselves
- a Deputy, other than the Appointee, has been appointed
- the claimant or the Appointee dies
- the appointeeship is transferred to another person

If the Appointee does not comply with the conditions on which it was granted, the appointeeship can be withdrawn.

The Appointee should notify the Benefits Agency of the death of the claimant at the earliest opportunity, and send an original copy of the white death certificate issued by the Registrar for this purpose if possible.

2.2.6 Court Appointed Deputies

If there is no EPA or LPA, the Court of Protection can appoint a Deputy to act. The Court of Protection deals with the management of the property and affairs of some mentally disordered people. The Mental Capacity Act 2005 safeguards the interests of anyone who, by reason of mental disorder, is incapable of:

- managing and administering their property and affairs and;
- making decisions about their welfare.

The Court of Protection Rules 2007 define the role of the Court and the Public Guardian. The Office of the Guardian (OPG), previously the Public Guardianship Office, is responsible for administering the court's decisions. The OPG registers LPA's and works together with other agencies such as the police and social services, to respond to any concerns raised about a donee under an LPA.

A medical assessment is required for an application for the appointment of a Deputy. The court will only accept jurisdiction if it is satisfied that the person lacks capacity to make certain decisions.

See section 1.2 *People Who Lack Capacity*, above, for definitions of mental incapacity.

An application must be made to the Court of Protection for the appointment of a Deputy when:

- The person without capacity has assets in excess of £5,000 and other means such as EPA or LPA are not possible either because one is not in existence or it was granted for limited application only.
- The balance in miscellaneous savings/ residents savings accounts is less than £5,000 but there are funds lodged elsewhere for example in banks, building societies, over which an Appointee has no control, which need to be used on the client's behalf.

A Deputy is a person appointed by the Court to deal with the day to day management of the patient's financial affairs, similar to the old system of 'receivers' under the Mental Health Act 1983. He or she can be a relative, friend, professional adviser such as a solicitor, or an official of the local authority. If there is no one else suitable or willing to act, the Public Guardian can appoint a "Panel Deputy" who would normally be a solicitor with specific knowledge or experience, and who gets paid to act from the person's assets.

A Deputy has power to do all things in relation to the property and financial affairs of the person that the Court of Protection orders or authorises.

Generally, the Deputy is responsible for receiving the person's income and ensuring that it is collected from all sources and using it to pay the person's living costs and to settle any debts. Any surplus must be used for that person's benefit, which would also include prudent reinvestment of income for their short and long-term requirements.

The Deputy's powers are listed in the Court Order appointing the Deputy and they may be either general or of a specific nature. It is usually necessary to obtain further specific authority from the Court where matters of a non-routine nature need to be dealt with. Examples of this are:

- Buying and selling property
- Incurring overdrafts
- Taking and defending legal proceedings
- Making or changing a will

The Deputy has a duty to account to the Court annually or as and when required by the Court, for the handling of the person's financial affairs. As with Appointeeships and Powers of Attorney, the Deputy appointed to manage finance and affairs does not have any power to make decisions about the person's welfare (for example, where the person should live).

However, the Court can now make specific decisions relating to welfare matters and can also appoint a Deputy for Personal Welfare if there are ongoing decisions on welfare matters. This can be someone other than the Deputy for Property and Financial Affairs. In practice, it is unlikely that welfare Deputies will be appointed very often as there is a preference for specific and 'one-off' best interests decisions about a person's welfare.

Should the person regain the capacity to manage and deal with their finance and property, the person may at any time apply for an order to bring the proceedings in the Court (for example, the Deputyship Order) to an end. They, or the Deputy, must produce medical evidence of their recovery to the Court.

3. Criminal law - violence and criminal offences against adults at risk

A wide range of different types of adult abuse may be dealt with under criminal law: assault, sexual assault, actual and grievous bodily harm, fraud or theft. The role of the police is to investigate the crime and to forward papers on to the Crown Prosecution Service who then decide whether to prosecute.

There are two stages in the decision to prosecute. First there is the evidential test; this is that the Crown Prosecutor must be satisfied that there is enough evidence to provide a "realistic prospect of conviction". Secondly, if the case passes the evidential test, the Crown Prosecutor must decide if a prosecution is needed in the public interest. Public interest factors that affect the decision to prosecute usually depend on the seriousness of the alleged offence or the circumstances of the defendant.

Some common public interest factors in favour of prosecution relevant to these guidelines are:

- The defendant being in a position of authority of trust
- The victim of the alleged offence being at risk
- A marked difference between the actual or mental ages of the defendant and the victim, or if there is any element of corruption
- There are grounds for believing that the alleged offence is likely to be continued or repeated.

Some public interest factors against prosecution include the following:

- A prosecution is likely to have a very harmful effect on the victim's physical or mental health, always bearing in mind the seriousness of the offence
- The defendant is elderly or is, or was, at the time of the offence suffering from significant mental or physical ill-health, unless the alleged offence is serious or there is a real possibility that it may be repeated.

If the defendant admits the offence, cautioning is the most common alternative to a court appearance. (*Appendix 3 has some guidance on charging standards in cases of assault. See also Section 16 of the Mental Capacity Act 05 – the five key principles need to be borne in mind when working with people who may lack capacity to make their own decisions.*)

3.1 Sexual Offences Against People with a Mental Disorder - Sexual Offences Act 2003

Sections 30-44 in the Sexual Offences Act 2003 relate to people with a mental disorder in England and Wales.

Mental disorder is defined as in the Mental Health Act 1983: "mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of the mind". The categories of mental disorder under the Mental Health Act 1983 are referred to in paragraph 1.1.1 above. This definition includes a person with a learning disability. Please note that the Mental Health Act 2007 will amend the definition of "mental disorder" in the Mental Health Act 1983 to any

disorder or disability of the mind, and will abolish the categories of mental disorder.

The offences are grouped under three categories, which will be outlined further below:

- Victim unable to agree to sexual activity because of a mental disorder which impedes choice (Sections 30-33).
- Victim may have agreed to sexual activity through vulnerability from inducement, threat or deception (Sections 34-37).
- Victim in a relationship of care with perpetrator of offence (Sections 38-41).

It is important to state that where a person with a learning disability has the capacity to consent to sexual activity then they have the same right as anyone else to do so.

Where a non-consensual offence is committed against a person with a learning disability, for example, rape or sexual assault, the defendant will be charged with the same offences as anyone else. The following specific categories of offence relate to different situations where a mentally disordered person lacks capacity, or the sexual activity is with a care worker.

3.1.1 Sexual offences against persons with a mental disorder impeding choice (incapable of refusing)

Section 30: Sexual activity with a person with a mental disorder impeding choice.

Section 31: Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity.

Section 32: Engaging in sexual activity in the presence of a person with a mental disorder impeding choice.

Section 33: Causing a person, with a mental disorder impeding choice, to watch a sexual act.

This makes it an offence if a person is unable to refuse involvement in a sexual activity because of a mental disorder or for reasons related to it.

The person is deemed to be unable to refuse if they lack the capacity to refuse or communicate refusal. This can include, for example lack of capacity to:

- Understand the nature or consequences of the activity
- Realise that sexual activity is different to personal care
- Realise s/he has a choice
- Communicate their decision.

For these offences to be made out the defendant must know, or reasonably be expected to know that the victim has a mental disorder and because of that disorder is likely to be unable to refuse sexual activity.

3.1.2 Inducements to people with a mental disorder

Section 34: Inducement, threat or deception to procure sexual activity with a person with a mental disorder.

Section 35: Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception.

Section 36: Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder.

Section 37: Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception.

It is recognised that some people with a learning disability can, and do, have the capacity to consent to sexual activity but that they may be more susceptible to bribes or threats than others.

These offences address situations where inducements, threats or deceptions are used by the defendant to obtain agreement to sexual activity by someone with a mental disorder.

Inducements could be things such as promises of holidays, marriage or favours. Threats could include the perpetrator saying they would harm the victim, or their family or friends.

Deceptions could be perpetrators saying that this is something that all friends do. For these offences to be made out, it is also required that the defendant knew, or could reasonably be expected to know that the person had a mental disorder.

3.1.3 Care workers for people with a mental disorder

Section 38: Care workers: sexual activity with a person with a mental disorder.

Section 39: Care workers: causing or inciting sexual activity.

Section 40: Care workers: sexual activity in the presence of a person with a mental disorder.

Section 41: Care workers: causing a person with a mental disorder to watch a sexual act.

This third category of offences is to protect a person with a mental disorder from any sexual activity with someone responsible for their care. This would be an offence, whether or not the person with the mental disorder consented. It is anticipated that many victims in this situation may consent to their carer.

It is to be taken with this category of offences that the defendant knew that the person had a mental disorder because of their relationship, unless sufficient evidence is produced to the contrary.

It is important to point out that the last two offences in this section are not intended to stop workers carrying out sex education with the people they work with. It needs to be proved that the activities are carried out for the

sexual gratification of the offender, therefore sex education as part of an agreed care plan for an individual would not be included within this.

Definitions

Care worker [Section 42]

- Workers from care/community/voluntary/children's homes.
- Workers from NHS Services or independent medical agencies.
- People in regular face-to-face contact with a client, regardless of whether they provide
- Physical or mental care.
- Paid or unpaid, full- or part-time.

Consent [Section 74]

If a person agrees by choice and has the freedom and capacity to make that choice.

Sexual [Section 78]

An activity is sexual if a reasonable person would either always consider it to be sexual because of its nature, e.g. oral sex, or that it may be deemed to be sexual depending on the circumstances and intention. For example, a medical examination in a doctor's surgery, where the purpose is not sexual, would not be considered an assault.

Touching [Section 79(8)]

This covers a wide range of behaviour involving touching any part of the body with anything else and through anything such as clothing.

3.2 Mistreatment or Wilful Neglect of Person with Mental Disorder

Under section 127 of the Mental Health Act 1983, it is a criminal offence for a person who is a staff member or is one of the managers of a hospital or a care home to ill treat or wilfully neglect a patient who:

- Is receiving treatment for a mental disorder as an in-patient in the hospital or home; or
- Is receiving treatment as an out-patient on premises of which count as part of the hospital or care home; or
- Is subject to guardianship or is otherwise in a person's custody or care (whether by legal or moral obligation or otherwise).

A person who is guilty of this offence may be liable to a term of up to 2 years imprisonment and/or a fine

3.3 Mistreatment or Wilful Neglect of a Person lacking Capacity

Under s44 of the Mental Capacity Act 2005, it is a criminal offence for a person (“D”) to wilfully neglect or ill treat another person (“P”) where D:

- has the care of a person who lacks capacity, or whom D reasonably believes to lack capacity;
- is the donee of a power under a Lasting Power of Attorney or Enduring Power of Attorney, created by P when they had capacity;
- is a Deputy appointed by the Court of Protection for P.

A person found guilty of such an offence may be liable to a term of up to 5 year's imprisonment and/or a fine.

3.4 Police and Criminal Evidence Act 1984

Where the police are taking action against an alleged perpetrator who themselves are at risk, i.e. they are under 17, or have a mental disorder or learning disability they will be required to appoint an appropriate adult. (Refer to guidelines held in Community Care Division.)

3.5 Physical Abuse

3.5.1 *Criminal Justice Act 1988 Section 39*

What is known in law as “common” assault may leave no physical evidence. It can cover a wide range of language and conduct. Any act or words, involving a use or a threat of violence towards someone will constitute an assault. If no-one has witnessed the assault, prosecution is unlikely, as it is the perpetrator’s word against the victim’s.

Serious offences where the assault results in injury:

- Assault occasioning Actual Bodily Harm (‘ABH’ - Section 47, Offences against the Person Act 1861).
- Assault occasioning Grievous Bodily Harm (‘GBH’ – Sections 18 and 20, Offences against the Person Act 1861).

3.5.2 *Domestic Violence, Crime and Victims Act 2004*

This Act is the biggest overhaul of domestic violence legislation for thirty years and heralds tough new powers for the police and the courts to tackle offenders, while ensuring victims get the support and protection they need. For the first time, a statutory code of practice provides a range of rights to victims together with the establishment of an independent Commissioner. The Act will ensure more offenders pay towards supporting victims. The Criminal Injuries Compensation Authority will be able to recover money from offenders and a surcharge will be placed on criminal convictions and fixed penalty notices, which will contribute to the Victims Fund. For motoring offenders the surcharge will only apply to the most serious and persistent offenders. The Act also creates a new

offence of causing or allowing the death of a child or an adult at risk. This will help to ensure that offenders who remain silent or blame each other do not escape justice.

Key provisions in the Act include:

- Making common assault an arrestable offence which means that the police can arrest without a warrant.
- Significant new police powers to deal with domestic violence including making it an arrestable, criminal offence to breach a non-molestation order, punishable by up to five years in prison.
- Strengthening the civil law on domestic violence to ensure cohabiting same-sex couples have the same access to non-molestation and occupation orders as opposite sex couples, and extending the availability of these orders to couples who have never lived together or been married.
- Stronger legal protection for victims of domestic violence by enabling courts to impose restraining orders when sentencing for any offence. Until now, such orders could only be imposed on offenders convicted of harassment or causing fear of violence.
- Enabling courts to impose restraining orders on acquittal for any offence (or if a conviction has been overturned on appeal) if they consider it necessary to protect the victim from harassment. This will deal with cases where the conviction has failed but it is still clear from the evidence that the victims need protecting.
- Putting in place a system to review domestic violence homicide incidents, drawing in the key agencies, to find out what can be done to put the system right and prevent future deaths.
- Providing a code of practice, binding on all criminal justice agencies, so that all victims receive the support, protection, information and advice they need.
- Allowing victims to take their case to the Parliamentary Ombudsman if they feel the code has not been adhered to by the criminal justice agencies.
- Setting up an independent Commissioner for Victims to give victims a powerful voice at the heart of government and to safeguard and promote the interests of victims and witnesses, encouraging the spread of good practice and reviewing the statutory code.
- Giving victims of mentally disordered offenders the same rights to information as other victims of serious violent and sexual offences.
- Giving the Criminal Injuries Compensation Authority the right to recover from offenders the money it has paid to their victims in compensation.
- A surcharge to be payable on criminal convictions and fixed penalty notices, which will contribute to the Victims Fund. For motoring offenders the surcharge will only apply to serious and persistent offenders.
- Creating a new criminal offence of unlawfully causing or allowing the death of a child or an adult at risk. The offence establishes a new criminal responsibility for members of a household where they know that a child or an adult at risk is at significant risk of serious harm.

- Bringing in the Law Commission recommendation for a two-stage court trial to ensure that high volume crimes like fraud and Internet child pornography can be punished in full.

3.6 Protection from Harassment Act 1997 (Section 2)

A person can be prosecuted under this Act if their conduct causes another to fear, on at least two occasions, that violence will be used against him/her. Such conduct includes verbal abuse.

Although court proceedings can only be considered after the second offence, the first incident should be reported to the police.

To provide protection from further violent conduct, a court can issue a restraining order or injunction, and/or impose a fine or imprisonment.

3.7 Corporate Manslaughter and Corporate Homicide Act 2007

This Act came into force on 6 April 2008 and created a new criminal offence. Certain organisations, including incorporated companies and public bodies such as the NHS and local authorities, will be guilty of an offence if the way in which their activities are managed or organised:

- causes a person's death, and
- amounts to a gross breach of a relevant duty owed by the organisation to the deceased.

The organisation will be guilty if (and only if) the way in which its activities are managed or organised by senior management is a substantial element in the breach, i.e. a substantial part of the failing must have occurred at a senior management level. The prosecution is not obliged to prove specific failings by individual managers but can aggregate management failings generally.

- a death has been caused as a result of the way in which the senior management of that organisation has arranged or managed the organisation's activities; and
- that the shortcomings in the organisations and management amount to a gross breach of a 'relevant duty of care' owed to the deceased.

A 'relevant duty of care' is defined within the Act. Where an organisation is convicted, it can be punished with an unlimited fine.

3.8 Financial abuse

3.8.1 *Theft Act 1968*

Section 1 sets out the definition of theft; Theft is the dishonest appropriation of property belonging to another, intending to permanently deprive the owner of it.

Theft does not necessarily involve physically moving something. Any form of taking over of the rights of the owner is enough. Dishonesty has to be proved, and it is a defence to show a reasonable belief that the owner would have consented had she or he known.

Adults who are dependent on others may be reluctant to make a complaint that will enable the police to act. Also, the informality of care arrangements can make a prosecution for misuse of funds difficult.

3.8.2 *Fraud Act 2006*

Section 4 concerns fraud by abuse of position. It is an offence for a person who occupies a position where he/she is required to safeguard (or not act against) the financial interests of another person, to dishonestly abuse that position, with the intent of self benefit or to benefit others.

4. Safeguarding People Receiving Care: People in Care Homes or Receiving Domiciliary Care - Care Standards Act 2000

4.1 National Minimum Standards for Care Homes - Older People and Adults 18-65

The National Minimum Standards for Care Homes for Older People and the National Minimum Standards for Care Homes for Adults, form the basis on which the Care Quality Commission (CQC) will determine whether such care homes comply with the Regulations supporting the Care Standards Act 2000, for example to meet the needs, and secure the welfare and social inclusion, of the people who live there.

The national minimum standards are core standards, which apply to all care homes providing accommodation and nursing or personal care for older people. The standards apply to homes for which registration as care homes is required.

While broad in scope, these standards acknowledge the unique and complex needs of individuals, and the additional specific knowledge, skills and facilities needed in order for a care home to deliver an individually tailored and comprehensive service.

Certain of the standards do not apply to pre-existing homes including local authority homes, "Royal Charter" homes and other homes not previously required to register. The standards do not apply to independent hospitals, hospices, clinics or establishments registered to take patients detained under the Mental Health Act 1983.

The National Minimum Standards for Care Homes for Older People and Adults focus on achievable outcomes for service users – that is, the

impact on the individual of the facilities and services of the home. The standards are grouped under the following key topics, which highlight aspects of individuals' lives identified during the stakeholder consultation as most important to service users:

- Choice of home
- Health and personal care
- Daily life and social activities
- Complaints and protection
- Environment
- Staffing
- Management and administration

Both the National Minimum Standards for Care Homes for Older People and the National Minimum Standards for Care Homes for Adults contain requirements to ensure that the Service users are protected from abuse.

These requirements are that:

- The registered person (that is, the registered care home) ensures that service users are safeguarded from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm, inhuman or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policies.
- Robust procedures for responding to suspicion or evidence of abuse or neglect (including whistle blowing) ensure the safety and protection of service users, including passing on concerns to the CQC in accordance with the Public Interest Disclosure Act 1998 and Department of Health (DH) guidance *No Secrets*.
- All allegations and incidents of abuse are followed up promptly and action taken is recorded.
- Staff who may be unsuitable to work with adults at risk are referred, in accordance with the Care Standards Act 2000, for consideration for inclusion on the ISA list.
- The policies and practices of the home ensure that physical and/or verbal aggression by service users is understood and dealt with appropriately, and that physical intervention is used only as a last resort and in accordance with DH guidance.
- The home's policies and practices regarding service users' money and financial affairs ensure service users' access to their personal financial records, safe storage of money and valuables, consultation on finances in private, and advice on personal insurance; and preclude staff involvement in assisting in the making of or benefiting from service users' wills.

4.2 National Minimum Standards for Domiciliary Care

The Care Standards Act 2000 brought domiciliary care agencies into the regulatory framework of CSCI. The National Minimum Standards for domiciliary care agencies including local authorities and NHS Trusts form

the criteria by which CSCI will determine whether the agency provides personal care to the required standard. The purpose of these minimum standards is to ensure the quality of personal care and support which people receive whilst living in their own home in the community.

These standards establish the minimum required; i.e. they identify a standard of service provision which an agency providing personal care for people living in their own home must not fall below. The following Protection Standards are a requirement for the provision of care at home:

- Safe working practices
- Risk Assessments
- Financial protection
- Protection of the person
- Security of the home
- Records kept in the home

The general public is aware of the effects of child abuse; far less publicity is given to adult and elder abuse and many people, even those employed in providing care to adults, are still relatively unaware of the existence of abuse and its effects. Home care and support workers need to be aware that abuse does not have to be extreme or obvious. It can be unintentional, insidious and the cumulative result of ongoing bad practice. No organisation that is concerned with maintaining standards in the provision of professional care services can afford to ignore any form of abuse which affects the well being of the people for whom they are responsible.

The role that home care and support workers play in the lives of people, for whom they care, is extremely important. It is the home care workers and support workers who have a key role in recognising and protecting people from abuse. They have a responsibility to the people for whom they provide the care service, to minimise both the likelihood of abusive situations occurring and the effects that it can have and to contribute to monitoring anyone who may be considered to be 'at risk.'

It is essential that care is taken in all financial transactions undertaken on behalf of the service user and a full written record kept to safeguard both the service user and the home care or support worker and to ensure no misunderstandings occur. For similar reasons home care or support workers must never seek to profit from the care they provide to service users by the acceptance of significant gifts or bequests.

The safety of service users is very important and for this reason care must be taken when entering or leaving the premises of people receiving care. This includes the need to carry and show proper identification at all times.

Appendix I: Protocol for inter-authority safeguarding adults investigations

July 2011 (to be reviewed July 2014)

This appendix is based on the ADASS Protocol for Inter-Authority Investigation of Vulnerable Adult Abuse, which was ratified by the ADASS on 20th February, 2004.

1. Introduction

These arrangements recognise the increased risk to adults at risk whose care arrangements are complicated by cross boundary considerations. These may arise, for instance, where funding/ commissioning responsibility lies with one authority and where concerns about potential abuse and/ or exploitation subsequently arise in another. This would apply where the individual lives or otherwise receives services in another local authority area.

2. Aims

This protocol aims to clarify the responsibilities and actions to be taken by local authorities with respect to people who live in one area, but for whom some responsibility remains with the area from which they originated.

This protocol should be read in conjunction with Section 3.8 of *'No Secrets'* (DoH 2000) and *'Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England'* (DoH 2010) - Which identifies these responsibilities in terms of:

- 2.1 The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for safeguarding adults;
- 2.2 The registering body in fulfilling its regulatory function with regard to regulated establishments; and
- 2.3 The placing authority's continuing duty of care to the adult at risk.

3. Principles

- 3.1 The authority where the abuse occurs will have overall responsibility for co-ordinating the safeguarding arrangements (and, for the purposes of this protocol, be referred to as the host authority)
- 3.2 The placing authority (i.e. the authority with funding/ commissioning responsibility) will have a continuing duty of care to the adult at risk.
- 3.3 The placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting adults at risk and for managing concerns, which in turn link with local policy and procedures set out by the host authority.
- 3.4 The placing authority will provide any necessary support and information to the

- host authority in order for a prompt and thorough investigation to take place.
- 3.5 The host authority will make provision in service contracts, which refer to this protocol, outlining the responsibilities of the provider to notify the host authority of any safeguarding concern.

4. Responsibilities of Host Authorities

- 4.1 The authority where the alleged abuse occurred should always take the initial lead on referral. This may include taking immediate action to protect the adult, if appropriate, and arranging an early discussion with the police if a criminal offence may have been committed.
- 4.2 The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the placing authority and other relevant agencies.
- 4.3 It is the responsibility of the host authority to co-ordinate any investigation of institutional abuse. If the alleged abuse took place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.
- 4.4 The Care Quality Commission should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for the protection of adults at risk.
- 4.5 There will be instances where allegations relate to one individual only and in these cases it may be appropriate to negotiate with the placing authority their undertaking certain aspects of the investigation. However, the host authority should retain the overall co-ordinating role throughout the investigation.

5. Responsibilities of Placing Authorities

- 5.1 The placing authority will be responsible for providing support to the adult at risk and planning their future care needs.
- 5.2 The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any safeguarding adults strategy meeting and/ or may be required to submit a written report.

6. Responsibilities of Provider Agencies

- 6.1 Provider agencies should have in place suitable safeguarding adults procedures to prevent and respond to abuse which link with the local inter-agency policy and procedures set out by the host authority.
- 6.2 Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Social Services, the Police, and/ or the Care Quality Commission in accordance with local inter-agency policy and procedures
- 6.3 Provider agencies will have responsibilities under the Health and Social Care Act 2008 to notify their local CQC area office of any allegations of abuse or any

other significant incidents.

- 6.4 Provider agencies who have services registered in more than one local authority area will defer to the CQC area office relevant to the area in which the abuse took place.

Appendix J (containing sub-appendices 1-6) Serious Case Review Protocol July 2011 (to be reviewed July 2014)

1. Introduction

- 1.1 The Islington Safeguarding Adults Partnership wants to learn how it can better help adults at risk stay safe from harm. The partnership has agreed the following protocol, so that it can learn from cases where adults at risk suffered significant harm as a result of abuse and/or neglect.
- 1.2 All Serious Case Reviews (SCR) in Islington will have regard to the experience and views of the adult at risk (or representative), and consider how these were sought and taken into account by the professionals involved.
- 1.3 This protocol draws on Department of Health, ADASS and SCIE guidance and standards (please see the section called 'Sources' for further details). This protocol also draws on national and local experience of conducting SCRs.
- 1.4 Appendix 6 contains a flowchart which can be referred to for an overview of the whole process.

2. The purpose of Serious Case Reviews

The purpose of a SCR is **not** an enquiry into how the death or serious incident happened. Neither is the purpose to find somebody to 'blame'. Such matters will be dealt with by the Coroner's or criminal courts, or other bodies.

The purpose of a SCR is to:

- learn from the way local agencies, staff and volunteers worked together to safeguard adults at risk (both what did and did not work well);
- agree how this learning will be acted on, and what is expected to change as a result;
- identify any issues for multi or single agency policies and procedures; and,
- publish a summary report, which is available to the public.

The desired outcome of a SCR is that:

- Through improved inter-agency working, adults at risk are better safeguarded from significant harm.

3. Requests for Serious Case Reviews

- 3.1 The Serious Case Review Subgroup of the Islington Safeguarding Adults Partnership will be the only body which commissions an SCR relating to the abuse

and/or neglect of an adult at risk in Islington. The subgroup has agreed Terms of Reference that include commissioning SCR's.

- 3.2. Any agency, professional or individual may request a SCR. The request should be made, in writing, to the chair of the SCR Subgroup. The vice chair of SCR Subgroup, the chair of the Islington Safeguarding Adults Partnership Board and the statutory director should also be copied in. Please see Appendix 1 for contact details.
- 3.3. All agencies/individuals submitting cases for consideration will be expected to comply with the Confidentiality Agreement (please see Appendix 5).
- 3.4. The SCR Subgroup will decide whether or not to accept the request for a SCR. The subgroup will make their decision based on the criteria set out in this protocol. The chair of the board and the statutory director will be advised of the decision as soon as possible. The decision will also be reported to the board at the next available opportunity.
- 3.5. Members of the SCR Subgroup may also request that a SCR is held. The SCR Subgroup will consider these requests, and in consultation with the chair of the board and the statutory director, decide whether to hold a SCR.

4. Criteria (and other factors) for a Serious Case Review

4.1 The key principles in deciding whether to conduct a Serious Case Review are:

- there are opportunities for the organisations involved to learn and improve as a result; and
- it is in the public interest to have a review.

4.2 A SCR should be considered where:

- a) an adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death;
- OR
- b) an adult at risk has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect;
- AND
- c) the case gives rise to concerns about the way in which local professionals and/or services work together to safeguard adults at risk;
- OR
- d) it is suspected that staff (from any organisation) may have contributed directly or indirectly to the circumstances leading to the death/serious harm of the adult at risk;
- OR
- e) a worker's failure to act may have contributed to the death of an adult at risk or to their sustaining serious harm;
- OR

- f) serious or apparently systemic abuse takes place in an institution or when multiple abusers are involved. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time.

4.3 When deciding whether or not to hold a SCR, the subgroup will also consider:

- What are the views of the adult(s) at risk, where possible, or their appropriate representative(s) – are they content for a review to be held?
- Was there clear evidence of risk or significant harm which was not recognised by agencies in contact with the adult at risk or person alleged to have caused harm, or not shared with others or not acted upon appropriately?
- Did the abuse occur in an institutional setting?
- Does one or more agency feel that it had significant concerns and these were not taken seriously or acted upon by another?
- Does the case indicate there are failings in the formal safeguarding procedures that go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that there might need to be a change in local protocols or procedures, or that protocols and procedures are not being adequately acted upon?

4.4 Individual agencies may have internal procedures to review cases. This protocol is not intended to duplicate or replace these. A SCR would be used to learn lessons beyond the scope of internal procedures.

4.5 The subgroup will take into account investigations and other types of review which may be planned or already underway. Local and regional liaison may be needed to decide the best way different roles and purposes can be addressed. Legal advice will be sought.

4.6 There are also statutory frameworks for reviews, which would need to be taken account when deciding whether or not to hold a SCR. Again, legal advice would be sought. Statutory frameworks apply in the following circumstances:

- death or serious incidents involving a child;
- homicide, suicide and related serious mental health incidents;
- domestic homicide or suicide involving a person over the age of 16 from violence, abuse or neglect by a relation or member of the same household;
- serious further offences committed by offenders subject to supervision by the Probation Service; and
- work-related deaths, but not arising from clinical judgement or treatment.

4.7 Various regulatory bodies are empowered to carry out investigations of serious incidents. The Secretary of State can direct statutory organisations to conduct investigations, or approve public inquiries recommended by the Health and Safety Executive.

- 4.8 The approach to the review will reflect locally agreed arrangements on the implementation of best practice guidance issued by the Department of Health in 2010: Clinical Governance and Adult Safeguarding Processes [Gateway Ref: 13549]. These guidelines are designed to secure an integrated approach of which consideration of a serious case review forms a part.
- 4.9 There may be grounds for one or more reviews – in which case a decision should be made at the outset as to which process is to lead and who is to chair. The potential to do a joint review may be considered to avoid duplication.
- 4.10 Having considered the criteria and other factors, the subgroup will decide whether to hold a SCR, including public interest considerations. The decision must have the support of a majority of a quorate meeting. The meeting minutes must record the reasons for the decision, and any minority views.
- 4.11 The decision should be made not later than one month of receipt of the request and reported as set out above.

5. Actions to be taken once a decision has been made

- 5.1 Whatever decision is taken, it should be reported to the chair of the board, board and statutory director. All decisions will be recorded in the board's annual review.
- 5.2 When the subgroup decides to hold a SCR
When the subgroup decides to hold a review, the chair of the subgroup will immediately notify all agencies involved to make sure all relevant records are secured. The subgroup will also take the actions set out in the following sections, to commission a SCR.
- 5.3 When the subgroup decides not to hold an SCR
When the subgroup decides not to hold an SCR, in accordance with the thresholds set out in section 4, the chair of the subgroup will write to the person requesting the review, explaining the reasons. If the person requesting a review still thinks it should be held, the matter will be considered at the next full meeting of the board. The decision of the board will be final.
- 5.4 Where the threshold for a SCR has not been met, the subgroup may recommend that an individual agency (or agencies) review an incident. Often, the agency will be asked to use its own internal investigation procedures to conduct this. For example, an NHS organisation may be asked to use its 'Serious Incident' procedure.
- 5.5 These reviews should be completed promptly and the findings of fact, learning and need for action shared with the SCR Sub group who will advise the board on any issues requiring further board consideration.

6. Commissioning a Serious Case Review

- 6.1 The Serious Case Review Subgroup will commission SCRs. This includes:

- drafting terms of reference for the SCR, the SCR Panel and the SCR Panel Chair;
 - appointing the SCR Panel and the SCR Panel Chair (the panel chair may be an independent person appointed on terms agreed with the statutory director);
 - making sure resources are available for the review;
 - setting timescales within which the review should be completed;
 - securing any legal advice required, in particular the Data Protection, Freedom of Information and Human Rights Act;
 - making sure that all agencies are bound by the Confidentiality Agreement for SCR's (please see Appendix 5);
 - managing the interface between the review and other investigations or reviews of the same case that may be taking place; and
 - agreeing arrangements for administrative and professional support.
- 6.2 Appendix 2 sets out questions the SCR Subgroup may consider when commissioning a SCR. The questions are not prescriptive and the particular circumstances of the case under review should be taken into account.
- 6.3 The Chair of the SCR Subgroup will notify the Care Quality Commission, Police and the Coroner's Office that a SCR is taking place.
- 6.4 Where appropriate, the subgroup will appoint a named 'liaison officer' who will keep the adult at risk, their family and/or friends, informed of developments relating to the SCR process. This officer will keep in close contact with the police family liaison officer, to make sure that communication is consistent.
- 6.5 The subgroup will agree and set out the media/communications strategy. The chair and the vice chair of the board will be advised along with the statutory director.

7. Membership of a Serious Case Review Panel

- 7.1 Membership of the Serious Case Review Panel will be made up of people of appropriate standing and experience with regard to the particulars of the case under review. The chair of the SCR Subgroup will write to the chief officers of agencies requesting nominations to the Serious Case Review Panel.
- 7.2 Agencies directly involved in the case may not be appropriate members of the SCR Panel.
- 7.3 The SCR subgroup will not itself undertake reviews but, as long as they have no direct involvement with the case, members of the sub-group may form part of SCR panels.
- 7.4 It is open for SCR panels to be chaired by an independent person on the recommendation of the SCR Subgroup to the chair of the board and the statutory director. If agreed, the terms of appointment would be agreed with the statutory director. This arrangement may be particularly relevant where there has been extensive agency involvement or where particular public or professional concern suggests this would be appropriate.

- 7.5 The SCR subgroup and/or the Review Panel when constituted will consider how the adult at risk and/or, appropriate representatives of the adult at risk, may be involved in the review process and kept informed about its progress. Please see section 6.4 for more information.
- 7.6 In constituting the review panel it is open to the SCR sub-group to include an “Expert by Experience” or a representative of a local or national service user or carer group. This arrangement is subject to the relevant checks being made (and the results being satisfactory) and the normal requirements on confidentiality being followed.

8. Conduct of a Serious Case Review

- 8.1 Throughout each SCR, the panel will keep in mind the experience and views of the adult at risk, and address how these were sought and taken into account by the professionals involved.
- 8.2 The SCR Panel will:
- establish what evidence will be required from each agency or person, stating whether this is through investigation or to be collected by way of Management Reviews (please see Appendix 3) or by other means;
 - request further information from agencies as required;
 - identify relevant policy, practice or procedural frameworks, both nationally and locally, that may be relevant to the conduct of the review;
 - consider the facts and circumstances of the case and evidence received;
 - cross-reference all agency management reports and reports commissioned from any other source;
 - consider relevant professional and practice standards and guidance;
 - analyse the evidence to understand why the incident took place. In particular, the panel will look for any wider systemic issues as well as individual practice issues;
 - identify any areas of effective practice and areas for improvement;
 - examine and identify relevant action points;
 - agree the key points to be included in both reports and proposals for action; and
 - agree the final version of the Review Report and Public Summary Report for submission.
- 8.3 If at any point, whilst undertaking the review, further information is received or issues emerge which require notification to a statutory body regarding significant omission by individual/s or organisations, this should be undertaken by the chair of the SCR Subgroup without delay.

A decision should be made as to whether the SCR process should be suspended pending the outcome of such notification. The reasons for the decision should be recorded and confirmed to all panel members, agencies, the chair of the board and statutory director.

9 Drafting the Review Report and Public Summary

9.1 The SCR Panel Chair, in consultation with the SCR Panel, is responsible for ensuring the Review Report and Public Summary are drafted and delivered within agreed timescales, consistent with the overall time frame and terms of reference agreed. The resulting Review Report should bring together all relevant information and include an analysis of events. The report should include recommendations where appropriate. The report should cover:

- an account of events and any findings of fact together with a chronology developed from individual management reviews submitted;
- any matters of concern affecting the safety and wellbeing of adults at risk in Islington;
- any general public health, safety or well-being arising from the death of an adult at risk;
- any need to review policy, practice or procedures;
- dissemination to other local authorities;
- identification and integration of learning points from serious case reviews from other areas or research and best practice guidance; and
- information on references and sources used to prepare the report.

9.2 When the draft Review Report has been prepared and is considered to meet the requirements of the review, the SCR Panel will:

- send a draft of the report to contributing agencies and invite comments on factual accuracy;
- invite contributing agencies to confirm they are satisfied that their information is fully and fairly represented in both reports; and
- invite agencies to confirm that the draft recommendations, as they apply to their agency or more generally, are clear.

It is important to note that agencies are not being asked whether they agree with the report or its findings. Rather, the focus is on ensuring the Review Report is factually accurate, understood and its proposed recommendations are clear. Agencies have 10 working days in which to respond.

9.3 The SCR Panel will consider all comments and agree the final version of the Review Report and Public Summary to be submitted to the SCR Sub group. Once signed off by the SCR Panel, only the Chair of the SCR Panel, in consultation with the Review Panel, may make amendments to the content of the draft report, as part of arrangements for its validation and finalization.

10. Considering the recommendations of the Serious Case Review Panel

10.1 On receiving the SCR Panel's signed Review Report (including Public Summary), the SCR Subgroup will arrange to meet within two weeks to consider it. The subgroup will satisfy itself that:

- the terms of reference for the SCR have been met;

- the Review Report may be considered to be factually accurate and a balanced and fair representation of events;
- the Review Report contains a separate summary report (the Public Summary) that can be made public following board endorsement, including, as a minimum, information about the review process, key issues and recommendations;
- the content is sufficiently anonymised to protect the confidentiality of contributors, the adult and relevant family members/others, and avoid risk of inferential identification. In some cases the identity of the subject of the review will be in the public domain but care must still be taken to ensure sensitive personal information is protected, consistent with the conditions of confidentiality associated with the SCR process.

10.2 The SCR Subgroup may not amend the factual content, findings or conclusions of the Review Report. It is open to the subgroup, however, to invite the SCR Panel to give further consideration to certain points. It is then a matter for the SCR Panel to do so and to resubmit their report. It is the final decision of the SCR Panel to accept these points or not (please see section 9.3 for further details). Any conflict between the SCR Subgroup and SCR Panel that cannot be resolved between the two bodies will be referred to the chair and vice chair of the board for mediation and potential resolution.

10.3 The SCR Subgroup should satisfy itself that the conclusions reached are consistent with the factual information and that the recommendations flowing from the findings are sufficiently evidenced and proportionate. It is open to the SCR Subgroup to make additional recommendations. These should be noted separately from the SCR Panel's Review Report. If the SCR Subgroup decides not to accept a particular recommendation or to change a particular recommendation then again this will be identified separately. The subgroup's recommendations can be issued alongside the Review Report, prior to formal submission to the board. If the Chair of the SCR Panel, in consultation with the Review Panel, is content to accept the changes they can be incorporated into the original Review Report.

10.4 Once the full report and proposed public summary have been endorsed by the SCR Subgroup, the subgroup will :

- translate recommendations from the report into a prioritised action plan that is clear, realistic and contains defined time frames and accountable persons to ensure its delivery;
- offer an opportunity to the chair of the SCR Panel to comment on the proposed action plan;
- make sure that the Public Summary, recommendations and action plans are sent to individual agencies and subgroups of the board for implementation;
- make sure that the Care Quality Commission receive a copy of the final report and action plans;
- advise the chair of the board and statutory director accordingly; and
- submit the approved action plan to the next board for endorsement.

10.5 Arrangements will be agreed with the chair of the SCR Panel, chair of the SCR Subgroup and chair of the board, for the presentation of the Public Summary Report to the board for approval, publication and arrangements for monitoring and sign off. The board will ask the SCR Subgroup to make sure that all recommendations are carried out and seek updates on progress from individual agencies until the action plan is completed.

10.6 The action plan will show:

- who is responsible for various actions;
- timescales for completion of actions;
- the intended outcome of the various actions and recommendations;
- ways of monitoring and reviewing intended improvements in practice and/or systems; and
- who the report, or parts of the report, will be made available to.

10.7 The chair of board will make sure the statutory director is informed of progress and outcomes of all SCRs.

10.8 The action plan will remain on the board agenda until the SCR Subgroup confirms all recommendations have been carried out.

10.9 The board will also report the outcome of every SCR completed in any one year's annual review.

11. Timetable

11.1 The process from the decision to conduct a review to the sign off of the final reports should normally be completed within six months. If a longer period is needed; this must be agreed with the chair of the board and statutory director.

11.2 In some cases it may not be possible to complete or publish a review until after Coroners or criminal proceedings have been concluded.

11.3 The family or representatives of the adult at risk will be kept informed of progress and of arrangements for publication of the Public Summary as appropriate.

12. Freedom of Information Act (FOI) 2000 & the Data Protection Act (DPA) 1998

12.1 In the event of requests under the Freedom of Information Act (FOI) 2000 or the Data Protection Act (DPA) 1998 for copies of submissions to or the full report of any review or investigation, the FOI and DPA Lead in Islington Council must be informed immediately as all review materials are held in confidence by the SCR panel on behalf of the council's statutory director.

12.2 The FOI or DPA lead will take advice from the chair of the SCR Subgroup, who will consult the Panel Chair, on the individual case. If appropriate the Board Chair or the Statutory Director may also be consulted.

12.3 Consultation will take place over the possible application of exemptions under FOI.

- 12.4 Any decision to withhold requested information is subject to review and appeal. Therefore it is important to ensure a record exists of how the public interest test was conducted and to seek advice from the council's legal team.
- 12.5 The council's FOI advisors will co-ordinate action for the review / appeal in accordance with the FOI Code of Practice.
- 12.6 Personal information may also be requested by data subjects under the Data Protection Act (1998). Subject access requests are also covered by specific regulations related to health and social work records. Please contact the Data Protection Lead Officer in the relevant organisation for further advice.
- 12.7 The Public Summary of every SCR will be published by the board in an anonymised form having regard to appropriate legal and other advice and any issues of inferential identification.
- 12.8 These provisions do not affect the normal arrangements for information-sharing between professionals for the purpose of a review.
- 12.9 For further general guidance on this legislation you may wish to refer to the relevant section on Islington Council's website.

Appendix 1

Request for a Serious Case Review

Requests for Serious Case Review must be made in writing and sent to the following:

Detective Chief Inspector of Islington and Chair of the Islington Safeguarding Adults Partnership Board

Please also copy in the following people:

Head of Safeguarding Adults, Islington Council and Vice Chair of the Serious Case Review Subgroup

Independent Chair of the Islington Safeguarding Adults Partnership Board

Director of Housing and Adult Social Services, Islington

Please send the request to the following address:

Care of the Safeguarding Adults Unit
338-346 Goswell Road
London
EC1V 7LQ

Appendix 2: Determining the scope of the SCR

The SCR subgroup should consider, in the light of each case, the scope of the review and draw up clear terms of reference. Relevant questions include the following:

- What are the most important issues to address in trying to learn from this case?
- How can the information best be obtained and analysed?
- Who should be appointed as the author for the report?
- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?
- Might it help the SCR Panel to bring in an outside expert, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, for example how far back should enquiries cover and what is the cut-off point?
- What family history/background information will help to better understand what happened?
- Which organisations and professionals should contribute and what contribution should they be asked to make?
- Is there a need to involve organisations/professionals in other boroughs, and what should be the roles and responsibilities of the different boards with an interest?
- How should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the SCR process fit with the processes for other types of reviews?
- Who will make the link with interested parties outside the main statutory organisations, for example independent professionals, independent and voluntary organisations?
- When should the review process start, and by what date should it be completed?
- How should any public, family and media interest be managed before, during and after the review?
- Does the board need to obtain independent legal advice about any aspect of the proposed review?

Some of these issues may need to be revisited as the review progresses and new information emerges.

Appendix 3: Management Reviews by member agencies and independent organisations

1. When a case meets the criteria for conducting a SCR the Chair of the SCR Panel will formally request the agencies (and possibly some independent practitioners) to conduct a management review of their involvement with the adult, the service and/or their family and to submit a report, recommendations and where necessary an agency action plan arising from that review. The review and report should comply with the SCR's terms of reference, which will be sent with the request, and the guidelines contained in this appendix.
2. The management review, report and chronology (if appropriate) must be sent to the SCR Panel administrator by email within 6 weeks of the report being requested.
3. The request for a management review and report including a chronology if appropriate will be addressed to the chief officer or chief executive of the agency concerned (or directly to any independent practitioners identified in the recommendations of the SCR Panel). The task of completing the chronology, review, report and where necessary an agency action plan, should be delegated to a suitably qualified and experienced senior manager within the agency/service. This should not be the original caseworker or anyone who has directly managed the case. It is important that the management review, report, recommendations and agency action plan are fully endorsed by the chief officer before submission.
4. The aim of the management review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, identify how those changes will be brought about.
5. The SCR to which the management reviews contribute are not part of the disciplinary inquiry or process. However, information that emerges in the course of reviews may indicate that disciplinary action should be taken under established agency procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases, for example alleged institutional abuse; disciplinary action may be needed urgently to safeguard other adults at risk.
6. The format below should guide the preparation of the management review. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues which need to be explored, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of particular circumstances.
7. Where staff or those preparing the management review interview others, a written record of such interviews should be made and this should be shared with the relevant interviewee. If any individual is interviewed directly by the SCR Panel a formal note will be put on record.

8. A report of the management review should be completed, endorsed by the agency's chief officer and sent to the administrator of the SCR Panel within the time set out in the original request. Any foreseeable delays should be communicated to the Chair of the SCR Panel or the Chair of the SCR Subgroup.
9. The SCR Panel will collate and comment on the recommendations of each agency. Any additional action points identified by the panel will be discussed with the agency concerned and maybe included in the SCR Review Report. It is recommended that the management report should not be longer than 10 pages.

Content of Management Reviews

What was the agency's involvement with the adult at risk and/or their family?

A comprehensive chronology should be compiled of involvement by the agency and/or professional(s) in contact with the adult and family over a period of time set out in the review's terms of reference. Decisions reached should be briefly summarised, the services offered and/or provided to the adult, family/carer, and other action taken.

Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgments were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider:

- were practitioners sensitive to the needs of the adult in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about an adult at risk?
- Did the agency have in place policies and procedures for safeguarding adults at risk and for acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult, family/carer? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did action accord with the assessments and decisions that were made? Were appropriate services offered/provided or relevant enquiries made in the light of the assessments?
- When, and in what way, were the adult's wishes and feelings ascertained and considered? Was this information recorded?
- Was the person's mental capacity appropriately assessed and taken into account throughout the agency's involvement with the client?
- Where relevant, were appropriate care plans or adult protection processes in place, and care plan reviews and/ or adult protection reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic, age, disability and religious identity of the adult, and family/carer?
- Were more senior managers or other agencies and professionals involved at points where they should have been?
- Was the work in this case consistent with agency and Islington Safeguarding Adults Partnership policy, protocols and guidance for safeguarding adults at risk and wider professional standards?
- Are there lessons from this case for the way in which this agency works to safeguard adults at risk and promote their welfare? Is there good practice to highlight ways in which practice can be improved? Are there implications for ways of working: training (single and inter-agency); management and supervision; working in partnership with other agencies; resources?

What has been learned from the case?

Each agency should produce and submit an action plan setting out any changes or improvements to their practice in light of this case. This should include possible disciplinary or regulatory action. The agency should set out how the plan will be reviewed to determine if the outcomes have been achieved.

Dissemination and Learning

The Individual Management Reviews are stand alone documents and should lead to individual actions by the respective agency:

- The agency-specific recommendations need to be implemented (**there is no need to await the outcome of the SCR**)
- The findings and recommendations from the management review need to be fed back to the relevant staff from the agency. This includes the media/communication, legal and environmental teams.

Appendix 4

Report by SCR Panel

The SCR report should bring together and draw overall conclusions from the information and analysis contained in the Management Reviews and any other reports.

The report should be produced according to the following outline format although, as with management reviews, the precise format depends on the features of the case.

SCR Panel Report Format:

a) Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to the review and the nature of their contributions.
- List panel members and the author of report.

b) The facts

- Set out a pictorial display of the person's relationship to family members, extended family and household and any care services provided.
- Compile an integrated chronology of involvement with the adult, family/carer on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the adult was seen and the adult's views and wishes sought or expressed.
- Prepare an overview that summarises what relevant information was known to the agencies and professionals involved about the carers, any perpetrator and the home circumstances of the adult.

c) Analysis

- This part of the report should look at how and why events occurred, decisions were made and actions taken or not taken.
- This is the part of the report where reviewers (those undertaking the reviews), can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.
- The analysis section is also where any examples of good practice should be highlighted.

d) Conclusions and recommendations,

- This part of the report should summarise, in the opinion of the panel, what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action.
- Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation.
- Recommendations should be few in number, focused and specific, and capable of being implemented.
- If there are lessons for national as well as local policy and practice, these should also be highlighted.

Appendix 5

Islington Safeguarding Adults Partnership Serious Case Review Panel: REF NO

I[full name]

holding the position of[job title]

within.....[name of agency]

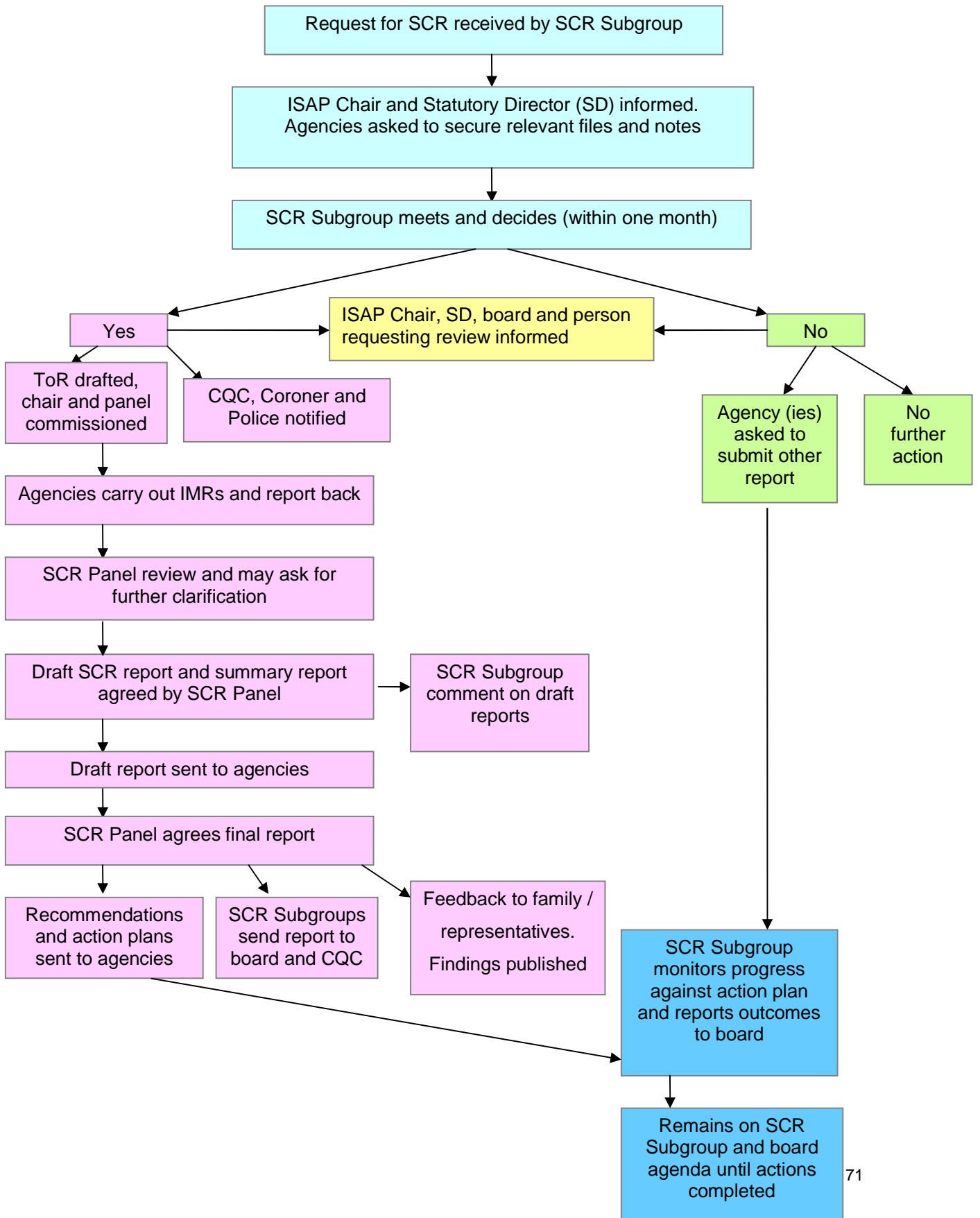
confirm my understanding and acceptance of the following confidentiality requirements in relation to this serious case review:

- All sensitive, personal and other information and documentation will be shared in confidence. This will be done consistent with the expectation that the duty of confidence will be maintained in line with the requirements of Data Protection legislation and local protocols for the sharing of information; including Caldicott requirements within health, education and social care.
- All information received or given (including all documentation and notes, whether in electronic or manual form) must be held securely and safely. All material relating to the review must be kept together in one place. This includes information stored electronically which will normally be supplied in protected form.
- Electronic data may only be stored on agency systems. Memory sticks or other portable devices must not be used for this purpose.
- All documentation should be marked 'Confidential' and may not be disclosed to others without the prior written consent of the Chair of the SCR Panel or the Chair of the SCR Subgroup.
- All information discussed at panel meetings or within the partnership as part of this review is and remains strictly confidential. It may not be discussed, disclosed or in any other way made available to other parties without the prior written consent of the Chair of the SCR Panel or the Chair of SCR Sub group.
- The unauthorised disclosure of information outside of meetings, beyond that which has been agreed and recorded within the minutes of the panel or board meeting, may have legal consequences. It would be considered as a breach of the data subject's confidentiality and a breach of the confidentiality requirements of the agencies involved.
- All information and documentation supplied as part of the review becomes and remains the property of the Islington Safeguarding Adults Partnership Board. It remains the confidential property of the board even when stored within agency systems. All materials must be returned to the Chair of the board or the Chair of the SCR Subgroup on being requested or at the end of meetings, or at the end of the review process.

- Confirmation of secure destruction will be provided.
- Advice on these requirements is available from the Chair of the SCR Subgroup and or Chair of the board.

Signed:Dated:

Islington Serious Case Review Flow Chart



Sources

The following sources were used in the development of this document:

ADASS (2005) [Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work.](#)

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Manthorpe, J. and Martineau, S. (2011) **Serious Case Reviews in Adult Safeguarding in England: An Analysis of a Sample of Reports.**

Ofsted (2008) **Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008.**

SCIE (2009) **At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews.**

SCIE (2010) **At a glance 34: Piloting the SCIE 'systems' model for case reviews: Learning from the North West of England.**

SCIE (2011) **Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.**

Solihull Safeguarding Adults Board (2009) **Serious Case Review Procedure.**

Surrey Adult Protection Committee (2005) **Serious Case Review.**

Warwickshire Safeguarding Adults Board (2009) **Warwickshire Inter-Agency Safeguarding Adults Serious Case Review Policy and Procedure.**