Our safeguarding arrangements will effectively prevent and respond to adult abuse

SAFEGUARDING ADULTS WORKBOOK

Module One

Learning from Serious Instances of Abuse and Neglect

Teeswide Safeguarding Adults Board

Contents

Revision Number	Date Approved by the Board	Links to Policies	Review Date:
One	28 June 2016		June 2017
Two	May 2017		May 2018
Three	Dec 2018	Listed on page 17	Oct 2019

Introduction

This workbook has been developed for staff and volunteers who have completed Safeguarding Adults awareness training, which may have been through attending a tutor-led course, completing an e-learning course or the TSAB Safeguarding Adults Awareness workbook. This workbook will build on your prior learning and is module 1 of 8. The modules are as follows:

Module 1:	Learning from Serious Instance of Abuse and Neglect
Module 2:	The Mental Capacity Act & Deprivation of Liberty Safeguards
Module 3:	Domestic Abuse
Module 4:	Forced Marriage
Module 5:	Female Genital Mutilation
Module 6:	Prevent
Module 7:	Modern Slavery
Module 8:	Self-Neglect.

You must complete all sections of the workbooks and return them to your Manager for assessment. When you have successfully completed all of the modules, you will be issued with a certificate and your training records will be updated: the workbooks will be returned to you to be used as a reference tool.

In the appendices, you will find the current Teeswide Inter-Agency Safeguarding Adults Policy and Procedures for reference purposes.

The workbook has been checked for legal accuracy and is accurate as of Sept 2018. Suggested study time to be allocated to complete this module: 2½ hours.

Once you have completed the workbooks please forward the ***Certificate of Completion*** page to the Teeswide Safeguarding Adults Board, Business Unit, using the contact details below, who will make a record of completion and issue a certificate.

Teeswide Safeguarding Adults Board Business Unit, Kingsway House, West Precinct, Billingham, TS23 2NX Email: tsab.businessunit@stockton.gov.uk

This workbook is aligned with nationally recognised competencies. It is based on the Bournemouth University National Competence Framework for Safeguarding Adults, reviewed in 2015, and mapped against the Safeguarding Adults: Roles and competences for health care staff- Intercollegiate Document issued August 2018.

On completion of this workbook, you will be able to:

Level 1 (Foundation)

1. Understand and demonstrate what Adult Safeguarding is
2. Recognise adults in need of Safeguarding and take appropriate action
3. Understand dignity and respect when working with individuals
4. Understand the procedures for raising a Safeguarding Concern
5. Have knowledge of policy, procedures and legislation that supports Safeguarding Adults activity
6. Ensuring effective administration and quality of safeguarding processes.

Target groups: **Alerters and NHS Level 1 & part of Level 2**

Including: All staff and volunteers in health and social care settings, all frontline staff in Fire and Rescue, Police and Neighbourhood Teams and Housing, Clerical and Administration staff, Domestic and Ancillary staff, Health and Safety Officers, staff working in Prisons and custodial settings, other support staff, Elected Members, Governing Boards and Safeguarding administrative support staff.

Although the word 'Alerter' is used here in conjunction with the national competency framework, the term 'Safeguarding Concern' was introduced in April 2015 to replace this.

Level 2 (Intermediate)

1. Demonstrate skills and knowledge to contribute effectively to the safeguarding process
2. Have awareness and application of legislation, local and national policy and procedural frameworks.

Target Groups: **Responders, Specialist Staff and NHS Level 2 & 3**

Including: Social Workers, Senior Practitioners, Social Work Team Managers, Voluntary and Independent Sector Managers, Heads of Nursing, Health and Social Care Provider Service Managers, Safeguarding Adult Co-ordinators, Police Officers, Probation Officers, Community Safety Managers, Prison Managers, MCA Lead, Best Interests assessors (including DoLS), Advocates, Therapists, Fire and Rescue Officers, staff working in Multi-Agency Safeguarding Hubs.

What is a Safeguarding Adult Review?

Since the Care Act 2014 was introduced (April 2015) the Teeswide Safeguarding Adults Board (Board) has had a statutory duty to undertake a Safeguarding Adult Review (SAR) when:

- An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- An adult in its area has not died, but the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the adult would have been likely to have died but for an intervention, or has suffered permanent harm, or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The Board can also arrange a SAR in any other situation involving an adult.

The Teeswide Safeguarding Adults Review Policy and Procedures are signposted on page 17 (1), which give full details on how the Board discharges the statutory duty to conduct a SAR.

Why it is Important to Conduct SARs?

The purpose of undertaking a SAR is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

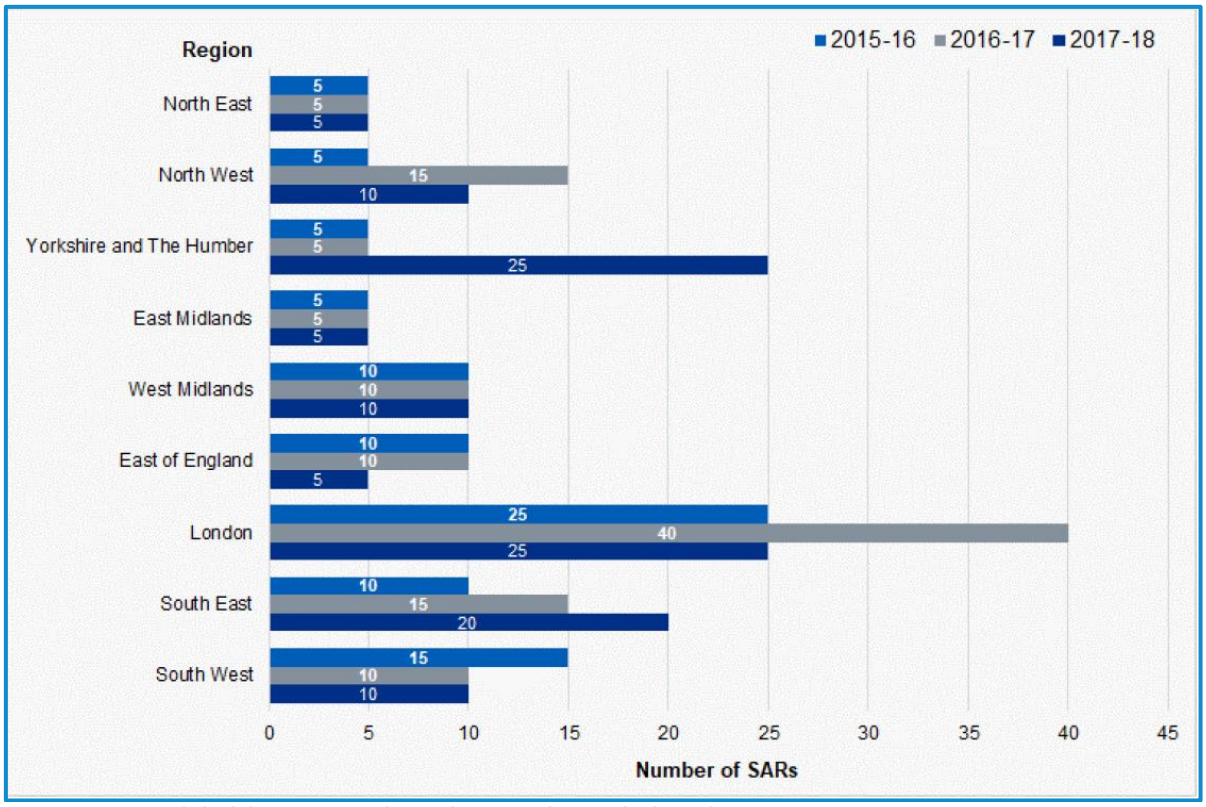
The Care and Support Statutory Guidance (page 17) issued under the Care Act by the Department of Health also suggests that SARs may be used to explore examples of good practice where this is likely to identify lessons that can be applied in future practice.

SARs are used to establish what the broader issues were in relation to the circumstances leading up to the death or serious abuse or neglect of the adult (s) involved in the case being reviewed.

These are called ‘Systems Findings’ and are designed to highlight the issues that are affecting a wider number of agencies collectively, rather than reviewing the practice of just one single organisation.

How Many SARs are Conducted Each Year?

Count of SARs: 2015-16 = 90 2016-17 = 110 2017-18 = 110



Source NHS Digital (Aggregated numbers and rounded to 5)

Since the introduction of the Care Act 2014, 310 SARs have been published in England up until the end of March 2018. Although SARs are still relatively rare locally, with only one published in Tees as of December 2018 (SAR Carol), there are lots of lessons that can learned from other SARs that are still relevant locally.

The Board publishes a short bi-monthly [1]summary of regional and national SARs to help disseminate the lessons learned in these cases.

Other Types of Review

Non-statutory reviews (Lessons Learned Reviews or LLRs) are conducted by the Board which also help to generate important multi-agency learning. In addition other review processes such as Domestic Homicide Reviews (DHRs), Mental Health Homicide Reviews and Child Safeguarding Practice Reviews (formerly called Serious Case Reviews or SCRs) are also considered, to ensure that any and all relevant sources are utilised to help improve practice across Tees.

[1] Teeswide Safeguarding Adults Board: Learning from Regional and National Cases
https://www.tsab.org.uk/key-information/safeguarding-adult-review-sar-reports/

National Themes and Lessons Learned

Approximately 50% of SARs are linked to the issue of self-neglect, but only 4% of safeguarding enquiries conducted by Local Authorities in England in 2017-18 were linked to this subject. This highlights the potential, for what is one of the least recorded types of abuse, to result in the most serious and significant harm to adults.

Professionals should understand how they can play a part in preventing this type of abuse from escalating, which is a key learning outcome from this workbook.

Several thematic or themed reviews have been published over the last two years, including the largest conducted in [2]London in July 2017, which examined 27 published SARs from across 17 Safeguarding Adults Boards. This report and the emergence of other trends in 2018 have been used to create the following themes.

Summary of Key Themes:

1. **Mental Capacity**: Missing or poorly performed Mental Capacity Act Assessments.
2. **Risk Assessment**: Absence or inadequacy of risk assessments.
3. **Challenges of Engagement**: Lack of persistence and flexibility from professionals working with adults unwilling or reluctant to engage with services.
4. **Professional Curiosity**: Lack of curiosity about the meaning of behaviour, or failure to recognise key features in life stories.
5. **Communication & Information Sharing**: Information not shared, or communications not timely, and inadequate pathways and systems across agencies to share information.
6. **Legal Literacy**: Agencies failing to consider how legal powers and duties could be exercised in a joint multi-agency strategy.
7. **Safeguarding Literacy**: Failures to implement safeguarding procedures, and inadequate responses to safeguarding referrals.
8. **Adults Placed Outside of their Local Area**: The risks identified with placing adults into care environments outside of their home Local Authority area.

Each of these themes is examined in more detail over the coming pages using references from the six Case Studies that are introduced on page 8, which help to highlight the significant lessons that were learned in respect of all these issues.

However, other factors should not be ignored and the [3]National SAR Library has been launched which is helping to identify other themes linked to Systems Findings.

[2] Learning from SARs: A report for the London Safeguarding Adults Board – Suzy Brae and Michael Preston Shoot: http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

[3] National SAR Library: Hosted by the Social Care Institute of Excellence (SCiE): https://www.scie.org.uk/safeguarding/adults/reviews/library/project

Case Studies

1

SAR Carol

Carol was a 39 year old woman discovered deceased at home on the morning of 9 December 2014. Two teenage girls were arrested for Carol's murder. Carol had been identified as having multiple care and support needs, and many agencies and professionals had long standing involvement with her.

2

SAR P

This SAR examines the way that service providers, Local Authorities and other agencies worked together to provide services to a man P, aged 28, with mild learning disabilities. P committed a series of sexual assaults over at least a ten-year period, with victims including other people with learning disabilities, as well as members of the public.

3

SAR Eva

There had been increasing evidence that Eva had been suffering from neglect and or self-neglect, which resulted in her admittance to Hospital with infected pressure ulcers and cellulitis of the leg. Eva then suffered from Hospital acquired pneumonia and infections, resulting in her death in February 2016.

4

SAR Ruth Mitchell

Ruth Mitchell was 40 years old when she died at her home on 2 September 2012. Ruth was known to have schizophrenia and was under psychiatric care, and at the time of her death weighed 7 stone. She appeared to have neglected herself over a long period of time.

5

Serious Case Review (SCR) Melisa

On 12 October 2014 Melissa who was 18 years old was strangled by another male resident (YA2) aged 19 years old in the Care Home (1) they both lived in, which supported people living with Autism and Asperger's Syndrome. Melissa died from her injuries on 16 October 2014, and the male resident was subsequently convicted of her murder. Although this report was published in September 2017, this was commissioned as an SCR due to the circumstances pre-dating the Care Act, which introduced SARs.

6

SAR Nightingale Homes

During 2015 - 2016 concerning themes emerged about the running of the three Residential Care Homes ran by Nightingale Services and the wellbeing of the people who lived there. After inspections in 2016 all three Homes were rated as 'Inadequate' and despite the efforts of a 'Turnaround Team', all of the Homes closed in 2017. The SAR examines why failings in the services were not recognised earlier, when there was so much professional interaction from the fourteen agencies who engaged with residents in these homes.

Mental Capacity

The [4]SAR Carol report states:
"Amongst professionals the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex".

The [5]SAR Ruth Mitchell report states:
"The concept of executive capacity appeared unknown at the time. Ruth had made a number of decisions herself which resulted in her being cold, experiencing a loss of income, being poorly nutritioned and having no comforts in her life. Whilst her 'ability to cope' with the results of her decisions was questioned, her capacity to do so was not, and a self-determining approach to the dilemma of whether to intervene in Ruth's life predominated".

This is a common feature found in many SARs were there has been a failure to appropriately assess executive capacity, which is the ability to put a decision into effect, in addition to the adult's ability to make a decision (decisional capacity). In complex cases such as this "the assessment of mental capacity is unlikely to be as straightforward as a simple yes or no" (SAR Carol).

Key Lessons Learned:

1. Frontline professionals should be encouraged to seek support for complex cases. This may involve a senior clinical specialist opinion or a more comprehensive deliberation in partnership with other agencies.
2. Professionals should know how to escalate concerns and be supported in difficult mental capacity assessments, both clinically and legally where necessary.
3. It is essential to differentiate between an 'assumption' of mental capacity, which can and should be made if there is no reason for concern that the individual's capacity may be impaired, and an 'assessment' under the Mental Capacity Act (MCA) which has concluded that the person has capacity.
4. All mental capacity assessments should be recorded comprehensively, outlining the evidence used to inform decision making.

The full SAR Carol report can be read here:
https://www.tsab.org.uk/key-information/safeguarding-adult-review-sar-reports/

The full SAR Ruth Mitchell report can be read here:
http://web.plymouth.gov.uk/safeguarding_adult_review_ruth_mitchell.pdf

[4] SAR Carol: Teeswide Safeguarding Adults Board – July 2017
[5] SAR Ruth Mitchell: Plymouth Safeguarding Adults Board – November 2017

Risk Assessment

The [6]SAR P report states:
"Risk assessments were not completed and information about risk was not shared. At times these acts were deliberate and at others the result of ignorance or poor systems; however the resulting harm to those who are vulnerable, remains the same. Professional networks must work together to ensure that people are safe as their first priority".

The [7]SCR Melissa reports states:
"There is a balance to be struck between the desire not to criminalise some behaviour and to manage this within the therapeutic setting, against the need to protect others who may be at risk from this behaviour. Incidents should always be reported to the police. This does not automatically mean that a criminal investigation will occur. It would however assist in the development of a better understanding of risks and enable the effective management of these within a multi-agency framework".

"There was a lack of clarity and assessment as to the appropriate level of supervision of YA2 within the placement at Care Home 1 and that this should have been resolved by all parties prior to his placement there".

Key Lessons Learned:

1. Professionals must not ignore serious allegations of abuse, including sexual abuse, when the adult has a learning disability or other cognitive impairment. The Police referral criteria must always be followed correctly. (See (1) page 17).
2. Risk assessment processes must always be robustly conducted when an adult is being considered for movement between residential care environments, and relevant information shared with other agencies appropriately in line with local data protection arrangements.
3. Risk assessments should take into account the specific issues that are relevant to each individual within a care environment, including Psychiatric Assessment Reports.
4. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

The full SAR P report can be read here:
https://mylife.enfield.gov.uk/media/24719/sar-report_p_march-2018.pdf

The full SCR Melissa report can be read here:
https://bristolsafeguarding.org/media/1301/mm-scr-final.pdf

[6] SAR into the care and risk management of P: Enfield Safeguarding Adults Board – March 2018
[7] SCR Melissa: Bristol Safeguarding Adults Board – September 2017

Challenges of Engagement

The SAR Ruth Mitchell report states:
“Ruth was clear that she did not want the intrusion of mental health services in her life. However, she appears to have worked well with the GP surgery in addressing her anaemia, attending blood tests, being honest about her medication use and ultimately choosing to take medication. She does report repairs she is concerned about to her housing provider”.

“The possibility of other agencies engaging with Ruth under the guidance of mental health professionals was not considered”.

“Ruth was not engaged in a relationship with any agency sufficiently to enable work to support her to make changes in her life”.

Key Lessons Learned:

1. Professionals must fully understand the link between self-neglect and adult safeguarding. (See (2) guidance on page 17).
2. When an adult is self-neglecting, relationship based work becomes crucial.
3. Having one worker as a single point of contact may be beneficial.
4. Using the label “hard to engage” may result in other agencies believing there is little point in attempting to do so.
5. Agencies should work together, and if one is struggling to achieve meaningful engagement with the adult, another may still be able to take the lead on behalf of multiple agencies in managing and monitoring risk.
6. Agencies should also consider the following in helping to improve engagement with adults:
   a. Creative, flexible and imaginative ways to communicate with adults.
   b. Producing information in a number of ways to meet individual needs.
   c. Involving family members appropriately to help support adults.
   d. The use of advocacy to engage with adults.
   e. Training staff to enable and improve engagement with adults.

   (See (3) User Engagement in Adult Safeguarding (SCiE Report 47) signposted on page 17).
7. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

Professional Curiosity

The [8]SAR Nightingale Homes report states:
"There was little professional curiosity about daily routines or indeed the wider domains which make up a person's sense of 'wellbeing', it is unknown whether documents, including care plans or risk assessments were viewed by reviewing staff, a few are commented upon by placing authorities and other agencies as of good and useful quality, but are usually not mentioned and potentially not seen".

"The staff (Community Health Team) defaulted to the expertise of the Nightingale staff, a dangerous position to take, as they felt they 'did not know the client group' and therefore could not trust their own perceptions".

Professionals must not assume that people living in an environment will not have the same reactions and worries that they have.

Key Lessons Learned:

1. Professionals need to practice 'respectful uncertainty' and apply critical evaluation to any information they receive, maintaining an open mind and 'Thinking the Unthinkable'.
   (See (4) Professional Curiosity & Challenge Resources for Practitioners on page 17).
2. Professional curiosity can require practitioners to think 'outside the box', beyond their usual role, and consider families' circumstances holistically.
3. Respectful uncertainty is needed when working with families who are displaying 'disguised compliance'. Disguised compliance involves family members or carers giving the appearance of co-operating with agencies to avoid raising suspicions and allay concerns.
4. The key to effective safeguarding practice is for professionals to ask the right questions, including:
   a. Would I live here, and if not, why not?
   b. Would I be happy with this standard of care for a member of my family?
   c. What does good look like?
   d. Is there anything else going on in this person's life which might be causing harm, or the potential for adult abuse or neglect?
   e. Are agencies working effectively together?
5. Professionals should follow the Making Safeguarding Principles. (See (5) page 17).
6. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

The full SAR Nightingale Homes report can be read here:
http://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2018/10/SAR-Nightingale-Final-Oct-2018.pdf

[8] SAR Nightingale Homes: South Gloucestershire Safeguarding Adults Board – October 2018

Communication & Information Sharing

The SAR Ruth Mitchell report states:
"Agencies are reliant on adult safeguarding to communicate information across agencies. If a concern does not reach the adult safeguarding team or does not meet the threshold for a statutory section 42 enquiry it is unlikely that information will be shared with other agencies".

The SAR Nightingale Homes report states:
"Information which indicated concern was picked up by each of the [9]placing authorities at some point during the period in scope. None of the placing authorities shared this information with the [10]host authority adult safeguarding team".

"An absence of relationship and for some, respect and understanding of family involvement, reduced the possibility of sharing information and understanding about the person's situation".

Key Lessons Learned:

1. Families and representatives should know how to express concerns and opinion regarding providers, and should, if the person consents, be regularly invited to reviews as a matter of course.
2. Alternative information sharing pathways need to be considered in order to prevent harm; in addition, agencies must develop their understanding of consent and data protection, and not assume that because a concern has been referred to adult safeguarding information sharing will follow.
3. Agencies must develop processes to share information to prevent harm. For example, a Multi-Disciplinary Team (MDT) can share non-clinical information with partner agencies, including housing and police colleagues.
4. The General Data Protection Regulation (GDPR) is not a barrier to sharing information, but provides a framework to ensure that personal information about an adult is shared lawfully and appropriately.
5. It is good practice to share information with consent, which supports the Principles of Making Safeguarding Personal, but you can share information without consent when there is a legal basis to do so.
   (See (1) Information Sharing Agreement on page 17).
6. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

[9] Placing or Home Local Authority: The place where the adult is ordinarily resident (home area).
[10] Host Local Authority: Location of the actual care home or where the adult is living at that time. It is the Host Local Authority's responsibility to conduct safeguarding enquiries.

Legal Literacy

The SAR Carol report states:
"The thresholds and criteria under which safeguarding referrals were made concerning Carol were applied differently and inconsistently by agencies, meaning that Carol's risks, multiple and accumulative, were not fully considered multi-agency".

"The PCSOs knew Carol well and sought to support her but they did not have full police powers to intervene nor any link up with the wider community strategy. There was a wealth of intelligence with the PCSOs, Carol's integrated mental health team and landlord, but this intelligence about the community was not being systematically linked with assessment or protection of an adult at risk".

The [11]SAR EVA report states:
"When there is clear evidence that an adult with care and support needs is at risk of significant harm, there should be a safeguarding referral in line with multi-agency safeguarding adult's procedures. Even if the harm is believed to be caused by self-neglect and the adult is assumed to have mental capacity to make the decisions resulting in self-neglect, safeguarding adults policies and procedures should still be applied".

The SAR Ruth Mitchell report states:
"In undertaking risk assessments, the mental health service appears to be operating within a silo and unable to extend its understanding of the risks in Ruth's life by reference to relevant information that may be held by other agencies".

Key Lessons Learned:

1. All professionals must understand the part they play in the wider adult safeguarding framework, and that other agencies may also be engaging and working with adults that they are.
2. Professionals should understand that other agencies may have powers or duties that they do not have that may be relevant in helping safeguard an adult, and generally be aware of the legal framework for adult safeguarding (See (6) page 17 for more details).
3. Frontline professionals should understand that there can be a link between community safety and adult safeguarding systems.
4. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

The full SAR Eva report can be read here:
http://www.sunderlandsab.org.uk/?page_id=163

[11] SAR Eva: Sunderland Safeguarding Adults Board – February 2018

Safeguarding Literacy

The SAR Nightingale Homes report states:
“Agencies were unclear on what is and is not reportable, what is poor practice, and what is safeguarding”.

“The safeguarding process is reported to be understood by staff, but not one that they felt part of, they report that they were often not aware of whether a referral sent in had met the eligibility criteria for safeguarding and were not routinely invited to strategy meetings”.

“Staff were remarkably siloed in thinking that someone else was concerned and doing something”.

The SAR Carol report states:
“The review has found that amongst the professionals and agencies working with Carol there was not, nor is there currently, a common understanding of adult safeguarding thresholds (i.e. in what circumstances should safeguarding referrals be made)”.

Key Lessons Learned:

1. All professionals must ensure that they fully understand what adult abuse and neglect entails, and that they update their knowledge on all of the relevant guidance in relation to safeguarding practice. This includes understanding Teeswide Adult Safeguarding Policies and Procedures. (Outlined (1) on page 17).
2. No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult.
3. An adult may be at greater risk of suffering abuse or neglect because of physical, mental, sensory, learning or cognitive illnesses or disabilities; and substance misuse or brain injury, and includes:
   - Those who purchase their care through personal budgets
   - Those whose care is funded by Local Authorities and/or health services
   - Those who fund their own care
   - Informal carers, family and friends who provide care on an unpaid basis
   - Adults who are in prison or living in approved premises on licence
   - Those aged between 18 and 25 years and in receipt of children’s services.
4. Professionals should understand when there is a need to submit an Adult Safeguarding Concern (in line with the Local Authority Safeguarding Duty) to ensure that a multi-agency response can be initiated if this is necessary.
   (See Appendix 2 on page 19).
5. Agencies must be told what the response to their concern is, and if there is no response they must be aware of how to escalate concerns that they believe need an adult safeguarding response.
   (See (1) Professional Challenge Procedures referenced on page 17).

Adults Placed Outside of their Local Area

[12]SAR Mendip House is another very prominent review that received a lot of national interest due to the comparisons that were made to the scandal at [13]Winterbourne View in 2011. There were a large number of residents at Mendip House that had been placed there from outside the host Local Authority area, but no residents living there from that locality (Somerset). This resulted in a lack of oversight by the hosting authority, and a lack of supervision by the placing authority.

The SAR Melissa report states:
"Home authority Adult Mental Health services did not exercise sufficient oversight of the placement process".

The SAR Nightingale Homes report states:
"Contact with the people who lived at Nightingale Homes show a very limited number of face to face contacts".

"Absence of multi-agency reviews or of assessment of care and support needs, meant that for some opportunities for independence was lost, for others coordination of very complex needs was neglected, or the decision that the provider could no longer meet a person's needs was not made".

Key Lessons Learned:

1. All professionals should be alert to the potential risks when an adult is placed outside of the Local Authority area where they are ordinarily resident.
2. Adults who are assessed as having complex needs which require the support of several agencies, or where the placement has been accepted as not being ideally suitable, should be referred to the host authority so that the placement is regularly reviewed.
3. Professionals from all agencies should develop strong relationships with families. If the only relationship families have is with the agency they are concerned about, this will add to the sense of helplessness and isolation experienced by the adults (and their families) living in Nightingale Homes.
4. Providers should have a strategy and culture that promotes, welcomes and responds appropriately to complaints.
5. Professionals should understand when there is a need to submit an Adult Safeguarding Concern to ensure that a multi-agency response can be initiated if this is necessary.

[12] SAR Mendip House: Somerset Safeguarding Adults Board – January 2018
http://ssab.safeguardingsomerset.org.uk/wp-content/uploads/20180206_Mendip-House_SAR_FOR_PUBLICATION.pdf
[13] Winterbourne View Hospital: Department of Health Review and Response:
https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

Useful References and Resources

1. **Teeswide Safeguarding Adults Board's Policies, Procedures and Guidance Webpage**

- Decision Support Guidance
- Inter-Agency Safeguarding Adults Policy
- Inter-Agency Safeguarding Adults Procedure
- Information Sharing Agreement
- Police Referral Criteria
- Professional Challenge Procedure
- Safeguarding Adults Review Policy and Procedure
- Safeguarding & Promoting the Welfare of Adults & Children at Risk Guidance
- Self-Neglect & Hoarding Policy and Guidance

https://www.tsab.org.uk/key-information/policies-strategies/

2. **Guidance on Self-Neglect**

- Self-Neglect (SCiE Report 71)
https://www.scie.org.uk/files/self-neglect/self-neglect-at-a-glance.pdf
- Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care (SCiE Report 69)
https://www.scie.org.uk/files/self-neglect/policy-practice/report69.pdf

3. **User Engagement in Adult Safeguarding** (SCiE Report 47)
https://www.scie.org.uk/publications/ataglance/ataglance47.pdf

4. **Professional Curiosity & Challenge – Resources for Practitioners**
https://www.manchestersafeguardingboards.co.uk/resource/professional-curiosity-resources-practitioners/ (Manchester Safeguarding Boards)

5. **Making Safeguarding Personal – Teeswide Guidance Webpage**
https://www.tsab.org.uk/key-information/prevention/making-safeguarding-personal-tsab-guidance/

6. **Key Legislation in Relation to Adult Safeguarding** (Not exhaustive)

- The Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- The Care Act 2014: Care and Support Statutory Guidance (October 2018)
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
- The Mental Capacity Act 2005 (Including Deprivation of Liberty Safeguards)
http://www.legislation.gov.uk/ukpga/2005/9/contents
- The Human Rights Act 1998
http://www.legislation.gov.uk/ukpga/1998/42/contents
- The Mental Health Act 1983
http://www.legislation.gov.uk/ukpga/1983/20/contents
- The Mental Health Act 1983: Code of Practice 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Appendix 1

Teeswide Safeguarding Adults Concern Form
https://www.tsab.org.uk/report-abuse/

Appendix 2

Teeswide Safeguarding Adults Inter-Agency Procedure Summary

In accordance with the Care Act 2014, safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect him/herself from either the risk, or the experience, of abuse or neglect

The adult experiencing, or at risk of abuse or neglect will be referred to the ***adult*** throughout this procedure.

		Stage of Procedure	Role	Responsibility	Maximum Timeframe
ENQUIRY PHASE	1	**Concern**	• Take immediate action to safeguard anyone at risk of abuse or neglect • Report and record concerns that an adult maybe at risk of abuse or neglect • Establish the ***adult's*** views, wishes if appropriate • Where an adult dies and abuse or neglect is suspected, a concern must be raised	Person raising concern	Immediate Inter-agency concern form completed within 1 day
	2	**Decision Making**	• Decision made as to whether the Inter-agency Safeguarding Procedure is appropriate to address the concern or whether more information is required as part of the enquiry • Decision support guidance used to inform the decision making process • Ensure that the views and wishes of the ***adult*** are taken into account • Determine who will undertake the initial enquiry if not the LA	Designated Officer	Within 3 days of receiving the concern

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Consider alternative action if safeguarding procedures are not appropriate • Consider providing feedback to the person raising the concern. • If the concern relates to a deceased adult, consideration to be given to raising a SAR notification • If the adult dies after the safeguarding concern has been raised, the enquiry will continue		
3	**Initial Enquiry**	• Further information gathered from identified sources in order to inform the decision as to whether to progress into safeguarding procedures • Seek or review the ***adult's*** views and wishes including their desired outcomes • Consider whether the ***adult*** requires an independent advocate to support them • Consider providing feedback to the person raising the concern *	Safeguarding partners; ***adult,*** their advocate, relative and carers	Within 3 days of receiving the concern
4	**Decision Making**	• Decision made as to whether the safeguarding procedures are appropriate to address the concern or whether more information is required as part of the enquiry • Decision support guidance used • Consider the ***adult's*** views and wishes including their desired outcomes	Designated Officer	Within 7 days of receiving the concern, if more time is required, the reason for the extended timescale must be recorded.

		Stage of Procedure	Role	Responsibility	Maximum Timeframe
ENQUIRY PHASE			• Consider whether the ***adult*** requires an independent advocate to support them • Consider alternative action if safeguarding procedures are not appropriate • Consider providing feedback to the person raising the concern *		
	5	**Strategy Meeting**	• Designated Officer co-ordinates the strategy discussion/meeting • Agencies invited to attend the strategy discussion to ensure they are prepared for the meeting and have the relevant information available to contribute to information sharing and decision • If the strategy discussion has taken place via telephone to ensure the adult is protected, then face-to-face strategy meeting will be convened at the earliest opportunity • Formulate a Inter-agency safeguarding plan if needed • Determine who will undertake the further enquiry if not the LA • Agree timescale for completion of enquiry • Involvement of the ***adult,*** their advocate, relative or carers to ensure that their views, wishes and desired outcomes are central to the process	Designated Officer/all attendees	Within 7 days of receiving the concern, if more time is required, the reason for the extended timescale must be recorded.

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Consider alternative action if safeguarding procedures are not appropriate • Consider providing feedback to the person raising the concern * • If a subsequent safeguarding concern is raised during an open safeguarding episode, this new concern must be explicitly considered and if necessary, a further face-to-face strategy meeting must be held		
6	**Further Enquiry**	• Agencies will provide an update on actions allocated at the previous strategy meeting • Co-ordination and collection of information about the safeguarding concern and the context in which it happened • On-going activity to address any protection needs • Involvement of the ***adult,*** their advocate, relative or carers to ensure their views, wishes and desired outcomes are central to the process • Identified lead investigator to report back to the Progress Strategy Discussion/Meeting every 28 days if the enquiry takes more than 28 days	Identified Lead Investigator	Within the timeframe agreed at the Strategy Discussion/Meeting
7	**Progress Strategy Discussion/Meeting**	• Review progress of enquiries, or if concluded evaluate the outcome • Review the views, wishes and desired outcomes of the ***adult***	All attendees	Within 28 days of the initial Strategy Discussion/Meeting

	Stage of Procedure	Role	Responsibility	Maximum Timeframe
		• Review the interim safeguarding plan • Develop full safeguarding plan if needed • Set a date for the next Progress Strategy Discussion/Meeting if needed • Decision made to conclude Safeguarding Adults Procedures if appropriate and outcome recorded • Consider providing feedback to the person raising the concern *		
8	**Review**	• Review progress of enquiries • Review the views, wishes and desired outcomes of the ***adult*** • Set a date for the next Progress Strategy Discussion/Meeting if needed • Decision made to conclude Safeguarding Adults Procedures and outcome recorded and evaluated • Establish and record whether the ***adult's*** desired outcomes have been met and to what extent (MSP Survey) • Consider whether alternative action is required if safeguarding procedures have been concluded • Provide feedback to the person raising the concern *	All attendees, the adult, their advocate, relative and carers	Within 28 days of the Progress Strategy Discussion/Meeting

* Particularly when the person raising the concern has an ongoing relationship with the adult

Teeswide Safeguarding Adults Board
Safeguarding Adults Workbook
Module One Assessment

Notice to Learners: You should complete the following questions without any help and submit answers to your line manager.

Question 1
What are the two types of capacity that should be tested when conducting a Mental Capacity Act Assessment?

a) _____

b) _____

Question 2
What two ways can professionals escalate the risk, and seek support, in relation to complex cases involving mental capacity?

a) _____

b) _____

Question 3
Why is it important that professionals do not ignore serious cases of abuse, including sexual abuse, involving adults in a residential care environment?

a) _____

b) _____

Question 4
Name two ways in which organisations can improve their engagement with adults who may be experiencing, or at greater risk of abuse and neglect:

a) _____

b) _____

Question 5
What is respectful uncertainty?

_____

Question 6
What could your organisation be doing better in relation to information sharing?

_____

_____

Question 7
Name two reasons why is it important for organisations and professionals to work together across agencies to help keep adults at greater risk of abuse safe?

_____

_____

Question 8
When does the Local Authority Safeguarding Duty apply to an adult?

_____

_____

Question 9
Why is it important for all professionals to develop strong relationship with family members in care environments?

_____

Name	
Job Role	

Appendix 4

Evaluation

Name:

Once completed please forward the workbook evaluation (i.e. this page) and the Certificate of Completion) to the TSAB, Business Unit, using the contact details below, who will make a record of completion and issue a certificate. Completion records may be shared with the training leads of your commissioning organisation to ensure that your staff development record remains up to date.

Teeswide Safeguarding Adults Board Business Unit, Kingsway House, West Precinct, Billingham, TS23 2NX Email: tsab.businessunit@stockton.gov.uk

Why did you complete this workbook? Module One
Where did you do your training?
❍ Home ❍ Work ❍ Mixture
Overall, how satisfied were you that the workbook gave you the information that you needed to know?
❍ Very satisfied ❍ Satisfied ❍ Partly satisfied ❍ Dissatisfied
What is the most important thing you have learned from this workbook?
How will you use the information from this workbook in your day to day work?
Would you recommend this workbook to other people? Please explain.
Is there any aspects of the workbook you feel could be improved?

Manager / Supervisor: Please provide feedback on how the learner managed this learning experience.

Appendix 5

Adult Safeguarding Workbook
Certificate of Completion – Module One

I have discussed the completion of the workbook with my manager / assessor.

Name *(please print)*: _____

Signature of employee: _____

Date: _____ / _____ / _____

Declaration:

I have seen the workbook completed by _____ *(as it will appear on the certificate)* and I can confirm that I am satisfied that they now have a good knowledge and understanding of Learning from Serious Instances of Abuse and Neglect.

Name *(please print)*: _____

Signature: _____

Date: _____ / _____ / _____

Details of Manager / Assessor:

Job Title: _____

Organisation: _____

E-mail Address: _____

Telephone Number: _____