SAFEGUARDING ADULTS

POLICY, PROCEDURE AND GOOD PRACTICE GUIDE

BIRMINGHAM
SAFEGUARDING
ADULTS
BOARD

Published by Birmingham
Safeguarding Adults Board

Safeguarding adults

Policy, procedure and good practice guide

Published by Birmingham Safeguarding Adults Board

Foreword

Birmingham City Council has a responsibility as the Local Authority (DOH, 2000 - 'No Secrets') to lead and co-ordinate the development of local policies and procedures for the safeguarding of vulnerable adults from abuse. Other statutory agencies have a responsibility to ensure the development, ownership and effectiveness of their local procedures in line with the safeguarding of vulnerable adults (DOH, 2000 - 'No Secrets').

This shared responsibility is reflected in the commitment of the Birmingham Safeguarding Adults Board (BSAB) to the Safeguarding Vision for Birmingham. The Vision is 'to promote and protect individual human rights, independence and wellbeing and secure assurance that the person thought to be at risk stays safe, is effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment and is treated with dignity, respect and enjoys a high quality of life' (BSAB Making a Difference, 2007: 3).

The purpose of this document

This document sets out Birmingham's multi-disciplinary and multi-organisational framework in accordance with the policy context as stated above. It covers every adult who '…is or may be in need of community care services' (DH, 2000 'No Secrets') facing a risk to their independence due to abuse or neglect. This document provides a structure to enable all agencies to work together in partnership with those thought to be at risk, their carers and communities to:

- protect and empower those at risk from being exploited or abused
- respond sensitively and consistently to reported incidents of self neglect and abuse
- ensure that action is taken as quickly as possible

- put in place plans to protect and assist the vulnerable person in the best way for them
- support carers who may themselves be vulnerable
- ensure regular monitoring is in place when concerns have been raised

Underlying principles

The following principles are the basis of this document and are subscribed to by all member agencies of the BSAB:

- to actively work together within an inter agency framework based on "No Secrets" guidance and relevant best practice guidance
- to actively promote through the services they provide the empowerment and well being of those who are thought to be at risk
- to act in a way that supports the rights of the individual to lead an independent life based on self-determination and personal choice
- to recognise people who are unable to take their own decisions and/or protect themselves, their assets and bodily integrity
- to ensure the safety of the person thought to be at risk by integrating strategies, policies and services relevant to abuse within the framework of current legislation
- to ensure that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate help, including advice, protection and support from relevant agencies
- to ensure that the law and statutory requirement are known and used appropriately so that persons thought to be at risk of abuse receive the protection of the law and access to the judicial process.

In applying these principles, agencies will balance the requirements of confidentiality with the consideration that, to protect persons thought to be at risk of abuse, it may be necessary to share information consistent with the Caldicott principles (see section 5 of the policy document) on confidentiality and information sharing.

Document structure

This document is divided into three sections:

Section 1 – In this section the **Policy** is used to provide the basis for the following procedure and good practice guide. The policy provides a framework that gives priority to adult safeguarding and the way in which this is shaped.

Section 2 – In this section the **Procedure** provides steps, roles and responsibilities to workers from all agencies who are involved in safeguarding a vulnerable adult.

Section 3 – In this section the **Good Practice Guide** provides useful applications to the safeguarding of vulnerable adults.

The whole document will inform workers and each section can be used either as part of the whole document and independently.

Review of this document

This document will be reviewed on an annual basis. Anyone may make comment on it at any time. Necessary updates will be published on the Birmingham Safeguarding Adults website on www.birmingham.gov.uk/safeguardingadults. People may forward their views in writing or by telephone to the following address:

Head of Service - Safeguarding Adults,
Birmingham City Council, Louisa Ryland House,
44 Newhall Street, Birmingham B3 3PL.
Telephone 0121 675 2632

BIRMINGHAM SAFEGUARDING ADULTS IN PARTNERSHIP

We are committed within the framework of this Memorandum of Understanding to safeguard vulnerable adults.

West Midlands Police

David Shaw – Chief Constable

Birmingham and Solihull NHS Mental Health NHS Trust

Sue Turner – Chief Executive

DWP Department for Work and Pensions

Teresa Fullilove - Local Service Manager

Birmingham East and North NHS Primary Care Trust

Sophia Christie – Chief Executive

Heart of Birmingham Teaching NHS Primary Care Trust

Dr Sandy Bradbrook – Chief Executive

Birmingham City Council

Peter Hay – Chief Executive

South Birmingham NHS Primary Care Trust

Moira Dumma – Chief Executive

University Hospital Birmingham NHS Foundation Trust

Julie Moore – Chief Executive

Sandwell and West Birmingham Hospitals NHS NHS Trust

John Adler – Chief Executive

Heart of England NHS NHS Foundation Trust

Mark Goldman – Chief Executive

National Probation Service West Midlands

Dr Ged Bates – Director Of Operations

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SAFEGUARDING ADULTS
POLICY

Contents

1 Introduction

1.1 This multi-agency (policy) document has been developed in order to enable all agencies to work effectively together through a clear and consistent framework towards the Safeguarding of vulnerable adults. The policy provides the basis for the multi-agency procedures and good practice guide.

1.2 The policy will:

- Define what Safeguarding means in the context of this document
- Define who is a vulnerable adult and what is abuse
- Define the different types of abuse and factors that may lead towards abuse
- Define roles and responsibilities
- Maintain confidentiality and information sharing.

1.3 The commitment of the BSAB and its member organisations, employees, agencies and partners will endeavour to support this policy document as part of their organisational, professional or individual philosophy that acts upon the Safeguarding of vulnerable adults.

2 Safeguarding Adults in Birmingham

2.1 Definition of Safeguarding Adults work

2.1.1 Everyone has the right to live their lives free from violence and abuse.

2.1.2 For the purpose of this policy, safeguarding is defined as action to prevent abuse or to protect persons thought to be at risk of abuse or neglect or poor standards of care by any other person or persons that violates their human and civil rights. Abuse or neglect may consist of single or repeated acts. It may occur as a result of failure to undertake action or appropriate care tasks. It may be an act of neglect or an omission to act. Abuse and neglect can occur in any relationship and may result in significant harm to, or exploitation of, the individual affected by it.

2.1.3 Any adult at risk of abuse or neglect should be able to get in touch with public organisations for appropriate interventions and to know that agencies will work together as needed. Safeguarding is not just about responding to abuse when it occurs. Some adults may not realise they are being abused. Others may be reluctant or unable to assert themselves. Safeguarding is also about raising awareness of the risk of abuse, how to respond and what action can be taken to reduce the risk of abuse occurring and changing behaviours.

2.2 Definition of Abuse

2.2.1 The Birmingham Safeguarding Adults Board has agreed the following definition of abuse.

2.2.2 Abuse is:

"…a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it" (No Secrets, paragraph 2.5, p 9).

2.2.3 It may be caused by anyone who has power or influence over the person whether they are a carer, a paid member of staff or professional. It can be caused by a person deliberately intending

to harm, failing to take the right action or through their ignorance. It can involve one or a number of people. Institutional abuse can occur when the abuse arises as a result of persistently poor care or a rigid and oppressive regime. Defining abuse is complex and can be subject to wide interpretation. Many instances of abuse will constitute criminal offences, involving intent, recklessness, dishonesty or negligence by the perpetrator.

NB Abuse as defined above can also be acted out as self-harm by the vulnerable person on themselves.

2.3 Definition of a Vulnerable Adult

2.3.1 The Birmingham Safeguarding Adults Board has agreed the following definition of a vulnerable adult.

2.3.2 A vulnerable adult is any person:

- who is aged 18 years and over
- who is or may be in need of community care services because of frailty, learning or physical or sensory disability or mental health issues
- and who is or may be unable to take care of him or herself, or take steps to protect him or herself from significant harm or exploitation

2.3.3 The above definition includes those people who are able to fund all or part of their community care services as well as those who are eligible for community care services but whose need in relation to safeguarding is for access to mainstream services. This includes self directed care, direct payments and individual budgets.

3 Abuse

3.1 Causation and Location of Abuse

3.1.1 Abuse may be deliberate or be caused by poor standards of care, lack of knowledge, understanding or training and may involve more than one type of abuse. Abuse can happen anywhere. For example a person may be abused in:

- Their own home, whether they live alone, with relatives or with others
- Care homes or care homes with nursing
- Day services
- Work settings
- Hospitals, clinics, treatment centres
- Other places in the community

3.2 Who might Abuse

3.2.1 Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the individual. A wide range of people may abuse adults. These include:

- A member of staff, owner or manager of a care home or care home with nursing.
- A professional worker such as a nurse, social worker or GP.
- A volunteer or member of a community group such as a place of worship or a social club.
- Another service user.
- A spouse, partner, relative or a friend.
- A carer.
- A neighbour, member of the public or a stranger.
- A person who deliberately targets vulnerable people in order to exploit them.

3.3 Self Neglect

3.3.1 Concerns may also arise from the person thought to be at risk due to their own lack of self-care or risky behaviour. Individuals have the right to choose their lifestyle or take risks. However, staff have a duty of care to ensure that individuals have the capacity to understand the risk implications of the decisions they make. In some circumstances a Mental Capacity assessment may need to be undertaken. Self neglect, where the person has capacity and where there is no allegation that someone else is abusing the person, should be addressed through the usual care management and inter-agencies processes, not using the safeguarding adults process. This does not preclude setting up a meeting with other agencies to plan how risks can be minimised and help offered.

3.4 Categories of Abuse

3.4.1 Based on "No Secrets" a consensus has emerged identifying the following main types of abuse.

3.5 Physical Abuse

3.5.1 Typical examples are:

- Hitting, slapping, pushing, kicking, spitting
- Unapproved use of physical restraint or restriction
- Use of force or the threat of force
- Harsh manual handling (including the inappropriate use of hoists)
- Misuse of medication

3.5.2 Signs and symptoms:

- History of unexplained falls or minor injuries especially at different stages of healing
- Unexplained bruising in well-protected areas of the body such as inside of thighs or upper arms, and so on
- Unexplained bruising or injuries of any sort
- Burn marks of unusual type such as burns caused by cigarettes, carpet burns and rope burns

- History of frequent changing of General Practitioners or the General Practitioner not being able to see the vulnerable person
- Storing of medicine which has been prescribed for the person thought to be at risk but not given
- Malnutrition, ulcers, bed sores and being left in wet clothing
- Agencies encounter difficulties in engaging with or being able to see the vulnerable person due to the actions of a third person such as a relative or a carer

3.6 Sexual Abuse

3.6.1 This can be any type of sexual or indecent act or activity including:

- Rape, exposure to pornography and any physical sexual touching which the vulnerable adult does not want or does not truly understand
- Where the person is unable to give their informed consent
- Any sexual relationship that develops between adults where one is in a position of trust, power or authority in relation to the other, e.g. day centre worker, social worker, residential care worker, health worker

3.7 Psychological/Emotional/Mental Abuse

3.7.1 Typical examples are:

- Blame, insults, humiliation
- Controlling, intimidation, bullying, harassment
- Being stopped from seeing other people or using services or supportive networks
- Being locked away
- Verbal abuse, swearing, threats, using tone and volume of voice to intimidate, body language
- Denial of cultural and language needs or restricting their right of access to their culture and language
- Denying the person the right to make their own decisions

3.7.2 Signs and symptoms:

- Inability to sleep or a tendency to spend long periods in bed
- Loss of appetite or overeating at inappropriate times
- Anxiety, confusion or just giving up
- Choosing to spend lots of time alone, away from others
- Appears fearful and shows signs of loss of self esteem

3.8 Financial or Material Abuse

3.8.1 Typical examples are:

- Theft of money and benefits, property, possessions, insurance
- Removal or control of the person's finances without permission
- Blackmail or taking advantage
- Pressure in connection with wills, property or inheritance or financial transactions

3.9 Signs and Symptoms

- Unexplained inability to pay for household shopping or bills
- Withdrawal of large sums of money which cannot be explained
- Personal possessions go missing from the person's home
- Living conditions are low compared to the money the person receives
- Unusual and extraordinary interest and involvement by the family, carer, friend, stranger or door to door salesperson in the subject's assets

3.10 Neglect and Acts of Omission

3.10.1 Typical examples include:

- Regularly leaving the person unattended for long periods or abandoning them
- Lack of care including food, warmth, medication and access to medical treatment
- Failing to attend to physical needs such as toileting, dressing and washing

- Failing to provide access to appropriate health, social care or education services

3.10.2 Signs and symptoms:

- Poor heating, lighting, food or fluids
- Poor physical condition of the person such as ulcers, bedsores
- The person's clothing and body seem to be scruffy and neglected
- Failure to give prescribed medication or get appropriate medical care
- Apparent unexplained weight loss
- Failure to provide appropriate privacy and dignity
- Carers reluctant to accept contact from health or social care professionals
- Refusal to allow visitors to see the person
- Inappropriate or inadequate clothing, or being kept in night clothes during the day
- Sensory deprivation - not allowed to have access to glasses, hearing aids or other communication aids
- The person thought to be at risk has no method of calling for assistance

3.11 Discriminatory Abuse

3.11.1 This includes discrimination on the grounds of:

- Race
- Faith or religion
- Age
- Disability
- Gender
- Sexual orientation
- Political views

3.11.2 **Racism** is racial discrimination or prejudice which is dismissive of a person's needs or does not respect that person's culture, religion, intellect, beliefs and lifestyle.

Ageism is discrimination or prejudice on the grounds of age which is dismissive of a person's needs or does not respect that person's age and experiences.

Disablism is discrimination through cultural and social attitudes and practices of people who have a variety of physical, emotional or learning impairments, so that they are seen as inferior to the stereotypical norm which results in unequal and differential treatment.

Sexism is sexual discrimination or prejudice which differentiates power and status between the sexes and which is dismissive of a person's needs or does not respect that person's gender.

Heterosexism is homophobic discrimination which is based on heterosexist beliefs and which is dismissive of a person's needs or does not respect that person's sexuality.

3.12 Institutional Abuse

3.12.1 "Institutional abuse" is sometimes used to describe abuse which pervades a particular establishment. Institutional abuse may take the form of repeated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to widespread and persistent ill treatment or gross misconduct at the other. There may be a variety of underlying factors in relation to poor care standards which could include, for example, inadequate staffing, an insufficient knowledge base within the service, lack of essential equipment, rigid routines or a controlling management regime. (See also paragraph 2.9 of 'No Secrets', p10). Any of the types of abuse outlined in 3.5 – 3.11 above may be raised as allegations in the context of abuse within an institution.

3.13 Multiple Forms of Abuse

3.13.1 A vulnerable person may be experiencing more than one type of abuse or more than one person may be abused. This may happen in an on-going relationship, or in an abusive service setting to one or more persons thought to be at risk at a time. It is important to look beyond single incidents or lowering of standards to underlying dynamics and patterns of harm. Any or all of these types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

3.14 Factors that may lead towards abuse

The following factors may lead to an adult becoming vulnerable whether they live in their own home on their own or with others in a care home or are receiving care support or services in hospital or any other place in the community:

- There is a relationship where someone has power over the person thought to be at risk, whether physical, emotional or financial.
- The person providing care is having difficulties in caring for the person thought to be at risk who has learning disabilities, mental health problems or a chronic progressive disabling illness because the care needs exceed the carer's ability to meet them.
- Adults living with other family members who are financially dependent on them.
- A personal or family history of violent behaviour, alcoholism, drug abuse or mental illness etc.
- The carer's own emotional and social needs are unmet.
- Breakdown in the vulnerable adult's relationship with the carer/s.
- Financial difficulties often leading to poor living conditions.
- Carers are not receiving any practical and/or emotional support from other family members or professionals.
- Serial abusing in which the abuser seeks out and 'grooms' vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse.
- Long term abuse of an ongoing family relationship, such as domestic violence between spouses and family members.
- One-off abuse such as theft because money has been left around.
- Abuse which arises because pressures have built up and/or because of difficult or challenging behaviour.

- Neglect of needs because those around them are not able to be responsible for their care. This may be because the carer has difficulties such as debt, alcohol or mental health problems.
- Institutional abuse which includes poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and poorly trained staff.
- Unacceptable 'treatments' or programmes which include restrictions or punishment such as withholding food /drink / cigarettes, being kept away from others, unnecessary and unauthorised use of control and restraint or over-medication.
- Failure of agencies to make sure staff receive guidance about anti-racist and anti-discriminatory practice.
- Failure to access health and social care services.
- Misuse of benefits and/or use of the subject's money by other members of the household or service providers.
- Fraud or threats in connection with wills property or other assets.

3.15 Data Collection about types of abuse

3.15.1 The types of abuse listed above are those used to classify safeguarding concerns when collecting data. The format of data collection will be compliant with Department of Health guidance.

4 Roles and Responsibilities within the Policy

4.1 Introduction

Birmingham City Council has the lead role for the safeguarding of persons thought to be at risk within its area. All agencies share responsibility for ensuring the development, ownership and effectiveness of local policies and procedures for the safeguarding of persons thought to be at risk.

4.1.1 The multi-agency policy identifies distinct roles in the Safeguarding Adults process:

- Alerter
- Safeguarding Manager
- Safeguarding Assessors/Investigators
- Safeguarding Adults Lead Officer
- Role of the Director of Adult Social Services
- Birmingham Safeguarding Adults Board

4.2 Alerter

4.2.1 The Alerter can be anyone – including the alleged victim, their families, carers, health workers, social workers, domiciliary care workers, social care workers, day services worker, college staff, emergency services staff, police officers, police community support officers, volunteers, care home and care home with nursing staff, or any member of the public.

4.2.2 If it is safe and appropriate to do so, the alerter should tell the person thought to be at risk that they have to report the information.

4.2.3 Anyone might see abuse taking place and/or be told that abuse or suspected abuse is occurring (see section 2, 3 and 4 of the procedure document for how to do this and how to record what you have seen and/or been told).

4.3 Safeguarding Manager

4.3.1 The Safeguarding Manager is the service manager, operational manager, team or assistant team manager employed by Birmingham Adults and Communities Directorate who has the responsibility for co-ordinating the response to a safeguarding adults alert. This manager has overall responsibility for ensuring that the correct procedures are followed according to this multi-agency document.

4.3.2 The Safeguarding Manager is responsible for:

- Making sure that sufficient information is gathered so that they can make a decision as to whether or not the alert should be managed as a referral under the safeguarding adults procedure
- Assessing, from the initial information, the level of risk and the priority to give to the referral
- Setting up and chairing a strategy discussion meeting, case conference, review meeting
- Making sure that a record is kept of all contacts and action taken on the appropriate safeguarding documentation, case file records and on CareFirst.

4.4 Safeguarding Assessors/Investigators

4.4.1 Only those workers identified by the safeguarding adults strategy discussion or meeting should undertake safeguarding adults assessments or investigations. They are likely to be Adults and Communities social workers or the Police.

4.4.2 Their tasks include:

- Collecting and verifying information from files, other agencies, relatives, staff etc.
- Interviewing the person thought to be at risk and other relevant people.
- Preparing a factual report of the assessment/investigation including an assessment of the risks and recommendations for action.

4.4.3 See the safeguarding adults procedure for more information.

4.5 Role of the Strategic Director for Adults and Communities Directorate

4.5.1 The Strategic Director for Adults and Communities has specific responsibilities under statutory guidance issued by the Department of Health (2005). These are:

- Maintaining a clear organisational and operational focus on safeguarding persons thought to be at risk,
- Ensuring relevant statutory requirements and other national standards are met,
- Meeting Independent Safeguarding Authority (ISA, formally POVA) requirements,
- Encouraging a culture of vigilance against the possibility of adult abuse,
- Ensuring all services within the Director of Adult and Communities remit remain focussed appropriately on safeguarding adults and children, and
- Promoting equality of opportunity and eliminating discrimination in respect of adult social care services.

The Strategic Director for Adults and Communities is responsible for nominating the Chair of the Safeguarding Adults Board.

4.5.2 The Adult and Communities Directorate is responsible for:

- Co-ordinating investigations or assessments when the person is thought to be at risk living in Birmingham. This includes people placed in Birmingham and funded by another Local Authority (LA). The other LA must be informed and closely involved in any investigation and outcomes, including monitoring arrangements.
- Collating records, including recording on an electronic database (CareFirst), of all incidents of suspected abuse referred to them.
- Co-ordinate training on the Safeguarding Adults Policy and Procedure.
- Serious Case Reviews.
- Chairing the Birmingham Safeguarding Adults Board.

4.6 Birmingham Safeguarding Adults Board

4.6.1 Each local authority has to establish a multi-agency partnership to lead Safeguarding Adults work (National Standards 1; "No Secrets" 3.4, p15).

4.6.2 The Birmingham multi-agency partnership is known as the Birmingham Safeguarding Adults Board (BSAB).

4.6.3 All statutory agencies should identify a senior manager as the Safeguarding Adults Lead Officer ("No Secrets" 3.12, p12; National Framework of Standard 2.2). They should have the authority to make strategic and resource decisions, and understand the organisational frameworks within which other agencies work.

4.6.4 They should be able to:

- Represent their agency and its service users on the Birmingham Safeguarding Adults Board and participate fully in its work.
- Take the lead role in the development of safeguarding policy and strategy in their agency.
- Ensure their agency has an up-to-date internal Safeguarding Adults policy and procedure that meets the requirements of "No Secrets", the National Framework of Standards and this multi- agency policy and procedure.
- Ensure that training at different levels is available for all relevant staff.
- Produce an annual report for their management board.

5 Confidentiality and Information Sharing

5.1 Introduction

5.1.1 The safeguarding adults process can only be successful if all agencies and their staff share relevant information in an appropriate and timely manner. Staff are bound by and must follow the joint information sharing protocol* and by the ethical and statutory requirements that cover confidentiality and data protection.

5.2 Caldicott Principles

5.2.1 Health agencies and the Adults and Communities Directorate are governed by the Caldicott Principles and these have been used to develop the joint information sharing protocol.

5.3 Information Sharing Protocol

5.3.1 Adult service users receive support and help from people in many agencies and organisations. The sum of the collective knowledge held by professionals provides a holistic view of their needs, family and support context and an understanding of what services they need to live in their chosen surroundings.

5.3.2 The information sharing protocol* is intended to support the multi-agency safeguarding procedures in clarifying the roles and responsibilities of professionals, staff or volunteers, when faced with suspected abuse or inadequate care of a person thought to be at risk. Information may also be shared if action needs to be taken on a preventative basis.

5.4 More information

- No Secrets, (2000: Section 5.5 to 5.10).
- National Framework of Standards (9.3.10).
- The information sharing protocol*.
- Information sharing (see section 8 of the good practice guide document).

* To access the Information Sharing Protocol go to the Birmingham City Council's website: www.birmingham.gov.uk/safeguardingadults

SAFEGUARDING ADULTS
POLICY APPENDICES

Appendix 1

Adult Safeguarding and the Law

The Children Act (1989) gives a legislative framework for cooperation between agencies working to safeguard children. In addition there is statutory guidance requiring agencies to work together to safeguard and promote the welfare of children, including protecting them from maltreatment (Working Together to Safeguard Children, 2006).

No Secrets (2000) provides guidance for Local Authorities to ensure that there are multi agency arrangements for the protection of vulnerable adults. However, there is no specific legislation currently in relation to safeguarding adults. This does not mean that the law cannot be used to protect vulnerable adults, the Human Rights Act (1998) for example enshrines the right to liberty and security (Article 5,1) and the Mental Capacity Act (2005) provides a framework for acting on behalf of someone who lacks capacity as well as including a new criminal offence of wilful ill treatment or neglect. There are numerous other pieces of legislation which may assist when dealing with safeguarding adult issues such as criminal and civil law or law relating to care practice.

If workers are unsure or suspect that a crime may have been committed, they should inform the VPO / police officer who can advise them on criminal law matters and make a decision on police involvement. Likewise the Court of Protection can advise in relation to some civil issues such as the use/abuse of Lasting Powers of Attorney.

If staff of any organisation feels that they need legal advice in relation to an adult safeguarding issue, they should follow their agreed internal process to request/access this advice.

Appendix 2

The Association of Directors of Adult Social Services (ADASS) Protocol for Inter-Authority Investigation of Vulnerable Adult Abuse

This agreement was ratified by the ADASS and is intended for adoption by all Local Authorities and Adult Protection Committees.

1. Introduction

These arrangements recognise the increased risk to vulnerable adults 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 LAC (93) 7 Ordinary Residence, which identifies these responsibilities in terms of:

- The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection;
- The registering body in fulfilling its regulatory function with regard to regulated establishments; and
- The placing authority's continuing duty of care to the abused person.

3. Principles

- The authority where the abuse occurs will have overall responsibility for co-ordinating the adult protection arrangements (and, for the purposes of this protocol, be referred to as the host authority).

- The placing authority (i.e. the authority with funding/ commissioning responsibility) will have a continuing duty of care to the vulnerable adult.
- the placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting vulnerable adults and for managing concerns, which in turn link with local policy and procedures set out by the host authority.
- 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.
- 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 adult protection concern.

4. Responsibilities of Host Authorities

4.1 The authority where the 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 (CQC) should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for the protection of vulnerable adults.

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 vulnerable adult 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 Adult Protection 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 adult protection 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 Adults and Communities, 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 Care Standards Act 2000 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 3

Whistleblowing Code

The Public Interest Disclosure Act 1998 (PIDA) provides a framework for Whistleblowing across the private, public and voluntary sectors. Each member organisation of the Birmingham Safeguarding Adults Board will have its own Whistleblowing code and can be accessed through their relevant communications systems. The Whistleblowing code will include most people in the workplace with protection from victimisation when genuine concerns have been raised about malpractice in the workplace and in accordance with the code. The aim of the code is to reassure workers that it is safe for them to raise such concerns and partner organisations should establish proper procedures for dealing with these concerns.

For example, Birmingham City Council has a Whistleblowing code to help and encourage employees to raise serious concerns within the Council rather than overlooking a problem or feeling the need to raise it with someone outside.

The above code applies to all Birmingham City Council employees and those contractors working for the Council on Council premises, for example agency staff, builders, drivers. It also covers suppliers and those providing services under a contract with the Council in their own premises, for example care homes. It does not apply to service users or members of the general public, although they are encouraged (if they have concerns about some apparent wrong doing within the Council) to raise their concerns with the relevant Council Directorate or if the concerns relate to financial matters, direct with the Director of Finance.

Birmingham City Council Whistleblowing code 'Volume B - Essential Documents Supporting the Constitution' (2008) can be accessed through:

www.birmingham.gov.uk/Media?MEDIA_ID=84250

Appendix 4

Multi Agency Public Protection Arrangements (MAPPA)

(to be issued at a later date).

Appendix 5

Birmingham Safeguarding Adults Board Sub-group terms of reference

Terms of Reference:

The Board is tasked with developing the partnership so as to ensure effective local arrangements are in place for the safeguarding of (vulnerable) adults consistent with statutory guidance and accepted best practice. The remit of the Board is reflected as follows:

- Prepare a Safeguarding Adults Strategic Plan and secure executive level agency approval and resourcing of it based on a shared understanding of the threshold and definition of abuse.
- Determine Safeguarding Policy and establish mechanisms to develop, approve, monitor and to keep under review multi-agency safeguarding policies, protocols, procedures, recording and practice; including that of all sub-groups, the chair, memberships, co-options and any task and finish project groups.
- Keep under review the development and delivery of safeguarding policies, protocols and procedures across all agencies and by all partners and providers of adult social care.
- Oversee safeguarding activity and generation of information that is accurate, timely, fit for use and meets audit guidance within "No Secrets".
- Promote assurance, board challenge and undertake audits to validate effectiveness and offer reasonable assurance on effectiveness of joint and single agency policy, protocols, procedures, practice and performance.
- Secure citywide consistency in safeguarding and ensure staff and stakeholders know what they mean and can use them effectively.
- Ensure involvement of patients, service users, and carers and adopt an inclusive approach to its role to secure community understanding and awareness and feedback on use of safeguarding.

- Provide for Serious Case Reviews and prepare, monitor and keep under review protocols and processes to support them.
- Consider outcomes of serious case reviews, identify and secure dissemination of relevant learning points.
- Set joint and single agency training standards to ensure awareness of and informed responses to recognise, respond to and reduce risk of abuse.
- Generate accessible information about safeguarding for the public, professionals, service users, patients, and carers about how to gain safety from adult abuse, to recognise and report concerns.
- Review effectiveness of policies and procedures for the recruitment and supervision of people working with vulnerable adults and compliance with national guidance; including integration of best practice and learning.
- Secure effective co-ordination of safeguarding adults work with the safeguarding of children, MAPPA, domestic violence, bullying, hate crime and wider work on crime and disorder reduction.
- Establish arrangements for information sharing, balancing the requirements of confidentiality and compliance with Caldicott principles.
- Identify and disseminate learning points from other investigations, feedback, reviews and best practice and safeguarding advice.
- Review progress in taking steps to recognise, report, respond to and reduce risk of abuse and monitor incidence of abuse; including institutional abuse and discrimination.
- Produce an annual report and audit on safeguarding adults, review progress in delivery of the strategic plan, development of the partnership, outcomes for people and to inform service planning and commissioning.

The Board will keep its terms of reference under review and its annual report and audit will be submitted to all partner agencies and to the relevant City Council Scrutiny Committee (BSAB Memorandum of Understanding, p 3-5).

Membership:

- People appointed to be Sub-group Chairs become members of the Board (with voting rights) for the period of their appointment. Vice Chairs of Sub-Groups may act as substitutes. The Board can also appoint up to five other Board members (Appointed Membership).

- The Board may vary all and any such appointments at any time. All appointments are subject to confirmation by the Director of Adult Social Services in the same way as for nominated Board Members.

- The Board may also co-opt additional (non-voting) members to cover skill gaps in Board membership or to secure specialist advice. All such co-options will be reviewed annually and all persons so co-opted shall sign a confidentiality statement. Co-options may be for a fixed period or a specific task.

- Observers from other agencies or third sector organisations may attend meetings by agreement of the Board. This does not include the right to speak or participate in discussion of matters before the Board. Observers may be excluded from those parts of the meeting considering exempt or other information.

Sub group structure to support the Board arrangements.

There are 5 subgroups which support the Board and are responsible for the discharge of the Board's remit in relation to:

- Policies, Protocols and Procedures

- Serious Case Reviews

- Training and Workforce Development

- Performance, Audit and Quality Assurance

- Communication

Each subgroup has multi agency membership, named chairing arrangements, Terms of Reference and work plans.

Policies, Protocols and Procedures.

The Sub-group is responsible to the Safeguarding Board for the discharge of its remit on the development, delivery, oversight and review of multi and single agency policies, protocols and procedures for the protection of vulnerable adults.

- Review existing policies and procedures to reflect guidance and best practice.
- Keep multi-agency policies under review and up to date.
- Advise and seek Board approval to significant changes in policies and procedures.
- Advise and seek assurance on single agency procedures
- Promote and develop interagency policies, procedures and practice consistent with principles of alert, referral decision, safeguarding strategy, assessment, planning, review, recording and monitoring.
- Develop effective mechanisms to identify and respond to whole service concerns and institutional abuse.
- Develop protocols to allocate and clarify agency roles and responsibilities
- Develop and build on existing protocols for sharing information
- Disseminate information on policy, procedures and best practise
- Co-ordinate the monitoring and audit of operation of procedures
- Improve and develop management of adult protection at an operational level
- Ensure all assessments and investigations are carried out in a setting, language and manner appropriate to the understanding and cultural background of individuals.
- Prepare policies, procedures and protocols for responding to perpetrators of abuse and risk to others; including definitions and thresholds.
- Undertake the Equality Impact Assessments on safeguarding adults.

- Maintain a forward plan of work and set time aside to review achievements, assess effectiveness, and consider future requirements.

Serious Case Reviews

The Sub-group will discharge serious case review functions on behalf of the Safeguarding Board within the framework of a Serious Case Review Protocol.

- Secure compliance with the Serious Cases Review (SCR) Protocol
- Keep the SCR Protocol under review, advise on effectiveness and best practice in the conduct of such reviews.
- Screen and consider review requests against agreed criteria and make recommendations on the need for serious case reviews
- Allocate responsibility for chairing and carrying out serious case reviews
- Create an accredited pool of associates to participate on SCR Panels
- Receive and consider reports on serious case reviews
- Identify learning points from serious case reviews
- Arrange, with panel Chairs, reporting of review outcomes to the Board
- Advise on and maintain confidentiality in relation to information for SCR
- Ensure briefing to staff, family members and media as appropriate.
- Promote transparency and objectivity and ensure declarations of interest and any conflicts of interest at all meetings and during reviews.
- Oversee action in response to review reports and advise the board when action plans are completed.
- Provide an annual review of all serious case reviews undertaken.
- Clarify and advise on sharing of reports [in whole or in part].

- Provide a copy of the overview report, action plan and individual management reports to CQC.

- Maintain a forward plan of work and set time aside each year to review achievements, assess effectiveness and consider future requirements.

Training and Workforce Development

The Sub -group is responsible for planning, implementing and evaluating the learning and developmental needs of health staff, social care staff and staff in other sectors that work with vulnerable adults on behalf of the Safeguarding Board.

- Ensure all agencies commission training and learning opportunities to ensure that, at all levels, staff and volunteers have appropriate knowledge and skills to understand, identify, respond, use and report and record abuse and neglect.

- Establish standards and agreed competencies for the local delivery of adult protection training; including the determination of mandatory training.

- Contribute to the development of wider local workforce mapping and ensure partner organisations develop workforce development plans that include knowledge and skill levels for adult protection; including audits

- Undertake an annual review of training needs and extent to which they are met.

- Commission multi-agency training to meet common learning needs.

- Assure that each organisation has the adult protection knowledge and skills levels for its staff roles and staff have access to training in line with agreed personal and professional development needs.[DN - ? QA group]

- Ensure training to meet learning needs is evaluated in terms of outcomes.

- Ensure multi-agency training delivers relevant national occupational standards in accordance with National Minimum Standards.

- Review effectiveness of policies and procedures for recruitment and supervision of people working with vulnerable adults and compliance with national guidance.

- Develop a multi-agency database for staff attending adult protection training to monitor progress, inform workforce planning, target training and access funding.
- Develop training and awareness raising strategies for service users and carers.
- Maintain a forward plan of work and set time aside for the group to review achievements, assess effectiveness and consider future requirements.

Performance, Audit and Quality Assurance

The group will discharge responsibilities for data quality and audit and effective information systems to meet current and future expected national and local data reporting requirements and enable performance to be managed and reasonable assurance secured on the quality of local safeguarding.

- Develop information and reporting arrangements consistent with "No Secrets" guidance requirements.
- Advise on future national audit and data requirements
- Develop a programme of audits to deliver core elements around assurance within "No Secrets".
- Monitor the "risk gap" between referrals opened and closed.
- Oversee preparation of regular performance reports for consideration by the board
- Secure assurance on the quality and timeliness of data on adult protection issues
- Consider and receive reports on single agency and multi agency audits of adult protection work
- Review contracting mechanisms in terms of reasonable assurance on effectiveness of safeguarding provisions
- Consider evidence on the prevalence or incidence of abuse and assess any implications for local strategic action, policies, procedures and practice.
- Consider data and other requirements associated with adult social care performance assessment, the annual health check and other performance assessment mechanisms applying to partner agencies.

- Maintain a forward plan of work and set time aside for the group to review achievements, assess effectiveness and consider future requirements.

Communication

The Sub-group is responsible to the Safeguarding Board for the discharge of its remit on the development, delivery implementation, oversight and review of a multi agency safeguarding communications strategy to ensure ongoing, appropriate, clear consistent and regular communication with service users, carers, staff provider agencies and the Public in Birmingham about safeguarding vulnerable adults.

- Develop a communications strategy which addresses issues within the Safeguarding vision as a whole.
- Undertake an audit across all partner agencies of current communication mechanisms/tools.
- Review existing mechanisms and tools of communication within each agency and across agencies to reflect up to date and best practice.
- Develop effective alternative multi agency mechanisms of communication which reflect up to date and best practice.
- Ensure that mechanisms developed are owned by all partner agencies.
- Keep all multi-agency communication tools/ mechanisms under review and up to date.
- Advise and seek Board approval to significant changes in communication tools/mechanisms and future developments.
- Promote mechanisms/tools of communication that are appropriate to the understanding and cultural background of individuals in relation to manner, style, language and format.
- Ensure that the audience is informed about and has access to existing and newly developed communication tools and mechanisms.
- Work closely with all other Safeguarding subgroups.
- Advise the Board on how to raise public awareness and ownership of the Safeguarding vision.

- Advise the Board on resource issues.
- Development of an interagency data log of mechanisms/tools available.
- Undertake the Equality Impact Assessments on safeguarding adults.
- Maintain a forward plan of work and set time aside to review achievements, assess effectiveness and consider future requirements.

Appendix 6

Serious Case Review Policy

1 Introduction

1.1 This policy forms part of agreed multi-agency policies and procedures to safeguard vulnerable adults. It aims to ensure that there is a consistent approach to the process and practice in undertaking Serious Case Reviews (SCR) where a vulnerable adult is the victim of abuse and concerns are expressed about factors in the case.

1.2 This policy has been devised to ensure that lessons are learned from incidents of abuse or neglect of vulnerable adults, which have caused serious death or harm. It must be followed in relation to all such incidents arising in Birmingham, irrespective of whether or not the person ordinarily resides there or they are funded by Birmingham. This is consistent with the Association of Directors of Adult Social Services (ADASS) Protocol for Inter Authority Investigations of Vulnerable Adult Abuse (Feb 2004). This does not affect existing statutory requirements or amend any other agreements and this protocol may need to be used in combination with or preceding other review mechanisms.

1.3 It is based on guidance contained in "Safeguarding Adults' published by the ADASS (Oct 2005) and provides a National Framework of Standards for good practice and outcomes in adult protection work. The standard recommends that each Safeguarding Committee/Board should have in place:

- a 'Safeguarding Adults' Serious Case Review policy and procedure,
- that it is agreed, on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a SCR will be undertaken. For example, when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults,
- links between this policy and a domestic violence homicide review to be established,
- there is a clear process for commissioning and carrying out of a serious case review by the partnership.

1.4 The policy also makes use of a further advice note issued by the ADASS in March 2007 on the preparation of serious cases review policies and procedures.

1.5 For the purpose of this policy the definitions of 'abuse', 'neglect' and 'vulnerable adult' are the same as outlined in the multi agency policy and procedure approved in 2007.

2 Purpose

2.1 The purpose of having a case review under this policy is to:

- Establish whether there are lessons to be learnt from the circumstances of the case in particular about the way in which local professionals and agencies work together to safeguard vulnerable adults.
- Identify clearly what those lessons are and how they will be acted upon and what is expected to change as a result.
- Inform and improve local inter-agency practice and better safeguard vulnerable adults.
- Review the effectiveness of procedures and any compliance issues (Both multi-agency and those of individual organisations).
- Improve practice by acting on learning (developing best practice).
- Prepare or commission an overview report, which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2 It is accepted that all agencies will have their own internal or statutory review procedures to investigate serious incidents and untoward incidents. The policy is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

2.3 There are also statutory frameworks for reviews in the following circumstances.

- Death or serious incidents involving a child (see sub-appendix 1a of appendix 4 of the procedure document)
- Homicide, suicide and related serious mental health incidents (see sub-appendix 1b of appendix 4 of the procedure document)

- 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 (see sub-appendix 1c of appendix 4 of the procedure document)
- Serious Further Offences committed by offenders subject to supervision by the Probation Service (see sub-appendix 1d of appendix 4 of the procedure document)
- Work-related deaths, but not arising from clinical judgement or treatment (see sub-appendix 1e of appendix 4 of the procedure document).

2.4 Various regulatory bodies also undertake investigations into serious incidents and the Secretary of State can direct statutory organisations to conduct investigations, or approve public inquiries recommended by the Health and Safety Commission.

2.5 Local and regional liaison may be needed to determine the most efficient and effective way in which different roles and purposes can be addressed by a designated single serious case review body in those circumstances where this would be appropriate.

2.6 Legal advice is relevant in that it must be noted that statutory organisations have duties with regard to certain reviews, and that agencies actions could potentially be subject to judicial review.

2.7 Where there are possible grounds e.g. for both a Serious Case Review and a Domestic Homicide Review then a decision should be made at the outset by the two decision makers as to which process is to lead and who is to chair with a final joint report being taken to both commissioning bodies. This process will be of specific benefit when the case involves a victim aged between 16 and 18.

2.8 The procedure for undertaking Serious Case Reviews (SCR) where a vulnerable adult is the victim of abuse and concerns are expressed about factors in the case are detailed in appendix 4 of the procedure document.

SAFEGUARDING ADULTS
PROCEDURE

Contents

1 Introduction

1.1 This multi-agency procedure document has been developed in order to enable all agencies to work effectively together through a clear and consistent framework towards the safeguarding of vulnerable adults.

1.2 If there is regular contact with service users, there is also a responsibility to be aware of the contents of the multi-agency document and to respond to and report any incidents of abuse that you witness or are told about.

1.3 This procedure document sets out the requirement that all staff work in accordance with the document "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" (March 2000).

1.4 This procedure reflects on the document "Safeguarding Adults - A National Framework of Standards for good practice and outcomes in adult protection work" published by the Association of Directors of Social Services in October 2005.

1.5 The above document sets out 11 standards for all local authorities and partner agencies to aspire to in terms of best practice.

1.6 The Safeguarding Adults procedure applies to every adult who is or may appear to be in need of community care services and who is facing a risk to their independence due to abuse or neglect. This is the same threshold for an assessment as for any other service user. See section 2 and 3 of the policy document for definitions of vulnerable adult and abuse and for information about types of abuse.

1.7 The procedure framework is as follows:

- Stages in the Safeguarding Adults process
- How to respond if someone tells you about abuse
- How to report abuse
- How Adults and Communities may respond to a Safeguarding alert
- How to make a safeguarding alert.

2 Stages in the Safeguarding Adults Process

2.1 Stages of dealing with alleged abuse (Based on the National Framework)

- **Alert** - This is the screening and reporting by partner agencies when they first become aware of an allegation and their immediate response/action including immediate addressing of any protection needs. If the partner agency is the Care Quality Commission (CQC) they will send Adults and Communities their Safeguarding Adults Alert Form to advise of the alert. There is a process for Adults and Communities Directorate to respond to this.

- **Referral** - This is the placing of information about the concern into a multi-agency context.

- **Social worker consults their manager** - A decision is then made as to whether the safeguarding adults procedures are appropriate to address the concern.

- **Safeguarding strategy meeting** - Formulating a multi-agency plan for assessing the risk and addressing any immediate protection needs (strategy discussion or meeting).

- **Safeguarding assessment/Investigation** - Co-ordinating the collection of the information about abuse or neglect that has occurred or might occur. This may include an investigation , for example a criminal or disciplinary investigation.

- **Case conference** - Set up a case conference to report back and decide if further safeguarding action is needed.

- **Safeguarding plan** - Add the safeguarding plan event to Carefirst6. Set review date within 12 weeks and agree and distribute the minutes and safeguarding plan.

- **Review** - Review of the safeguarding plan.

Recording and monitoring - Recording and monitoring the "Safeguarding Adults" process and its outcomes.

2.1.1 Not all referrals will require all these stages to be followed. The action taken will depend on whether or not the situation can be resolved at an early stage and may not need to go to the safeguarding plan stage.

2.2 Safeguarding Adults Process flowcharts

Flowchart 1 shows the multi-agency process from information being received by a partner agency such as a care home through to making an alert and the stages in the procedures (see section 5 of the procedure document: Flowchart – Multi-agency process in making an alert).

Flowchart 2 is the multi-agency process following the Adults and Communities Directorate receiving an alert (see section 7 of the procedure document: Flowchart – Multi-agency process following an alert).

3 How to report abuse

3.1 This is everyone's responsibility

3.1.1 All agencies in Birmingham are committed to ensuring the safety of adults and children thought to be at risk.

3.1.2 Anyone who works or has contact with a person thought to be at risk of abuse has a responsibility to report actual or suspected abuse. This includes family members, volunteers, social care workers, health workers, managers and staff in private and voluntary agencies. Doing nothing is not an option.

3.2 Reporting a priority (Refer to section 5 of the procedure document, Multi Agency Process in Making an Alert flowchart)

3.2.1 Every staff member and volunteer in all agencies and services has a professional and moral duty to report any witnessed or suspected abuse to their line manager. If there is sufficient cause for concern, the line manager must ensure that the information is referred to Adults and Communities Directorate as quickly as possible and within 12 hours of you receiving the information.

3.3 How quickly do you need to contact Adults and Communities Directorate?

3.3.1 It is important that any concerns are passed on as quickly as possible, and within 12 hours of you receiving the information.

3.4 How to report your concerns to the Adults and Communities Directorate

3.4.1 If you know that the person thought to be at risk of abuse has an allocated social worker or care co-coordinator you should contact them direct. If this is not the case or they are not available, contact one of the Adults and Communities offices listed in section 4 of the good practice guide document. If they are not the responsible office they will pass your concerns on to the correct office or team. If abuse is witnessed or suspected in, or before, admission to services provided by a hospital trust, report your concerns to the social work team at the hospital. Out of office hours contact Adults and Communities Emergency Duty Team, see section 4 of the good practice guide document. They will take any emergency protective action considered necessary and pass the alert to the appropriate Adults and Communities team.

3.4.2 Telephone the relevant social work team (See above). Tell the person who answers your call that you are making a Safeguarding Alert. The ACF0030 form will guide you in giving them the relevant information. However, don't wait until you have all the information if this will significantly delay reporting the alert.

3.4.3 When you have passed on the information by telephone, you must fax or post the completed ACF0030 form to the appropriate office to confirm your information. This must be done within 12 hours of contacting the Adults and Communities Directorate. If you are going to fax the form you must arrange for a named person to collect your fax as soon as it arrives.

3.5 Is there anyone else you need to inform?

3.5.1 If the person thought to be at risk lives in a care home or a care home with nursing and you are the manager of the home you must also tell the Care Quality Commission (CQC).

3.5.2 If you have an obligation to inform the contracts department of a Primary Care Trust, Birmingham and Solihull Mental Health NHS Trust or the Adults and Communities Directorate you must do this in line with existing arrangements.

3.5.3 If you have managerial responsibility for a member of staff or a volunteer who is accused of abusing a vulnerable adult, consult your Human Resources Department for advice.

3.6 What happens next and what else might you be asked to do?

3.6.1 The appropriate Adults and Communities team will assess every reported alert as matter of urgency to determine an appropriate course of action. This assessment will take place either through telephone consultations with other agencies / professionals (strategy discussion) or by holding a formal strategy meeting to plan an assessment strategy.

3.6.2 When the Adults and Communities team manager receives the alert they will decide whether or not the alert should be accepted as a safeguarding referral (see appendix 1 of the good practice guide document). If the decision is not to accept the alert as a safeguarding referral this is recorded with the reasons why. You will be informed of the decision.

3.6.3 The manager will then consult other relevant professionals either by phone or by setting up a strategy/meeting. This is to formulate a multi-agency plan for assessing the risk and addressing any immediate protection needs. If there is any suspicion that a criminal act is taking place then the team manager will contact the police. The police will decide whether a criminal investigation is required.

3.6.4 You may be asked to participate in a strategy or meeting and/or in a safeguarding assessment if you are well known to the person thought to be at risk. If you are, you will also be asked to participate in a safeguarding case conference if one is held after the assessment or investigation is completed.

4 How to make a Safeguarding Adults alert

Agencies other than Birmingham City Council Adults and Communities Directorate use the Multi-Agency Alert referral form ACF0030 (see appendix 6 of the procedure document) and guidance (see section 2, 3, 4 of the procedure document). This section of the procedure gives instructions and information for in-house Directorate staff that are told or become aware of an allegation of abuse of a person thought to be at risk (See section 5 of the procedure document: Flowchart – Multi-agency process in making an alert).

4.1 Identifying Abuse

4.1.1 See sections 2 and 3 of the policy document for definitions of vulnerable adult and abuse and information on types of abuse.

4.2 What to do if you have concerns

4.2.1 All allegations of abuse must be treated seriously, regardless of the source of the information. Your role is to respond sensitively and pass the information on to your line manager or to a senior manager within your service. It is not your job to conduct an investigation. Staff must report all allegations, and must not agree to a request from anyone, including the person who has been abused, to keep information confidential. Even if it is decided not to carry out a Safeguarding Adults assessment or abuse is not found, there may be a need for a risk assessment.

4.2.2 Disclosure may take place many years after the event or when someone has left a place where they were being abused. You should take all these disclosures seriously.

4.2.3 See section 3 and 4 of the procedure document for information about how you should respond to a disclosure.

4.2.4 The Safeguarding Adults procedure also applies to where the alleged perpetrator is a vulnerable adult.

4.3 Reporting an allegation or concern

4.3.1 Key principles

4.3.1.1 All employees have a duty and responsibility to protect and safeguard the interests of persons thought to be at risk. If you become aware, or see that anyone, including a member of staff or another professional colleague, has been or is being abusive towards a service user, in a physical, emotional, financial, sexual

or discriminatory manner, you must report it. If you are concerned about reporting an incident, see 4.3.1.3 below.

4.3.1.2 At times a person thought to be at risk may confide in you that they are being abused but do not wish matters to go any further. In such a situation you will have to say that you have a duty to pass this information on to your manager.

4.3.1.3 An organisation's "Whistleblowing" code is based on the protection provided to employees by the Public Interest Disclosure Act 1998 (see appendix 3 of the policy document) and is there to support employees from harassment or victimisation as a result of them having reported , for example a colleague, team in good faith.

4.3.2 Reporting to your line manager

4.3.2.1 If you see or hear of an incident that causes you to feel concerned, you must report your concerns. Normally you must speak to your manager about your concerns. Your manager will report your concerns to the appropriate social work team. If you think that your manager is involved in the abuse or incident, or your manager is not available, or your concerns are not taken seriously you must speak to a more senior manager in the Directorate. This must be done immediately so that the assessor team can be informed with the least delay, and certainly on the same working day. The reporting process is the same if your concerns are about a number of employees or a team rather than an individual.

4.3.2.2 If you cannot contact any manager you must report your concerns to the local social work office.

4.3.2.3 It is important that the information or concerns are passed to the appropriate adults assessor team in Adults and Communities (or the Emergency Duty Team if out of office hours) on the same working day. The social work team manager will decide whether or not to accept the alert as a safeguarding referral and to start the safeguarding procedure (see section 2 to 6 of the procedure document).

4.3.3 Reporting to a social work team

4.3.3.1 When you contact the area office tell the receptionist that your concerns are to do with safeguarding adults.

4.3.3.2 You should have ready as much information as possible. Ideally this should include the following, but do not delay contacting

the social work team if you do not have all the information:

- The person's name and address
- The person's date of birth
- Their ethnic background
- Their language and if an interpreter might be required
- Their faith or religion
- Who their GP is
- Whether or not the person thought to be at risk knows you are making this contact
- Names of people living in their household
- The name of their nearest relative and/or next of kin
- Details of your concern
- Name of the alleged abuser
- The current wellbeing of the person thought to be at risk and if anything needs to be done urgently to protect the individual, for example if medical help is needed
- How to get access to the person thought to be at risk and/or their alleged abuser.

REMEMBER: Do not delay contacting the social work office if you don't have all this information.

4.4 Write a report

You must make a note of what has been disclosed to you as soon as you can, preferably in black pen or biro so it can be photocopied. Date and sign your report and print your name under your signature. Your manager can help you if necessary.

Your report may be required later a part of a legal action or disciplinary procedure.

You should:

- Write down what was said, using the exact words and phrases spoken wherever possible or write down what you saw. Include the dates and times.

- Describe the circumstances in which the disclosure was made or you saw concerning actions or behaviour.
- Say where it happened and who else was there at the time.
- Write what exactly happened, not your opinion.

The manager that the employee reports to must record the action they take. Include any support the employee needs. Date and sign the report and print your name under your signature.

4.5 Issues where the alleged perpetrator is an employee

4.5.1 If an employee is alleged to have been abusive, the organisation's disciplinary procedures must be followed. All managers have a duty to carefully examine the known facts and to make a judgement and decision on what immediate or long-term action might be required (see organisational disciplinary procedure).

The paramount concern and consideration has to be the wellbeing of the person thought to be at risk and how a risk is to be managed. If the alleged perpetrator has access to other service users, any potential risks to these individuals must be considered.

If you become aware that an adult is, or may be, experiencing abuse tell your line manager immediately. If it is alleged or suspected that your line manager is perpetrating or colluding with abuse then report to a more senior manager.

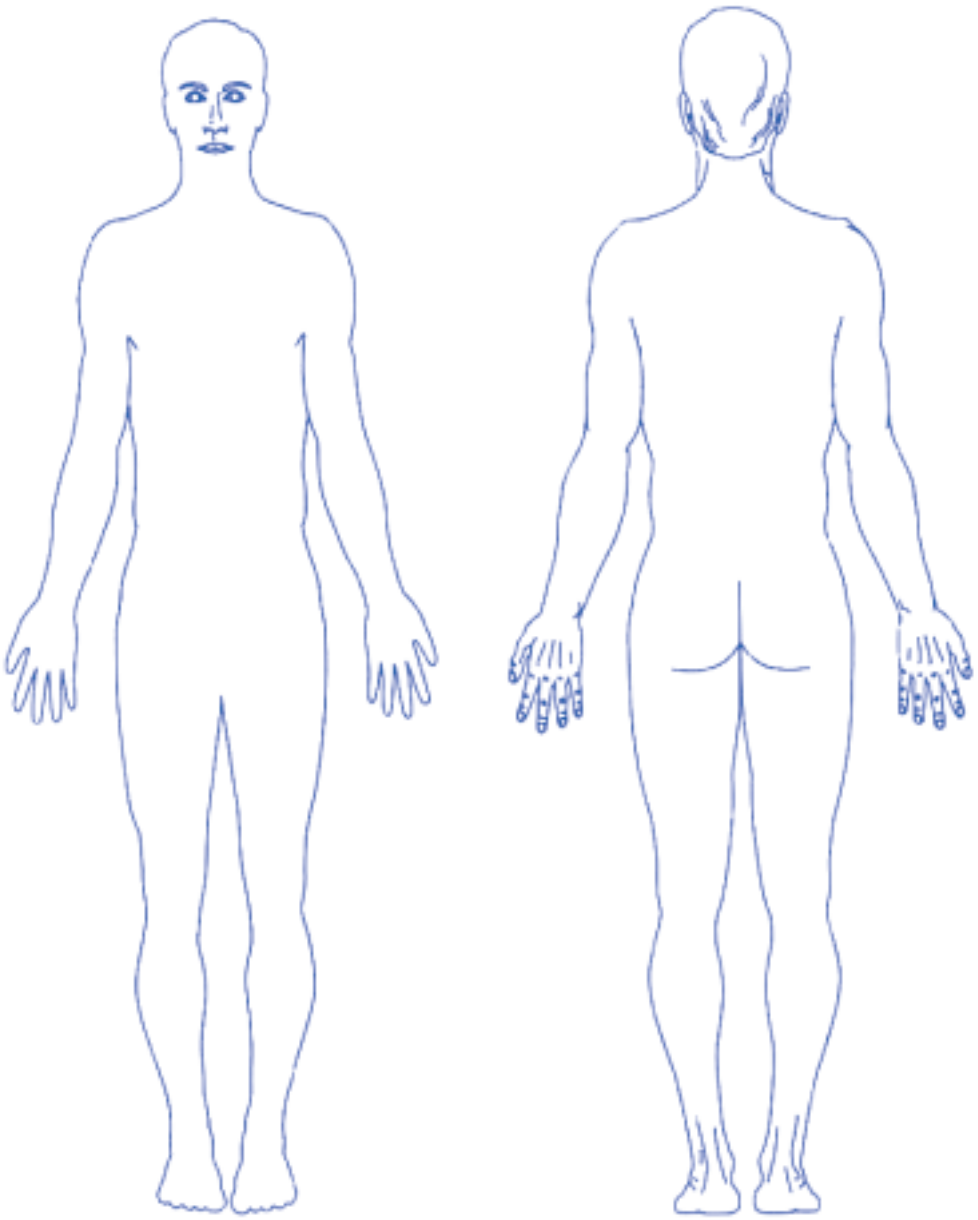
4.6 Body Map

4.6.1 Staff are not required to record the location of marks, bruising or injuries that cannot be seen and should respect the dignity of the individual concerned. If you suspect a criminal act has been committed, you should contact the police who will coordinate any medical investigation that they deem necessary, which may include mapping marks, bruising or injuries.

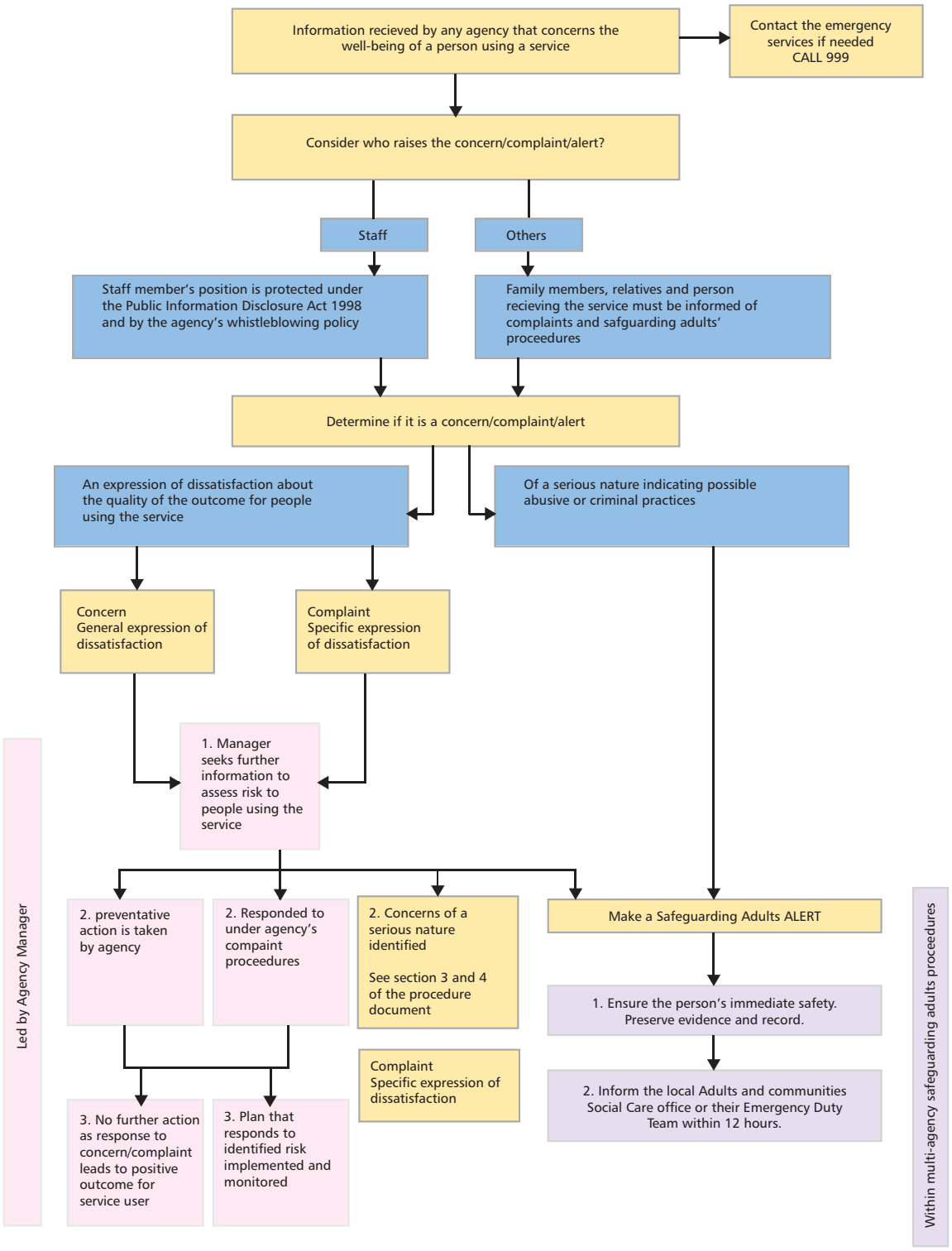
The body map (see 4.6.2) can be used to indicate any marks, bruising or injury that you have been told about or can clearly be seen without conducting an examination.

Other agencies other than Adults and Communities Directorate staff are required to use the multi-agency form (ACF0030) body map to indicate such concerns.

4.6.2



5 Flowchart 1: Safeguarding Adults – Multi-Agency Process in Making an Alert Source:



Flowchart adapted from flowchart in CSCI bulletin "Better Safe than Sorry" - Nov. 2006

6 Multi-agency process following an alert

6.1 Responsibilities of all staff

6.1.1 Whatever your post, if you receive a Safeguarding Alert or become aware of an allegation of abuse you must ensure the appropriate social work team is alerted (see section 4 of the good practice guide).

6.1.2 If you know that the person thought to be at risk has an allocated social worker or care co-coordinator you should contact them direct. If this is not the case or they are not available, contact one of the Adults and Communities offices listed in section 4 of the good practice guide. If they are not the responsible office they will pass your concerns on to the correct office or team.

6.1.3 If the abuse is witnessed or suspected in services provided by a hospital trust report your concerns to the social work team at the hospital.

6.1.4 Out of office hours contact Adults and Communities Emergency Duty Team (see section 4 of the good practice guide). They will take any emergency protective action considered necessary and pass the alert to the appropriate Adults and Communities team (see section 5 of the procedure document: Flowchart – Multi-agency process following an alert).

6.2 Responding to an alert – Social Work Team's reception staff responsibilities

6.2.1 Identifying the responsible worker or manager.

If someone tells you that they are making a possible Safeguarding Adults alert, or that abuse is occurring, you must pass the person immediately to:

- the allocated worker if there is one and they are available,

OR

- the person on duty if there is no allocated worker or they are not available,

OR

- the ATM / TM if there is no person on duty,

OR

- if the responsible manager is not available, a manager from another team should speak to the person.

6.2.2 The Safeguarding Alert is the responsibility of another team:

If the alert is about someone who is the responsibility of another team you should:

- First try to connect the caller to the correct office.
- If there is no reply within a reasonable time put the caller through to their own duty team who will take the details and pass the referral as soon as reasonably possible to the appropriate office.

6.2.3 The subject of the Safeguarding Alert is in an acute general hospital or a community hospital

If the person is in an acute general or a community hospital and there is a new allegation of abuse the hospital social work team is responsible even if there is an allocated worker on another team. (The allocated worker should co-work the investigation with the hospital social worker).

6.2.4 The subject of the Safeguarding Alert is in an acute psychiatric hospital the ward manager will make a referral to the appropriate mental health team.

6.2.5 Complex alerts - the Safeguarding Alert affects a number of people

If the alert is about abuse which affects a number of people, for example if they are living in a care home or hostel or abuse is alleged about a member of staff of a home care agency, the area office in which the unit / organisation is situated will take lead responsibility for taking the referral and co-ordinating the investigation (see appendix 2 of the procedure document).

6.2.6 Safeguarding Alert concerns a registered provider outside Birmingham but service is funded by Birmingham

Where there is an allegation of abuse in another local authority concerning a Birmingham funded service user the lead should be taken by that authority. They will have all the necessary links, for example with the police, CQC, and health. There is no reason why Birmingham City Council cannot conduct a joint investigation particularly where we do know the person involved well rather than just on a review basis (see ADASS protocol about cross-boundary issues in appendix 2 of the policy

document).

6.2.7 Safeguarding Alert concerns a registered provider in Birmingham but service user is funded by another local authority

Where a service user funded by another local authority is living within the Birmingham City boundary it is this Directorate's responsibility to take the lead in the Safeguarding Adults process. See ADASS protocol about cross-boundary issues in appendix 2 of the policy document.

6.3 Alerts about Children and Young Adults

6.3.1 Under 18 years

All child protection concerns are the responsibility of the Children, Young People and Families Directorate until the young person's 18th birthday. All referrals about people younger than 18 years of age must be referred to the appropriate duty and assessment team.

6.3.2 18 years and over and supported by the Care Leavers Service

Where the Children, Young People and Families Directorate Care Leavers Service is working with a young adult aged 18 or older who hasn't an allocated social worker, and there are concerns about Safeguarding Adults issues, the Care Leavers Service will pass the alert to the appropriate adult assessor team for a decision as to whether the concerns come under the Safeguarding Adults procedure. The Safeguarding Adults assessment is the responsibility of the adults team not the Care Leavers Service. The Care Leavers Service is expected to co-operate and work with the team leading the investigation (see appendix 3 of the procedure document).

6.4 Action by allocated worker/Duty Officer taking the alert

6.4.1 Timescale

The manager must see the completed SA1 within 1 hour of the alert information being taken by the worker.

6.4.2 Action by a worker

The alert should wherever possible be taken by a social worker but may be taken for example by a social work assistant or community health care co-ordinator where a social worker is not available.

Whoever receives the alert must inform the relevant manager within 1 hour.

The worker taking the alert will:

- Establish if the person who is the subject of the Alert is in immediate danger. If they are, call the emergency services (999) and inform a manager. If there are considerable concerns but they do not require emergency action consider what options can be offered/are available to protect the individual such as staying with relatives/friends, hospital admission, etc.
- Does the information received make the worker feel that other adults or service users may be in immediate danger? If so, consider actions above.
- Establish if any children are at risk of harm. If they are, liaise immediately with the appropriate Children, Young People and Families Directorate team
- Has a criminal offence been committed? The Vulnerable Persons Officer must be consulted if this is suspected.
- Ask for a Carefirst6 check for previous contact, including the "History" section, in case there have been previous safeguarding events or activities involving the vulnerable person.
- Start to complete the SA1 form
- Attach the Carefirst front sheet to Form SA1.
- Locate the file, if the person being referred is known.
- Ask for a CareFirst check on alleged perpetrator.
- Identify service providers or other professionals who know the person who is the subject of the Alert.
- Find out if the person who is considered to have been abused/at risk of abuse knows about the alert. If so, do they want us to take action under the Safeguarding Adults process?
- Consider whether the person considered to be at risk of harm has issues of capacity to make decisions (see appendix 5 of the procedure document). Is an assessment of capacity in relation to specific decisions required?

- If a provider or professional is the alleged perpetrator, discuss action with your line manager. Do not contact the person/ agency until you have done that.
- If the vulnerable person is in receipt of services contact service providers (where appropriate) to gather information about their involvement, concerns and when the service user was last seen.
- Take the completed SA1 form to a duty manager, assistant team manager or team manager for them to decide on the action to be taken.

6.5 Manager's decision about the alert

6.5.1 The manager must consider all the information available and decide on the same working day the alert is received whether the person is:

- a vulnerable adult
- the victim of adult abuse or something else
- possibly the victim of a criminal offence

6.5.2 Options

a) The alert is accepted as a Safeguarding Adults referral, a multi-agency strategy discussion/meeting is required within 5 working days of receiving alert (see appendix 1 of the good practice guide document).

- Are there any issues about the person's capacity to make decisions?
- Do any other procedures need to run alongside the Safeguarding procedures, for example the disciplinary or complaints procedures?
- Is this a complex case (involving multiple service users/a whole service) if so advise the Operations Manager (See Appendix 2 of the procedure document) who will lead in such cases.

OR

b) Further information is required before a decision can be made on how to proceed with the alert.

OR

c) No further action to be taken in respect of the Safeguarding Adults procedure. Care management involvement or referral to another agency may be required.

In all situations the responsible manager must:

- Record the action to be taken and the reasons for the decisions on form SA1, which should be either to arrange a strategy meeting or that no further action is to be taken under the Safeguarding procedures. Advise the Operations Manager about the referral and send them a copy of the SA1 where no further action is planned and the Safeguarding procedures are concluded.
- Ask the worker to advise the alerter of the decision and agree with the worker what information to give to the alerter. If the alert is from CQC ensure that they are advised within 24 hours re the decision as to whether or not the Alert is accepted as a Referral. Also advise the person who contacted them, if any.

6.6 Manager's decision about seriousness and priority

6.6.1 To help workers and managers to evaluate the information received to determine how the concerns should be addressed the Risk Assessment Tool within the Carefirst6 forms needs to be completed by the social worker. The manager should use this to evaluate the seriousness of the information received and the priority to be given to this referral.

6.7 Manager's decision about who to consult

6.7.1 Which teams / agencies should be consulted?

Consider which other agencies or teams need to be consulted (This list is not exhaustive):

- Police
- Local Authority
- Care Quality Commission (CQC)
- Mental Health team
- PCT where NHS or nursing service are involved
- Children, Young Person and Families Directorate team
- Service contracts if an agency contracted with the Directorate is involved

- Appointee and Court Deputy section and/or the Department of Work and Pensions if financial abuse is alleged
- Customer Relations Service
- If there are capacity issues, has a decision-specific capacity assessment been made and is an Independent Mental Capacity Advocate (IMCA) needed (see section 2 of the good practice guide document).

6.7.2 Involving the Police

Consult with the Police for all referrals where a crime has been or may have been committed or where you are unsure:

- Contact the Vulnerable Persons Officer (VPO) in the first instance either on a local OCU telephone number or the central number - 0845 113 5000.
- If you can't contact the VPO or it is a very urgent matter you should speak to the Public Protection Unit Sergeant/inspector or the Duty Inspector at the OCU.
- In the event of there being no staff available within the Public Protection Unit covering the area where the person has been abused, you should contact 0845 113 5000 and ask to speak directly to the Duty Officer on the area that the abuse is said to have occurred. The Police give a log number to every report that is made to an Operations Centre. Record this log number on form SA1 so that it can be quoted in all contacts with the Police to help them locate the report.
- The Police have a duty to respond in cases where a referral of criminal abuse involving a person thought to be at risk is reported but they still have to prioritise which incidents they respond to first. If the response seems unreasonably slow, contact the Crime Manager or Detective Chief Inspector in the Public Protection Unit.
- If you consider the Police need to use an intermediary discuss this with the VPO or the police officer you speak to. Information on intermediaries and the Crown Prosecution Service will be issued in due course as appendices.

In circumstances where the referral information is vague but on the balance of probability, which includes a risk assessment of available information, a person thought to be at risk of abuse or has been subject of criminal abuse, arrangements can be made

for the VPO to conduct a joint visit with a social worker within 24 hours of the referral being made. The purpose of the visit will be to:

- determine whether a criminal offence has in fact been committed,
- determine the seriousness of the allegation,
- ensure no other individuals are at risk from the alleged perpetrator,
- An initial decision that there is no need for a police investigation may need to be revisited if, in the course of gathering information or carrying out an assessment, information comes to light which indicates that a criminal offence may have been committed.

6.7.2.1 Medical examination:

- If a medical examination is required to gather evidence that a crime has been committed, it is the responsibility of the Police to arrange the medical by a suitably qualified medical practitioner,
- If the person requires urgent medical attention, whenever possible this must be discussed with the police so that there is no possibility of medical evidence being lost or contaminated. However, do not delay seeking urgent medical assistance,
- If the person cannot give their consent to the medical decision,
- If consent is not required immediately, you should contact the Court of Protection to find out if a deputy has been appointed to give consent in relation to particular medical matters or if a Lasting Power of Attorney has been registered dealing with the issue of consent to medical treatment.

6.7.2.2 Care Quality Commission (CQC)

- Where a registered provider is involved, such as a registered care home or home support agency, inform the appropriate CQC office and discuss possible actions and roles and responsibilities.

The Birmingham office is located at:
77 Paradise Circus
Queensway
Birmingham B1 2DT
Tel: 0121 600 5730
Fax: 0121 600 5351

- Appendix 2 of the procedure document gives guidance on the process to follow in complex cases where a registered care home/home support agency is involved.

6.7.3 Service Contracts

Service Contracts must be informed if a registered provider is involved in case:

- There could be other service users affected, either placed by Birmingham or by other local authorities and/or
- In case the concerns affect contract compliance and monitoring.

Service contracts have a co-ordination role and will attend strategy meetings if relevant.

6.7.4 Legal and Democratic Services

There may be situations where legal advice is required. Obtain your Operation Manager's agreement before contacting the Adults and Communities Legal Advice Adults:

On the following Lotus Notes address
Adults&CommunitiesLegalAdvice@birmingham.gov.uk

OR

Tel: 0121 464 3096
Fax: 0121 464 1822

OR

By using the request form on the electronic library in section 01B Directorate Information under Legal and Democratic Services - Request for Legal Advice (see appendix 1 of the policy and procedure document).

6.7.5 Department for Work and Pensions

If there are concerns or evidence about benefits misuse, consult the customer services manager at the appropriate Department for Work and Pensions office for advice.

6.7.6 Appointeeship and Court Deputy section.

If there are concerns about financial or material abuse, other than benefits misuse, the Directorate's Appointeeship and Court Deputy section can give advice on how legal control of a vulnerable person's money can be arranged if the person is unable to look after their financial affairs themselves.

See also the Public Guardianship Office website for information about the services they provide in relation to deputies, enduring power of attorney and Lasting Power of Attorney:

www.guardianship.gov.uk

Financial or material abuse includes theft, fraud exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

A multi agency Information Sharing Protocol in relation to Safeguarding Adults has been agreed (see section 5 of the policy document).

6.7.7 National Probation Service

If the alleged victim or perpetrator is known to the National Probation Service contact the local office to establish the reason and nature of their involvement and whether they have any information that may assist the investigation.

If you do not know if the Probation Service is involved contact:

Assistant Chief Probation Officer
18/28 Lower Essex Street
Birmingham SB5 6SN
Tel: 0121 248 6400,
Fax: 0121 248 6450.

6.7.8 Local Services Constituency Manager

If the person thought to be at risk or alleged perpetrator lives in multi-occupied housing or supported housing, consider if you should contact the appropriate Constituency Manager.

6.8 Strategy Discussion/Meeting

6.8.1 Definition

A strategy discussion is a telephone discussion.

A strategy meeting is a face-to-face meeting.

The manager will decide which is the most appropriate depending on the urgency, nature of the allegation and whether or not a joint investigation is needed.

The strategy discussion/meeting is between professionals (including the alerter) who may have a role in the safeguarding assessment and plan. The person thought to be at risk and carer(s) and their advocates are not included.

It is important that if a strategy meeting takes place it is not confused with a case conference and that the minimum number of people attend.

NB Certain cases are recognised as being potentially complex, for example where a number of service users are potentially at risk of abuse or a whole service is implicated appendix 2 of the procedure document looks more specifically at the management of the safeguarding process in relation to such cases.

6.8.2 Purpose

The purpose of the strategy discussion or meeting is to formulate a multi-agency plan for assessing the risk and addressing any immediate protection needs.

6.8.3 Timescale

It must be held within 5 days of the alert being received.

6.8.4 Format of a strategy meeting

The Risk Assessment Tool within the SA forms on Carefirst6 can be used to assess the seriousness of the abuse, its impact and the likelihood of it being repeated when information is shared at the strategy meeting.

The manager should start to complete form SA2.

6.8.5 Setting up a strategy discussion or meeting

The team manager or assistant team manager is responsible for ensuring that a strategy discussion or meeting occurs and that

the appropriate information is available for the discussion/meeting. An Assistant Team Manager (ATM) can chair a strategy meeting.

Further strategy discussions/meetings may be needed to ensure the continued co-ordination of more complex investigations.

6.8.6 Key players in a strategy discussion/meeting

These may change depending on the situation. The Team Manager/Assistant Team Manager must decide which agency to contact and at what level. The representatives must be able to represent their agency and participate in decision-making. See also 6.7 above for list of possible agencies to participate. Where the Safeguarding issue concerns a regulated care provider CQC will provide information on a Safeguarding Adults Assessment Strategy Meeting form for the meeting whether or not they attend.

It is important to consider the role of the Police if it is suspected that a crime may have been committed in all referrals. The Vulnerable Persons Officers should consider involving the Crown Prosecution Service at the earliest possible stage if the police are to investigate.

The team manager/assistant team manager will lead the strategy discussion/meeting. The worker who took the referral must attend.

Please note that a Confidentiality statement should be read out at the beginning of each strategy meeting (see SA forms on Carefirst6).

6.8.7 Record of the strategy discussion or meeting

6.8.7.1 Telephone discussion

If there is a telephone discussion the manager must record:

In the case notes, on a separate CR8(A), that a strategy discussion has been held, the name and agency of all persons consulted, the substance of the discussion and actions agreed including timescales and responsibility for carrying out tasks. If an action plan is agreed, send this out typed up to those who took part to confirm actions.

Attach a copy of the CR8(A) to the SA2b form.

6.8.7.2 Strategy meeting

If there is a formal multi-agency meeting, business support will provide a trained minute taker to provide accurate documentation of the discussion and plan of action. It is the chair's responsibility to make sure that a written and accurate record of the strategy meeting is made and circulated within 10 days of the meeting being held. The Action Plan should be circulated earlier where there is a high level of risk and agencies need to act quickly.

6.8.8 Outcome of Strategy Meeting

Decisions

6.8.8.1 Continue with the safeguarding process: Agree Action Plan to address immediate risks and plan assessment/investigation. Ensure that the safeguarding referral event is closed and an investigation event is opened by admin.

6.8.8.2 No need to continue with Safeguarding process but other action required: Record reasons on file or in strategy meeting minutes. Agree what other support or action is required and record on file or in minutes.

6.8.8.3 No further action under Safeguarding or any other process:

If the outcome is covered in sections 6.8.8.1 or 6.8.8.2, then the Safeguarding paperwork including SA1 and SA2 forms and the Managers Checklist must be sent to the Operations Manager for sign off or comments.

Any open Safeguarding Events on Carefirst6 should be closed by administration.

At this point the TM or ATM should consider whether there is any learning from the Safeguarding process which could be shared (see appendix 5 of the good practice guide document).

In addition, there may be circumstances where a vulnerable adult dies or sustains a potentially life threatening injury through abuse or neglect and there are concerns about the way in which professionals and services work together to safeguard that person. In such cases a referral to the serious care review sub-group must be considered (see appendix 4 of the procedure document).

Ensure that Service User and the alerter are fully aware of all decisions reached (except rarely where this might jeopardise or

compromise their safety and wellbeing or where they have been assessed as lacking capacity to understand the implications of the decisions being made).

6.9 The Safeguarding Adults Assessment/Investigation

6.9.1 The focus of the assessment/investigation

There may be more than one assessment/investigation required:

- The abuse assessment/investigation
- A disciplinary investigation
- An investigation into the running of an establishment
- A criminal investigation
- An investigation into a complaint

The co-ordination of the various procedures must be agreed at the strategy meeting/discussion to avoid one investigation compromising another.

6.9.2 Who can do a Safeguarding Adults assessment/investigation?

Follow this section when Adults and Communities social work staff are taking the lead or when acting as co-worker when the police lead the investigation. See below if the service user is receiving a service from Birmingham Institute for the Deaf (BID).

Where the Police take a decision to investigate, the strategy discussion/ meeting will agree the roles of the Directorate's staff and other agencies whilst the Police investigation takes place.

In the Adults and Communities Directorate Safeguarding Adults assessments/investigations must be carried out by social workers who have successfully completed the Safeguarding Adults training modules 1 and 2 (or at least one of the workers should have) or who are senior social workers.

Where BID is providing an assessment and care management service through the Service Level Agreement with this Directorate, the BID worker may be the lead worker in the investigation if they have done the necessary adult protection training. The Directorate worker will act as the co-worker and take notes based on the BID worker's verbal interpretation. The Adults and Communities Directorate manager is still the responsible manager for the adult protection investigation and process, not the BID manager.

6.9.3 Timescales for completing the Safeguarding Adults assessment/investigation

The timescale will have been agreed at the strategy discussion/ meeting. The maximum time is 28 days from the date the alert is accepted as a referral. If the timescale cannot be met record the reasons on the SA3 form and if necessary reconvene the strategy discussion/meeting. It is acknowledged that some police investigations (particularly in complex cases) may take longer but this should not delay implementing an action plan to safeguard or moving onto a case conference where required (See 6.10 below).

6.9.4 Purpose of Safeguarding Adults assessment/investigation

- To make sure the subject of the allegations knows about the concerns, and their carer if appropriate,
- To establish the person thought to be at risk's and carer's viewpoint about the allegation and what has happened and their views about what they would like to happen,
- To assess the person's capacity to understand and appreciate the concerns and possible consequences of the abuse, and their ability to make decisions,
- To collect information as to whether it is likely that abuse has taken place and the nature of the possible abuse,
- To establish the risk factors, and identify how these can be managed
- To gather any other relevant information,
- To establish what support is available for the abused adult and whether additional support is needed,
- To establish if any support is required for the alleged abuser if he/she is also vulnerable.

6.9.5 Proceeding to a Safeguarding Adults assessment/investigation

6.9.6 Information to give to the abused adult/carer

Where this Directorate/BID are taking the lead the investigating worker must:

- Verbally inform the abused adult and the carer about the Safeguarding Adults process, and what will happen,

- Give a copy of the appropriate adult protection leaflet(s) for the public,
- Establish what the abused adult and the carer wish to happen,
- You may also at some point need to offer a SAP (community care) assessment if it appears that either/both individuals may require services,
- Give information about the complaints procedure.

6.9.7 An interview should be postponed if:

- The person thought to be at risk needs urgent medical attention, for example because of mental health issues,
- The person is able to make choices and does not wish the interview to continue,
- The investigating worker cannot communicate with person although alternative methods of communication have been tried,
- The investigating worker is in danger,
- There is no police presence and the worker feels that information is being given that could compromise a subsequent police investigation.

6.9.8 Action to take if unable to gain access to the vulnerable person

Follow the procedure in the 'Good Practice Guide' document. Convene an urgent case conference if required.

6.9.9 Recording

One of the workers present must take detailed notes during interview/ investigation. These do not have to be verbatim but if the vulnerable person describes a scenario or conversation about the allegation of abuse it is important that as much of the person's actual words are recorded as possible. The notes should be dated and signed by the worker who made them and filed with forms SA1 and SA2b. The person thought to be at risk does not sign them.

Complete form SA3 (investigation) from these notes (provide add-on sheets if necessary).

6.9.10 SAP assessment and providing services

A Safeguarding Adults assessment is not a community care assessment. In an emergency, services may also be needed. These may be commissioned through a Safeguarding Adults assessment on a temporary basis until the SAP assessment and documentation is completed.

6.10 Outcome of Safeguarding Assessment/Investigation

6.10.1 Information/evidence to support the allegation and / or concerns is found

If the assessment or investigation found information/evidence to support the allegation or other concerns, the manager will set up a case conference within 10 days to report back to the multi-agency partners for a decision to be made as to whether further safeguarding action is needed.

6.10.2 No evidence to support the allegation is found

If there is no evidence to support the allegation and the manager considers that no further action appears necessary under safeguarding, the manager can decide that a case conference may not be necessary. In this situation only, the manager can phone the multi-agency partners to report the assessment/investigation outcomes and get agreement from all the appropriate partners that no further action is necessary under the safeguarding procedure.

If there is not multi-agency agreement to stop the safeguarding process, the manager must set up a case conference. See 6.11 below for more information and SA4C for the suggested format of a case conference.

6.10.3 All situations

The team manager must always see a copy of forms SA1, SA2b and SA3 and record their comments on the SA2b.

If there is to be no further action under the safeguarding procedures, the manager should ensure the SA1, SA2b and SA3 and any relevant paperwork associated with the Safeguarding process should be forwarded to the Operations Manager for sign off/comments.

At this point the TM or ATM should consider whether there is any learning from the Safeguarding process which could be shared (see appendix 5 of the good practice guide document).

In addition, there may be circumstances where a vulnerable adult dies or sustains a potentially life threatening injury through abuse or neglect and there are concerns about the way in which professionals and services work together to safeguard that person. In such cases a referral to the serious care review sub-group must be considered (see appendix 4 of the procedure document).

6.11 Case Conference

6.11.1 Who to invite:

- The case conference should involve all the people who may have information to contribute to the planning process, provided they do not appear to be implicated in the alleged abuse. These are:
- The professionals, including service providers, who participated in the strategy discussion/meeting.
- Any other relevant professionals consulted during the assessment/investigation.
- The Independent Mental Capacity Advocate (IMCA) if appointed.
- The person thought to be at risk (who will be invited whenever possible). If they are not invited, or do not attend, the reasons must be recorded. If the person thought to be at risk has no capacity and there is no IMCA appointed, identify a family member/advocate to take part/represent them.
- The carer and/or other family members may be invited but do not have an automatic right to be present. The wishes of the person thought to be at risk about this should be considered.
- If the person thought to be at risk and their carer are to attend, they need to be properly briefed beforehand by the assessing / investigating officer, for example purpose of conference, what will happen, possible outcomes. They have a right to bring an advocate if they wish.
- If the person and their carer are not to be invited, they should be informed that a case conference is taking place and of the outcome.
- If a solicitor is attending at the request of the person, the chairperson should make clear to the solicitor that they are not permitted to attend as a lawyer or legal advocate, but as

an advisor, supporter and/or advocate to facilitate communication for the person. The chairperson should consider whether they should take legal advice in this situation.

- Interpreters need to be briefed beforehand by the investigating worker, for example purpose of conference, what will happen, possible outcomes.
- It is the chairperson's responsibility to identify if anyone should be excluded from any part of the case conference. This will depend on:
- The information a person needs to know.
- Any possible criminal proceedings.
- The sensitivity of information.

6.11.2 Written reports for the case conference

Each agency that had a role in the investigation/assessment must provide a written report of that work for the case conference. (National Standards 9.8.2)

Written reports are required from those who are unable to attend. This should include the length of time the vulnerable person/carer has been known, date of last contact with them, concerns and risks, recommendations.

6.11.3 Chairperson

Where possible the chairperson should be an Adults and Communities manager who has not been involved in the assessment / investigation, for example assistant team manager, team manager, operations manager depending on the circumstances of the assessment / investigation

6.11.4 Arranging the case conference

The investigating worker's team manager is responsible for making sure that the case conference is arranged, providing a venue and minute taker and arranging interpreters, signers etc.

The venue does not need to be a Directorate office. Where the conference is held will depend on the frailty of the person thought to be at risk, implications for their and staff's safety, the location of the majority of the people attending, etc.

6.11.5 A trained administration worker will take minutes of the case conference and produce them within 10 working days of the meeting, or sooner if the risk assessment demands it. Neither the chairperson nor the investigating worker should attempt to be the minute taker.

The chairperson is responsible for agreeing and signing the final minutes.

For guidance on the structure and circulation of minutes and the standard format for case conference/review case conference minutes see the SA forms on Carefirst6.

6.11.6 Purpose of the case conference

The Safeguarding Adults case conference is a formal forum for the exchange of information between professionals who are or might be involved with the person endangered by abuse. It allows for an interagency, multidisciplinary discussion of the vulnerable person's circumstances, the roles and responsibilities of various professionals and the legal context of intervention. A case conference is not a court of law and it is not intended that the conference should decide that a crime has been committed or the guilt of any person. Its purpose is to:

a) To share information, developments since the strategy discussion / meeting, and the current situation (see section 5 of the policy document).

b) To assess the level of risk of further abuse to the person thought to be at risk (see Risk Assessment Tool in SA forms on Carefirst6).

c) To agree a safeguarding plan if required and to set the date for the review case conference.

d) Where there is disagreement between agencies in relation to the safeguarding plan please see the 'Good Practice Guide' document.

A case conference will focus on the specific allegations of abuse to the person but may consider matters of more general concern.

See also the guidance on the format of the case conference.

6.11.7 Format for the case conference (see SA4c for guidance on Carefirst6).

6.11.8 In all cases a case conference (SA4c) event should be completed by member of the business support team.

Where a safeguarding plan has been agreed a Safeguarding Plan event should be put on Carefirst6 to indicate significant on-going risk and a need to review the case.

A review date should be set and the review should be held by Day 122 (12 weeks after the Case Conference -see Flowchart- Multi Agency Process following an Alert, section 5 of the procedure document).

Where the Case Conference concluded that there was no need for further action under the safeguarding procedures but other actions were required, for example signposting to other services then a plan of action should be agreed.

In all cases where there is no further action under the Safeguarding procedures the completed SA1, SA2, SA3, SA4 and other paperwork associated with the Safeguarding process should be forwarded to the Operations Manager for sign off/comments.

At this point the TM or ATM should consider whether there is any learning from the Safeguarding process which could be shared (see appendix 5 of the good practice guide document).

In addition, there may be circumstances where a vulnerable adult dies or sustains a potentially life threatening injury through abuse or neglect and there are concerns about the way in which professionals and services work together to safeguard that person. In such cases a referral to the serious care review sub-group must be considered (see appendix 4 of the procedure document).

6.12 The Lead Worker

6.12.1 Who can be the lead worker?

The lead worker is a worker who is appointed by the case conference to take responsibility for co-ordinating the work detailed in the adult protection action plan.

They must be an appropriately qualified worker from Adults and Communities, a health agency or BID.

The lead worker will not necessarily be the worker who has most face-to-face contact with the person, or even play the most active role in any treatment or service provided.

6.12.2 Responsibilities of the lead worker's agency

It is the responsibility of the lead worker's agency to ensure that:

- A worker is always available to take on this role.
- Other agencies involved are notified if a change occurs

6.12.3 Responsibilities of the lead worker

The lead worker's responsibilities are to:

- Act as a link person for other professionals.
- Co-ordinate the adult protection action plan, i.e. interagency work of the professionals working with the person.
- Monitor the implementation of the case conference decisions ensuring that protection of the service user is maintained as the primary focus.
- Act on any serious concerns that arise, following liaison with the Adults and Communities team manager.
- Arrange reviews and ensure invitations are sent out for them.
- Refer back to the Adults and Communities team manager for identification of a new lead worker if the current lead worker role is time limited.
- Prepare a report for future reviews.

6.12.4 Responsibilities of all agencies involved:

It is essential that all individuals involved in supporting the person thought to be at risk notify the lead worker of all concerns.

6.13 Safeguarding Plan Review

6.13.1 Frequency of review.

The person's situation must be reviewed at least every three months, more frequently if appropriate. The first Review should be held within 12 weeks of the Case Conference.

6.13.2 Chairperson of the review

The case conference chairperson, if this was someone independent of the case, should chair the first review after the case conference. The responsible team manager should chair

subsequent reviews unless the case conference chairperson decides that there are overwhelming reasons that require them to continue to chair.

6.13.3 Who to invite.

All those people who were invited to the case conference and the lead worker if different from the assessing worker (see Carefirst6 document SA5b).

6.13.4 Purpose.

To review the safeguarding plan and reassess the level of risk – the Risk Assessment Tool that is integral to the SA forms should be used to evidence whether as a result of implementing the action plan the level of risk has reduced.

To set the date of the next review if it is considered there is still a risk to the person and consider whether the action plan needs to be revised.

If safeguarding work is to continue to reconfirm the lead worker, or to reallocate to a new lead worker. If a new lead worker is appointed all relevant agencies/persons must be informed of the change and how to contact the lead worker.

6.13.5 Recording the review

6.13.6 The recording of the review must reflect the meeting. The SA5c form (on Carefirst6) will help structure the minutes that should be documented by a trained admin worker.

The minutes should be circulated **within 10 working days**.

Where the Review concluded that there was no need for further action under the safeguarding procedures but other actions were required, for example signposting to other services then a plan of action should be agreed.

In all cases where there is no further action under the Safeguarding procedures the completed SA1, SA2, SA3, SA4, SA5, minutes and other paperwork associated with the Safeguarding process should be forwarded to the Operations Manager for sign off/comments.

At this point the TM or ATM should consider whether there is any learning from the Safeguarding process which could be shared (see appendix 5 of the good practice guide document).

In addition, there may be circumstances where a vulnerable adult dies or sustains a potentially life threatening injury through abuse or neglect and there are concerns about the way in which professionals and services work together to safeguard that person. In such cases a referral to the serious care review sub-group must be considered (see appendix 4 of the procedure document).

Ensure that Admin are asked to complete the Safeguarding Plan event.

6.14 Further Safeguarding Adults Referrals

6.14.2 Safeguarding Adults investigation closed

Any future safeguarding adults' allegations must follow the procedure from the beginning.

6.14.2 Safeguarding Adults investigation open

If the alert is about a new alleged perpetrator or a different form of abuse complete a new SA1 and follow the procedure from the beginning.

If the alert is about the same alleged perpetrator or form of abuse, discuss the allegation with the responsible manager and follow their directions on how to proceed.

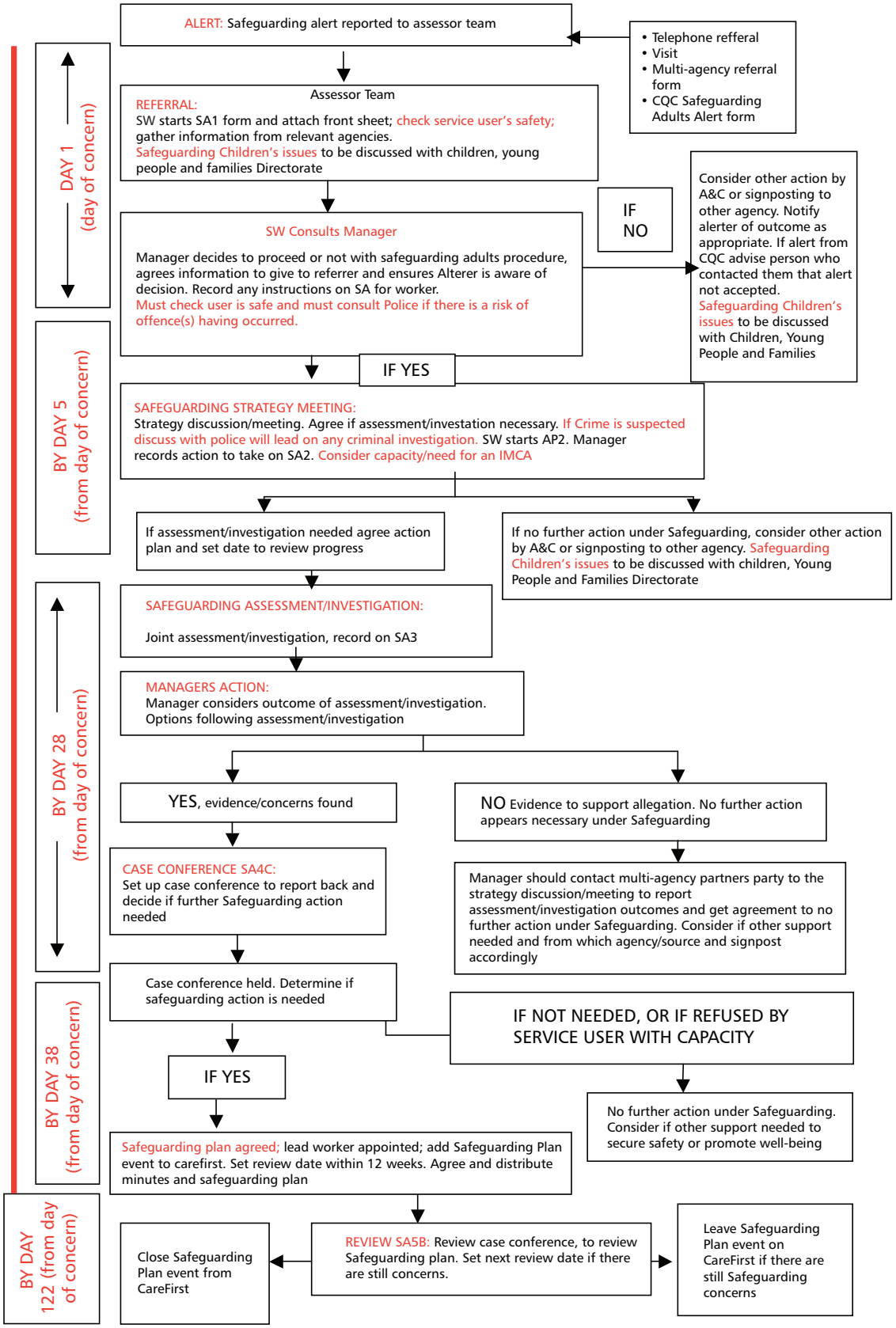
6.14.3 All further Safeguarding Adults referrals

In all situations report all fresh allegations to the responsible manager within one hour for a decision on how to proceed.

6.15 Quality Assurance

6.15.1 Managers are expected to review cases on a 6 monthly basis that have been reported under the Safeguarding Adults policy and procedure (see the 'Good practice guide' document).

7 Flowchart - Multi-agency process following an alert



SAFEGUARDING ADULTS
PROCEDURE APPENDICES

Appendix 1

Process to Access Legal Advice

Staff of any organisation will need to follow their agreed internal process in gaining access to legal guidance. This may be similar to the example below that is used by the Adults and Communities Directorate.

To contact Legal and Democratic services or to make a referral please complete the form below and e-mail or fax to:

Lotus Notes: Adults&CommunitiesLegalAdvice
Email: Adults&CommunitiesLegalAdvice@birmingham.gov.uk)

Tel: 0121 464 3096
Fax: 0121 464 1822

REQUEST FOR LEGAL ADVICE

Your name	
Your office address	
Your telephone number	
Your fax number	
Your team managers name address, telephone and fax number	
The name of your service director	
The name of the person who has authorised you to obtain legal advice (must be operations manager or equivalent)	
The name address and date of birth of the service user which this request relates	
Briefly set out the details of the advice you seek	
Are there any relevant documents such as correspondence, assessment – if so please fax them on 0121 464 1822 when you send this request. Address the fax to: Charmaine Murray Head of Adult Services (legal) Adults and general team	

PLEASE SEND THIS REQUEST TO:

Lotus Notes: Adults&CommunitiesLegalAdvice
Email: Adults&CommunitiesLegalAdvice@birmingham.gov.uk

Appendix 2

Managing complex cases

1. Referrals that are not complex

1.1. Where the allegation/s is related to:

- One individual
- There is little suggestion of risk to other people
- And the allegations, whilst having safeguarding implications or issues, are less serious/complex after an initial risk assessment by the Team Manager or Assistant Team Manager

The strategy meeting/discussion and investigation will be led by the Team Manager or Assistant Team Manager, or an Adults and Communities Directorate or Birmingham and Solihull Mental Health Trust equivalent, responsible for the service user or client group of the service user. Where possible a Team Manager from another team will chair any case conference.

1.2. See forms SA2a/c on Carefirst6 for information about the format of the strategy meeting and minutes.

1.3. The Team Manager will also ensure that the relevant Operations Manager or Service Manager receives a copy of the information if the allegation involves a regulated care provider in another part of the city or covering the whole city.

1.4. The Team Manager will also ensure Service Contracts are advised (where a concern is about a regulated care provider)

2. Complex Referrals

2.1. Where the allegations are related to:

- More than one service user
- One service user but there have been other allegations related to a whole service, for example a care home or regulated car services provider
- Or are more serious/complex after an initial risk assessment by the Team Manager or Assistant Team Manager

Then the relevant Service Director in conjunction with the Head of Service or Operations Manager for the service area will lead the safeguarding process.

The Team Manager or Assistant Team Manager for the geographical area of the home/service or the relevant equivalent where the service users/home is for a specific client group managed on a city wide basis will support the management of the process.

3. Roles of Managers/Staff in Complex Cases

3.1. Service Director (SD)

- Receive feedback from Head of Service or Operations Manager on progress or issues
- Role in any decision to suspend or terminate the contract
- Support/supervise Head of Service or Operations Manager

3.2 Head of Service (HOS)

- Receive feedback from Operations Manager on progress/issues
- Role in decision to suspend or terminate the contract
- Support / supervise Operations Manager

3.3 Operations Manager (OM)

- Lead and coordinate process
- Call and chair strategy meetings/discussions
- Ensure minutes are distributed
- Support/supervise Team Manager(s) involved in complex case
- Agree involvement of legal services

3.4 Team Manager for Service User Group for the Geographical area of the Home/ Service Provider

- To coordinate links with allocated social workers from their own team
- To coordinate links with allocated social workers and their team managers from other teams or Local Authorities.
- To coordinate reviews

- To contribute to strategy meetings/discussions
- To coordinate actions agreed at strategy meetings/discussions
- To deputise for the Operations Managers/Service Managers , for example chairing meetings when necessary.

3.5 Team Managers for any Individual Safeguarding Adults Alerts and Investigations Concerning Residents of the Home or Users of the Service.

- To provide information and up to date position for strategy meetings about any individual investigations, which have either happened or are currently happening
- To ensure actions for their team which are identified and agreed at the strategy meeting/discussions are carried out
- To support the team manager coordinating the reviews and provide information/records as requested in relation to the investigation.

3.6 Service Contracts – Managers and/or Contract Monitoring Officers

- To provide historical information about the service – including concerns around contract compliance
- To provide information about current Adult Protection concerns
- To provide information about the provider shared with them by the Care Quality Commission
- To ensure that other Local Authorities are aware of current concerns raised
- To give advice to Team Managers and Operational/Service Managers regarding suspension of contract or contract termination
- Head of Service Contracts to sanction decisions concerning suspension/termination of contract
- To assist in the collation of the names of service users/residents
- To ensure decisions, for example around suspensions are communicated to all. Teams or Local Authorities with responsibility for service users / residents

3.7 Lead Nurse or Equivalent from Primary Care Trust (PCT)

- To provide historical information on the service
- To collate the names of known service users/residents
- To provide information on current concerns/issues in relation to the service or service users/residents or perpetrators
- To ensure staff assist in the implementation of agreed action plans, for example in relation to reviews or removal of service users/residents

3.8 Vulnerable Person Officer (West Midlands Police)

- To discuss concerns and advise on possible criminal offences
- To act as a link between any police investigatory officers and the Operations Manager to provide historical/current data in relation to service users/service/perpetrators
- To participate in strategy discussions/meetings and assist as appropriate in the implementation of agreed action plans

3.9 Care Quality Commission (CQC)

- To provide information from inspections and reports including service ratings and outstanding regulatory requirements
- To share concerns about services with Adults and Communities Directorate
- To participate in strategy meetings/ discussions where it is deemed appropriate

4. Strategy Meetings

4.1. Process to Follow in Complex Cases

It may be necessary for the Service Director (or delegated Head of Service/Operations Manager) to contact partner agencies prior to setting up a strategy meeting. The discussion should be used to agree who to invite, who can feedback to or represent others at the meeting, whether the service provider should attend.

A strategy meeting in complex case services the same function as in “non complex” cases.

- It is a multi agency meeting to:
- Share information and concerns
- Assess risks to individual residents/service
- Assess general risks to all residents/service users
- Agree an action plan including the management of the investigation and risk management
- Agree the frequency of future meetings

4.2. Preparation for all Strategy Meetings

The Lead Manager within the Adults and Communities Directorate should:

I. Be familiar with the case file/records

II. Be clear why they are calling a meeting in terms of

- Its purpose
- Their role
- Their contribution

III. Ensure that the duty/investigating/allocated social worker prepares a report on the allegation(s) received, relevant background information and any work undertaken in relation to the allegations.

4.3 Complex Case Strategy Meeting

4.3.1 Part 1 of the Meeting should:

I. Focus on the individual service users where safeguarding concerns have been raised i.e:

- What are the allegations,
- What measures are in place to prevent further abuse,
- What ongoing risks exist.

II. Agree an action plan to:

- Investigate concerns including who investigates, timescales, personnel involved
- How the immediate risk(s) are addressed/reduced

III. If all service users need to be reviewed/assessed agree:

- Who will lead the reviews, format and questions to be asked, communication strategy with the service provider and the service users/their families, how the potential media interest will be handled.

4.3.1.1 Review

Where safeguarding concerns are raised in relation to a whole service, each person will require one or a combination of options below.

I. A safeguarding check, which is:

an overall check of the wellbeing of a person using a service / living in a care setting,

and / or

a specific check about concerns raised in relation to the way services are / are not being provided, for example medication, choice, dignity manual handling etc).

II. An early Annual Review where the review is due within two months that considers the safeguarding concerns,

III. No further review if an Annual Review has been completed within two months and this covered the area of concern now being raised and no issues were highlighted,

IV. A Safeguarding check where the recent annual review did not address the current safeguarding issues being raised.

4.3.1.2 Carefirst6

Once the review or check has been completed for the existing Birmingham service user, the social worker needs to record the activity on the appropriate Carefirst6 event screen.

Social work action:

I. If a safeguarding check has been undertaken – record it in Provide Services event and enter 'Complete' and date.

II. If an early Annual Review has been held – record in Scheduled Review event and enter 'Complete' and date.

III. If an Annual Review has recently been completed and no further check is required – record in Assessment / Reassessment event and enter 'Complete' and date.

If safeguarding concerns are raised during 1 or 2, above, then the usual safeguarding process needs to be followed for each person.

Where a person is self funding or funded by another local authority and not known to Carefirst6, then the administrator should create a new person entry on to Carefirst6 as a new referral and add a safeguarding check activity or an early review as appropriate.

4.3.2 Part 2 of the Meeting should:

Focus on the wider issues where a service provider/whole service is implicated:

- Is there a need for extra support from Adults and Communities or PCT staff to go into the service?
- Should new admissions/placements be suspended and if so, for how long?
- What is the role of CQC, Contracts Monitoring Officers, others in relation to the provider?
- Are the allegations so serious or so numerous that contract termination or closure of the service needs to be considered?

4.3.3 Agree Action Plan In Relation To Concerns Around Whole Service Which States:

- What actions are to be taken, by which agencies and within what timescale?
- Agree feedback and communications strategy between agencies
- Set date to meet again

4.3.4 Purpose of Follow up Strategy Meeting and/or Case Conference is to:

- Share information and concerns
- Review minutes of last meeting
- Review current action plan

- Feedback on current investigations
- Identify learning points
- Assess risks to individual residents/service users
- Assess general risks to all residents/service users
- Agree an action plan which includes risk management and relates to the whole service as well as individual service users
- To agree frequency of future meetings

4.4 Guidance on additional documentation to manage the process

The SD (or delegated HOS/OM) needs to take a project management approach and develop the following:

4.4.1 Minutes of all Meetings

- include lists of who is present, apologies and circulation of minutes
- include appendices
- identify Chair and Minute Taker
- do not combine general details and concerns about the Home/Service with details about individuals, which may need to be in a separate appendix or individual investigation.

4.4.2 An Action Plan

- updated at every meeting
- may or may not be included in the minutes
- may be an appendix of the minutes

4.4.3 List of all Residents/Service Users Receiving the Service

- the following can be used to ensure that the list is complete:

Service Contracts List
CareFirst Printouts
CQC List
PCT List
Provider's List
Local Social Work List

Be mindful that there may be discrepancies of details and different spellings of names etc

The list should include:

- title
- full name
- date of birth
- date of admission
- next of kin/representative details
- relevant mental capacity details
- date of discharge from the Provider
- details of new Provider
- date of death if the resident service user is deceased

4.4.4 List of Contact Details of all Staff Involved in the Strategy Discussions at any Time

4.4.5 Risk Register

- ongoing
- reviewed and updated at each meeting
- includes assessment of level of risk
- includes risk management action plan
- may be needed as future evidence to justify actions taken

4.4.6 Running Record

- essential that each member of the multi-agency strategy group keeps a written running record of all telephone contacts, discussions, letters and meetings

4.4.7 Learning Log

- essential that a learning log is maintained from the beginning
- learning points need to be identified and recorded at each meeting
- learning points need to be followed up and shared

4.4.8 Communication Strategy

- essential that there is agreement on who needs to be briefed, how families/users will be informed, how media will be briefed and how all agencies involved will be coordinate communication between themselves within their own agency

4.5 Contingency Plan in the Event of Sudden Closure of this Home

- Essential that this is considered as part of the strategy meeting/case conference process and agencies have agreed how they will work together should this occur.

4.6 When a Home Closes

- Separate guidance – Appendix to be issued later.

4.7 De-briefing Meeting and Record

When the complex case procedures are concluded, agencies should meet to de-brief, look at lessons learnt from the case and the processes followed and record the learning and practical/resource implications raised.

These should be copied to Heads of Services and Head of Safeguarding for the consideration of BSAB subgroups.

Appendix 3

Interface between Safeguarding, Promoting Welfare and Child Protection and the Safeguarding Adults Procedures

1. Introduction

This appendix identifies processes to enable the Children, Young People and Families Directorate and Adults and Communities Directorate to work together where a young person subject to Child Protection procedures may need to be considered for assessment / services by Adults and Communities staff. This will include those in transition.

2. Safeguarding and promoting the welfare of children

2.1 Safeguarding and promoting the welfare of children is defined in 'Working Together to Safeguard Children' (2006) as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

2.2 Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are at risk of suffering significant harm. See www.lscbbirmingham.org.uk/child-protection-procedures/ child-protection-procedures.aspx

2.3 Effective child protection is essential as part of wider work to safeguard, to promote the welfare of children and provide continuity in transition to adulthood. All agencies and individuals are required to work in partnership to safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced.

3 Safeguarding and the promotion of the independence, well-being and choice for adults

3.1 Safeguarding Adults is a phrase which encompasses all work which enables an adult "who is or may be eligible for community care services" to retain independence, wellbeing and choice and to access their human rights to live a life that is free from abuse and neglect (Safeguarding Adults ADSS 2005).

There are three main strands to Safeguarding:

- Prevention: developing and sustaining preventative strategies –these include raising public awareness, developing and disseminating empowerment, advocacy, publicity and information.
- Adult Protection – recognising, reporting and responding effectively to alleged abuse or neglect when it occurs. This includes policies, procedures, training and raising awareness.
- Evaluation – learning and building on best practice in Safeguarding and having a competent workforce for prevention as well as protection. This includes serious case reviews, audits, evaluation of performance, monitoring and annual reporting.

4 Interface between Child Protection and Safeguarding Adult Procedures

4.1 Where a young person subject to Child Protection procedures may need to be considered for assessment / services by Adults and Communities staff, the following must be carefully thought through:

- whether a young person is subject to a Section 47 Inquiry under the Child Protection procedures no less than 6 months before their 18th birthday,
- whether a Child Protection Plan is still in place and the young person is less than 6 months from their 18th birthday.

4.2 In all such cases Children's Social Care Staff working in the Children, Young People and Families Directorate will contact Adults and Communities Team Managers.

The decisions to be made by the Adults and Communities Manager are:

- Will the young person meet the definition of a vulnerable adult?

If so:

- is there a need to activate / follow the Safeguarding procedures?
- is there a need to reassess and / or consider a new Safeguarding Plan?

If not:

- do they need a care management assessment?

OR

- do they need sign posting to alternative support services?

5 Process

5.1 It is essential that Children's Social Care Staff invite the Adults and Communities Manager to the strategy discussion / meeting or the Child Protection conference to enable the decisions above (4.2) to be considered.

5.2 The strategy discussion / meeting or Child Protection conference will need to address the transfer of responsibility. The minimum expectation is that there will be handover of assessment and other relevant paperwork on the young person's 18th birthday. It would be preferable however if arrangements could be made for joint working which overlaps within the handover period as part of the assessment process between Children and Adult Services (see the draft transition framework, Brighter Futures – Transition to Adulthood, where applicable).

5.3 If concerns regarding the young person need to be dealt with under the Safeguarding Adults procedures then the Adults and Communities Team Manager must open a referral event and follow current Carefirst guidance in relation to the Safeguarding Adults procedures as per any other alert/referral.

Appendix 4

Serious Case Review Procedure

Section

Serious Case Review Procedure

1 Criteria for Serious Case Review (SCR)

1.1 The Birmingham Safeguarding Adults Board (BSAB), working through its Serious Cases Review Sub-group, has responsibility for conducting a serious case review. A serious case review should be considered where:

a) A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death.

OR

b) A vulnerable adult 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

the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults (See section 4 for commissioning guidance).

c) Where 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 vulnerable adult

d) Where a workers failure to act may have contributed to the death of a vulnerable adult or to their sustaining a life-threatening injury

e) Where serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review may apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case. These may require members who are independent of the SCR subgroup and who have no involvement with the case being reviewed.

2 Process for Requesting a Serious Case Review

2.1 The BSAB will be the only body which commissions any SCR in relation to vulnerable adults. The BSAB has identified a SCR sub-group with agreed Terms of Reference that include the management of the arrangements for commissioning a serious case review.

2.2 Any agency or professional may refer a case believed to meet the criteria for a serious case review. Sub-appendix 2 includes guidance to assist an agency/professional to make a decision as to when to refer to the SCR where the criteria on page 73.1(a) – (e) appear to be met. The format set out in Appendix 3 must be followed to request a review. The Referral should be made directly to the BSAB SCR sub-group chair in writing and copied to the Chair of the Board and the Director of Adult Social Services. The notifying agency should immediately ensure that all files and notes relating to the case are secured and the SCR subgroup chair will notify all involved agencies to ensure that all records relating to the case are secured. All agencies/individuals submitting cases for consideration will be expected to comply with the BASB Confidentiality Agreement (see Sub-appendix 9)

2.3 Where a request for an SCR is part of the recommendations of another statutory review process, for example Part 8 Children's Review, these will be received by the panel for consideration as to whether they should be addressed through SCR or through smaller scale management reviews to enable an action plan to be drawn up to address the concerns highlighted.

2.4 The SCR sub-group will consider requests for a serious case review. In making a judgement on whether or not to hold a review the SCR sub-group will take the following into consideration:

- Was there clear evidence of a risk of significant harm, which was:
- Not recognised by agencies/professionals in contact with the adult/perpetrator?
- Not shared with other agencies?
- Not acted upon appropriately?
- Was the adult in an institutional setting, for example care home, day service, hospital?

- Was the adult abused whilst being supported by the local authority?
- Do one/more agencies consider that their views were not taken seriously or acted upon appropriately by another
- Does the abuse indicate that there may be failings in the local operation of the Safeguarding Adults Procedures that may go beyond the handling of this case?
- Does the case have implications for a range of agencies/ professionals?
- Does the case suggest that the Safeguarding Adults Procedures or Protocols may need to change or that they are not widely acknowledged understood or acted upon?

2.6 Having considered the criteria, the Group will then make a recommendation to the BSAB Chair on whether to commission a Panel to undertake the review. Recommendations to the BSAB Chair must command the support of a majority of a quorate meeting of the sub-group and record the reasons for the decision with appropriate recording of minority views if any. A meeting will be deemed quorate when the following members are present: SCR Subgroup Chair (or Vice Chair), Police, Health, Legal Services and Adults and Communities Directorate.

2.7 Recommendations to the BSAB Chair must be made no later than one month of the request being received. As part of the process of consideration the sub-group may request further information from agencies involved with the vulnerable adult.

2.8 If the Board Chair endorses the recommendation the full Board will be informed at its next meeting. The Director of Adult Social Services will also be advised on the intention to commission a review. If the Chair so determines, the recommendation can be considered by a full Board.

2.9 Where the criteria are not met, the SCR sub-group may recommend that one or more agencies conduct internal reviews or audits to address areas of concern. Such reviews should be completed promptly, and the findings shared with the main Board to enable training, learning and practice to be informed and amended/enhanced accordingly. The guidance in Appendix 6 Individual Management Reports should be used to assist agencies to structure their review. Their report should focus on whether there were any lessons to be learnt, recommendations for actions with timescales for completion and for reporting

back to the SCR subgroup for subsequent feedback to the BSAB Board.

2.10 Where the SCR sub-group recommends that a review does not take place the reasons for this recommendation must be given to the Chair. If the Chair endorses the recommendation the person requesting the review must be advised in writing with reasons. If the requestor is still of the view a review should be held then the matter will be considered at the next full meeting of the Board whose decision on the request will be final.

3 Commissioning a Serious Case Review

3.1 Where the criteria for a SCR are met the SCR Subgroup will be responsible for

- Considering the scope of the review process
- Establishing clear and individual terms of reference
- Establishing evidence required from each agency or person stating whether this is through investigation or collected in other ways (This will be presented in a report to the Panel - see sub-appendix 6 for guidance).
- Support and other resources needed (any perceived deficits to be referred to Chair of BSAB)
- Time scales within which the review process should be completed
- Dates, times and venues for meetings
- Ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference. (See sub-appendix 5).
- Securing any legal advice required, in particular: Data Protection, Freedom of Information and Human Rights Act
- Ensuring that all agencies are bound by the BSAB Confidentiality Agreement for SCR's (see sub-appendix 9)
- Managing the interface with the Children, Young people and Families Directorate where there are issues to be addressed with potential implications for both adults and children

3.2 The SCR Subgroup Chair, on commencement, must advise the following, as appropriate, that a Serious Case Review is taking place:

- CQC
- Coroners Office
- Police

3.3 The SCR Subgroup will determine the media/communication strategy which will address, for example if and how newspapers, TV, radio should be told about the SCR

3.4 Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered; including, how a victim of abuse or relative are contacted, to what extent and what about.

3.5 The SCR sub-group will not itself undertake reviews but, provided they have no direct involvement with the case, members of the sub-group may form part of review panels. Where the criteria are met then a multi-agency Serious Case Review Panel will be set up.

The SCR sub-group Chair, in conjunction with the Chair of the Safeguarding Board, will appoint an independent Chair of the SCR Panel. The SCR Panel Chair must be demonstrably capable of undertaking the role (i.e. they have had an appropriate level of experience of adult protection and interagency work and relevant training to enable them to undertake the role. They must also have had no direct involvement with the case to be reviewed.

3.6 The SCR subgroup will ensure that the SCR Panel Chair receives adequate support.

3.7 Membership of the Serious Case Review Panel will be comprised of appropriate representatives of the agencies. The Chair of the SCR subgroup will write to the Chief Officers of all the agencies involved requesting nominations to the Serious Case Review Panel.

3.8 Each agency will nominate a representative who has appropriate experience.

3.9 The Chair of the SCR sub-group will contact all relevant agencies in writing giving guidance on the content of the review and requesting that they;

- Instigate an internal management review (See sub-appendix 5) to be returned within six weeks of the request

4 Conduct of a Serious Case Review

4.1 The SCR panel will meet to consider receipt of evidence. At the first meeting this will consist of a formal 'information sharing' session. All members will be expected to be bound by the BSAB Confidentiality Agreement for SCR's (see sub-appendix 9).

4.2 Each agency involved will be asked to:

- Present a comprehensive report of the actions by their agency, with a chronology of events, highlighting any discrepancies and where things have gone wrong and also highlighting good practice
- Make recommendations to ensure that the same thing doesn't happen again
- Ensure that any other management reports and other relevant information are made available

4.3 Serious Case Review Panel then commences a process of discussion of evidence/adjudication. This is where the assessment of alternative courses of action takes place and 'next steps' are agreed.

4.4 The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Agree the key points to be included in the report and the proposals for action
- Request further information from agencies as required

4.5 If at any point, whilst undertaking the review, further information is received or issues emerge which require notification to a statutory body, for example GSCC, DfES,

regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

4.6 The Chair of the review panel should report back to the BSAB/SCR subgroup chairs. A decision should be made as to whether the serious case review process should be suspended pending the outcome of such notification. The reasons for the decision should be recorded and confirmed to all panel members and agencies and the Director of Adult Social Services.

4.7. The review panel will complete the review of agency management reports, and those commissioned from any other source, and advise the Chair on the production of an Overview Report which brings together information, and makes an analysis and recommendations.

4.8 Sub-appendix 8 sets out guidance on producing an overview report that will be circulated to and involve agencies for comment. These draft reports are confidential and should be returned to the chair of the panel after each stage of consideration. The panel will reconvene to agree the final overview report. The SCR Panel Chair will ensure that the Report is written and delivered within agreed timescales and covers:

- Any matters of concern affecting the safety and wellbeing of vulnerable adults in the area of the authority
- Any general public health, safety or well-being arising from the death of a vulnerable adult
- 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

5 Considering the recommendations of the Review

5.1 On completion of the review, an Overview Report will be presented to the BSAB/SCR sub-group, which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the

Overview Report

- Ensure that the Overview Report contains an Executive Summary that can be made public (See note) including as a minimum, information about the review process, key issues and recommendations. The content should be anonymised to protect the confidentiality of the adult and relevant family members/others
- Translate recommendations from the overview into an action plan, which will be endorsed at senior level by each agency
- Ensure that the executive summary, recommendations and action plans are sent to individual agencies and sub-groups of the BSAB for implementation
- Ensure that CQC receive a copy of the final report and action plans

5.2 Arrangements will then be agreed with the review panel chair and the chair of BSAB for the presentation of the report to the BSAB for approval and sign off and action to take forward its learning points and recommendations. The board will task the sub-group with ensuring that all recommendations are actioned and to request updates from agencies as required. This will need to be cross-referenced to an audit process once developed

5.3 The action plan will remain on the BSAB Agenda until such time that the sub-group confirms all recommendations have been implemented. The action plan will indicate:

- Responsibilities for various actions
- Time-scales for completion of actions
- The intended outcome of the various actions and recommendation
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems
- To whom the report or parts of the report should be made available and indicate the means by which this will be carried out
- The processes for dissemination of the report and/or key findings to interested parties, for the receipt of feedback and for any debriefing to staff, family members and, where appropriate, the media

5.4 The chair of BSAB will be responsible for keeping the Director of Adult Social Services informed on the progression and outcomes of all Serious Case Reviews, the effectiveness of local arrangements and key learning points related to the discharge of his responsibilities.

6 Timetable

6.1 The process from the decision to conduct a review to the sign off of the final overview report should normally be accomplished within four months. If a longer period is needed this must be agreed with the Chair of the Board and the Director of Adult Social Services.

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

6.3 At all times agencies and individuals with a direct interest should be kept informed about progress and reporting arrangements; including the victim and their relatives as appropriate.

7 Annual Report

7.1 All Serious Case Reviews conducted within the year should be referenced within the Board's annual report and audit along with relevant service improvements.

7.2 Given the focus on learning, the normal expectation is that the executive summary of each investigation or review would be published and become a public document. Any personal data or information that could be used to identify a person must be removed from the document before it is published.

7.3 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 the Directorate must be informed immediately.

7.4 The FOI or DPA lead will take advice from the Chair on the individual case.

7.5 Consultation will take place over the possible application of exemptions under FOI - see sub-appendix 4.

7.6 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 and Democratic Services.

7.7 The Council's Corporate FOI Team will co-ordinate action for the review / appeal in accordance with the FOI Code of Practice. Contact the Council's Corporate FOI Team at this address:

Corporate Information Governance Team
1st Floor
1 Lancaster Circus
Birmingham B4 7AB

Tel: 0121 303 1909
Email: foi.mailbox@birmingham.gov.uk

Applicants will also be informed of their right of appeal to the Information Commissioner.

Sub-Appendix 1

Statutory framework for reviews

(a) Report to the Safeguarding Children's Board within one month. Also see Working Together to Safeguard Children, 1999

(b) Strategic Health Authority commissions independent investigations; report to Confidential Inquiry into Homicides and Suicides by Mentally Ill People

(c) Domestic Violence, Crime and Victims Act, 2004, currently consulting on enactment of statutory reviews to be completed within 3 months

(d) Revised Notification and Review Procedures For Serious Further Offences, Probation Circular PC08/2006, Home Office, under MAPPA arrangements will involve liaison by the Public Protection Unit

(e) These are investigated by Professional bodies

Sub-Appendix 2

Triggers for Referral to Serious Case Review

1. Where an individual or agency is aware of a vulnerable adult where abuse or neglect is known or suspected to be a factor in their death.

   OR

2. A vulnerable adult 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,

   OR

3. Serious abuse takes place in an institution or when multiple abusers are involved

   OR

4. 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 vulnerable adult

   OR

5. A workers failure to act may have contributed to the death of a vulnerable adult or to their sustaining a life-threatening injury

   OR

6. The case gives rise to serious concerns about the way local professionals and services work together to safeguard vulnerable adults, for example

   - Were safeguarding procedures activated and adhered to
   - Were the procedures inadequate or ignored
   - Could this death have been prevented if agencies had worked together?
   - Do staff understand their roles within the Safeguarding process?

AND

7. There are lessons to be learned in respect of the safeguarding procedures and/or their interpretation/implementation

AND

8. There may be implications in respect of the training offered within individual agencies and on a multi-agency basis including how staff are trained, who receives training and to what level.

Then the individual or agency may wish to refer to the SCR Subgroup using the referral form in sub-appendix 3.

The SCR Protocol is not intended to replace the Safeguarding Adults procedures or an agency's internal or statutory review procedures to investigate serious incidents and untoward incidents but any of these investigations may lead agencies to consider the need for a Serious Case Review.

Sub-Appendix 3:

Referral to Birmingham Safeguarding Adults Board requesting a Serious Case Review

Instructions

All requests will be assessed by the Serious Case Review sub-group when it next sits. If the matter requires urgent attention, it will be sent directly to the BSAB Chair of the Serious Case Review Subgroup to consider in accordance with the agreed protocol.

Address

Head of Safeguarding Adults
Birmingham City Council
Adults and Communities Directorate
Level 5
Louisa Ryland House
44 Newhall Street
Birmingham B43 3PL

Name of Person submitting this referral:

Job Title:

Organisation:

Work Address:

Tel:

Fax:

E-mail:

Name of vulnerable adult/service you are concerned about:

Address:

Postcode:

DoB:

GP Details (name, address, contact number)

Agencies/Team(s) involved in Safeguarding /Multi-Agency Public Protection Arrangements case: (name, address, contact number for each)

Name of Adults and Communities or the Chair of any Safeguarding meeting (if known)

Date(s) of Safeguarding/Incident Report:

_____

Details of why, in your opinion, the case meets the serious case review criteria and guidelines contained in sections 3 of the Protocol:
(any additional information can be provided later)

Signature:_____

Date: _____

Sub-Appendix 4:

Access to Information Considerations

The approved version of this protocol and any associated codes of practice and procedures will be published and made available to the public. The Final Report of every investigation will be published in an anonymised form on completion.

It is possible that information submitted to a review, or the review report, may be requested by a member of the public and their agents or by the media. It is also possible for this to be requested by Data Protection subject access process.

- The right under the Freedom of Information Act (2000) to request information held by public authorities came into force in January 2005.
- Requests for information should be recorded by the receiving authority and processed in line with their FOI Code of Practice. Please contact the Freedom of Information Lead Officer in the organisations for advice.
- Where information falls under an 'absolute exemption' under FOI, the authority can withhold the information. If a public authority believes that the information is covered by a 'qualified exemption' it must apply the 'public interest test'. Each case is judged on its own merits and legal advice must be sought in every case.
- The public interest test requires that information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- All decisions to withhold information are subject to internal review and may be appealed against to the Information Commissioner and Information Tribunal.
- 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.
- Information on the deceased is covered by separate guidance. Requests for such information should be handled under FOI.

These provisions do not affect the normal arrangements for information sharing between professionals for the purpose of a review.

For further guidance please see the BCC Code of Practice for the Freedom of Information Act (2000) Rights of Access at the link below: Temporarily relocated.

Sub-Appendix 5:

Determining the scope of the review

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

- What appear to be the most important issues to address in trying to learn from this specific case?
- How can the relevant information best be obtained and analysed?
- Who should be appointed as the independent author for the overview 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 Review Panel to bring in an outside expert at any stage, 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 better to understand the recent past and present?
- Which organisations and professionals should contribute to the review and should they be asked to submit reports or otherwise contribute?
- How should family members contribute to the review, and who should be responsible for facilitating their involvement?
- Will the case give rise to other parallel investigations of practice, for example independent health investigations or multi-disciplinary suicide reviews, a homicide review where a vulnerable adult has been murdered? If so, how can a coordinated or jointly commissioned review process best address all the relevant questions that need to be asked, in the most economical way?

- Is there a need to involve organisations/professionals in other Safeguarding Board areas, and what should be the respective 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 serious case review process fit in with the processes for other types of reviews, such as homicide, mental health or prisons?
- Who will make the link with relevant interests 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 BSAB 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. The PCT should always inform its SHA of every case that becomes the subject of a serious case review. The Director of Adult Social Services must also be informed of all such cases (adapted from Working Together to safeguard Children, 2006).

Sub-Appendix 6:

Individual management reports by member agencies and independent organisations

1. When a case meets the criteria for conducting a SCR (see Sections 2 and 3 of this process), the Chairperson of the SCR 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 individual review's terms of reference, which will be sent with the request, and guidelines contained in this Appendix. The management review, report and chronology (if appropriate) must be sent to the SCR Panel Administrator by e-mail within 6 weeks of the report being requested.

2. 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 Serious Case Review 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 to the SCR Panel Administrator.

3. On receipt of a SCR request the SCR subgroup chair will notify all agencies to ensure that action is taken to secure all relevant records relating to the case to guard against loss or interference.

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 vulnerable adults. Domestic Violence Homicide Reviews (DVHR) may run concurrently with this process and reports submitted as a result of a SCR may be made available to inform a DVHR.

6. The following format should guide the preparation of management review: to help ensure that the relevant questions are addressed and to provide information to the SCR Panel in a consistent format to help with preparing the overview report. 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 those 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 Panel a formal note will be put on record.

8. Content of management review

8.1. What was the agency's involvement with the vulnerable adult 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. (A standard format for the chronology must be used to enable the amalgamation of all chronologies). Briefly summarise decisions reached, the services offered and/or provided to the adult, family/carer, and other action taken.

8.2. 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 specifically:

- 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 a vulnerable adult?

- Did the agency have in place policies and procedures for safeguarding vulnerable adults 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 assessments and decisions 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 BSAB policy, protocols and guidance for safeguarding vulnerable adults and wider professional standards?
- Are there lessons from this case for the way in which this agency works to safeguard vulnerable adults 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?

8.3. 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?

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 stipulated in the original request. Any foreseeable delays should be communicated to the Chair of the SCR Panel or the Adult Protection Policy Manager for Birmingham as a matter of urgency.

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 final report. It is recommended that the management report should normally be limited to 10 pages.

6 a. FORMAT FOR INTERNAL AGENCY MANAGEMENT REVIEW

1. SUBJECTS FULL NAME:	
2. DOB:	
3. ADDRESS OF SUBJECT:	
4. ETHNIC ORIGIN:	**5. GENDER:**
6. MARITAL STATUS:	
7. DATE FILE SECURED:	
8. Sources Of Information From Which Report Compiled:	
9. Family/Household Composition:	
10. Dates Covered by chronology:	

Date	Who contacted /Seen	By Whom	Medium of contact	Content of contact (include decisions taken and services offered/provided)	Outcome of contact	Source of Evidence	Any other Actions Taken	Comment

12. Analysis Of Involvement: (Consider events that occurred, decisions made, actions taken/not taken – see Appendix 6, 8.2):	
13. What has been learned from this case? **Include action plan which references:** • **Changes or improvements to practice as result of this case** • **Disciplinary/regulatory action** • **Outcomes, timescale and review plan**	
14. Who has endorsed the completed management review report – ensure this is the agency's chief officer.	

Sub-Appendix 7

Request for an Individual Management Review Report

Dear

SERIOUS CASE REVIEW

Name: **Date of Birth:**

Date of Death/Incident:

Home Address:

The death/ serious injury of has been referred to the Serious Case Review Subgroup of the Safeguarding Adult Board. In accordance with Birmingham Serious Case Review Protocol, it has been decided that the case provides an opportunity to learn new lessons about the way in which professionals and agencies work together in such cases and we will therefore be conducting a review.

I would be grateful if you could arrange for your agency to undertake a Management Review of this case. I attach guidance for you in conducting the review and would be grateful if your review could follow this format.

The review should primarily cover contact of your agency with the Vulnerable Adult and family over the should also cover contact with adults and any other significant persons in as much as the information is relevant to the decision making and care of

In accordance with BASAB SCR Protocol would you please forward the completed management review by .

Please ensure that the completed management review and any recommendations for action have been approved by the senior person within your agency.

Following receipt of the completed individual agency management reviews the Review Panel will meet to produce a composite chronology of events.

You will be notified of any discrepancies and any need for further information. You may be asked to come and meet the panel for further clarification. The finalised Overview Report, as approved by BSAB, will be forwarded to CQC. The Executive Summary, Recommendations and Action Plan will be circulated after approval by BSAB.

To assist in tracing records and carrying out the management review I set out below details of the family composition and of those members of staff in your organisation who I believe have had involvement in this case. This list may not be complete or accurate at this stage.

If having checked the adult is not known to your agency please send a 'nil' return.

Family Composition:

Agency Staff Known to be Involved With Family:

Background Information

COULD YOU PLEASE ENSURE THAT ANY CASE NOTES/FILES IN RELATION TO THIS ADULT ARE REMOVED TO A SECURE PLACE WHERE THEY ARE NOT ACCESSIBLE TO AGENCY PERSONNEL OTHER THAN THROUGH YOU OR YOUR NOMINATED REPRESENTATIVE.

COULD YOU ALSO ENSURE THAT ANY PAPERS RELATING TO THIS REVIEW ARE KEPT SEPARATELY FROM THE CASE PAPERS.

If you require further information about the process please contact

Chair of BSAB Serious Case Subgroup on telephone number

Yours sincerely

Chair – Serious Case Review Panel

Sub-Appendix 8:

Overview report by SCR Panel

1. The SCR overview report should bring together and draw overall conclusions from the information and analysis contained in the individual management reviews and reports commissioned from any other relevant interests.

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

3. SCR Panel Overview Report Format:

a) Introduction

- Summarize the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to review and the nature of their contributions, for example, management review by LA, and report from adult mental health service.
- List Review Panel members and author of overview report.

b) The facts

- Prepare a genogram, a pictorial display of the person's membership 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 overview 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 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 Review 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 organization.
- 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.

(Adapted from Working Together To safeguard Children (2006) Chapter 8 Serious Case Reviews and Kent and Medway Safeguarding Adults Committee Procedure for Review of Serious Adult Protection Cases 06/12/06)

Sub-Appendix 9:

BSAB Confidentiality Agreement re Serious Case Reviews

Purpose and function of meeting the Confidentiality Statement

All members of the Birmingham Safeguarding Adults Board and the Serious Case Review sub-group/panel need to be clear about the circumstances under which serious case reviews are conducted and discussed at Board meetings and during the review process and the nature of the confidentiality in relation to this process.

The purpose of a case review is to establish whether there are lessons to be learnt from the case, identify what those lessons are, how they will be acted on and what is expected to change. The consequence of this should be to improve interagency working and better safeguard and promote the welfare of vulnerable adults.

When a decision to review a case has been made, a SCR panel is established to conduct the review under the terms set out in the guidance.

Following completion of the review the panel produces an overview report which is presented with the recommendations and action plan to the BSAB. On receipt of the Overview Report the contributing agencies and individuals need to declare that they are satisfied that their information is fully and fairly represented in the report

At the time that the review is presented to the Board it is in its final draft stage and remains confidential. The BSAB will make decisions as to whom and when the report or any part of it should be made. All agencies and BSAB and SCR subgroup/panel members or deputies who are in receipt of the papers must agree to the following confidentiality agreement:

1. All documentation is to be marked CONFIDENTIAL DRAFT- NOT TO BE DISCLOSED WITHOUT CONSENT OF BSAB and returned to the BSAB chair after the Board meeting

2. All agencies asked to adhere to their own Data Protection procedures which include security of electronic data.

3. All information discussed at BSAB or SCR subgroup/panel meetings is STRICTLY CONFIDENTIALITY and must not be disclosed to third parties without discussion and agreement with the BSAB/SCR subgroup chair. The disclosure of information outside these meetings (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

4. As a member of BSAB and/or the SCR subgroup/panel I agree to abide by this agreement in relation to all serious cases discussed at Board or SCR sub-group/panel meetings

Name	Agency and Full Contact Details (postal address, telephone number and email)	Signature
1		
2		
3		
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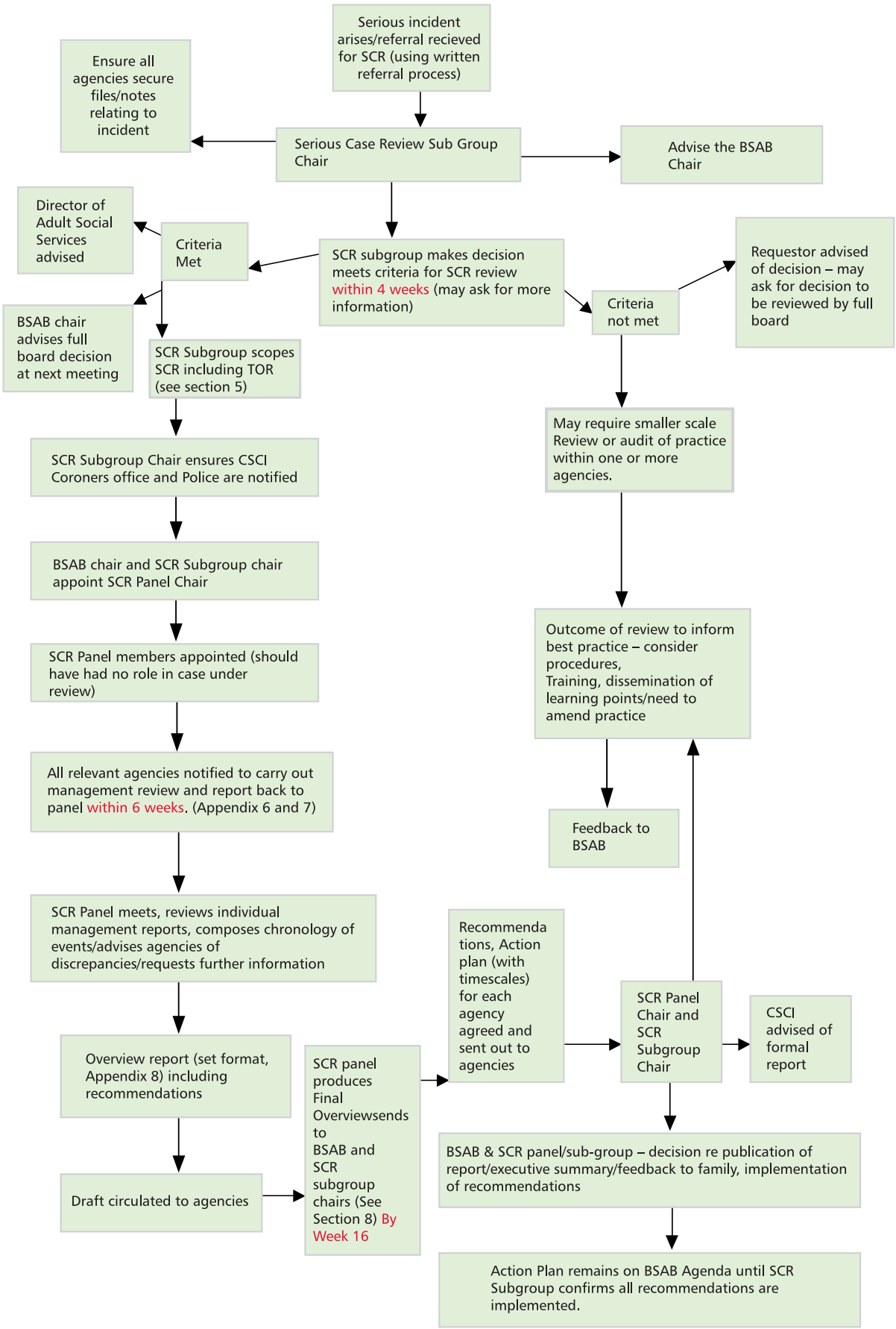
Sub-Appendix 10:



Sources

The following protocols/Procedures were used in the development of this Serious Case Review Protocol:

Vulnerable Adults Serious Case Review Guidance: Developing a local protocol ADSS 2006

Working Together to Safeguard Children 2006
The Interagency Child Protection Procedure Birmingham Safeguarding Children Board

Kent and Medway Safeguarding Adults Committee Procedure for Review of Serious Adult Protection Cases (06/12/06)

Serious Case Review Protocol Somerset Safeguarding Adults

Serious Case Review Protocol (Redrafted 02/07/06)
Sandwell Adult Protection Committee

Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 June 2007

Appendix 5

Interface between the Mental Capacity Act 2005(MCA)/Deprivation of Liberty Safeguards (DoLS) and the Safeguarding Adults Procedures

1. Introduction

This appendix identifies processes to enable staff of the Adults and Community Directorate to integrate their work of safeguarding adults with the requirements of the MCA and DoLS.

2. The Mental capacity Act 2005 and Safeguarding Adults.

2.1 The Mental Capacity Act has five governing statutory principles that influence every decision made under the Act(as set out in section 1 of the Act)

The five statutory principles:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2.2 The purpose of the Act is to empower people to make decisions for themselves wherever possible, and to protect people who lack capacity by providing a flexible framework that places individuals at the very heart of the decision making process. It will ensure that all decisions made are in the best interests of the person.

2.3 The single assessment process (SAP) will be the process whereby "capacity" issues are identified and considered, and appropriate referrals directed through the DoLS procedures.

2.4 Staff guidance and good practice.

The Adults and Community Directorate staff will follow the guidance and good practice as contained in the MCA procedures manual, and integrate that guidance into their daily safeguarding roles and responsibilities.

3. Safeguarding, and the promotion of the independence, wellbeing and choice for adults

3.1 Safeguarding Adults is a phrase which encompasses all work which enables an adult "who is or may be eligible for community care services" to retain independence, wellbeing and choice and to access their human rights to live a life that is free from abuse and neglect (Safeguarding Adults ADSS 2005).

3.2 There are three main strands to Safeguarding:

- Prevention: developing and sustaining preventative strategies – these include raising public awareness, developing and disseminating empowerment, advocacy, publicity and information.
- Adult Protection – recognising, reporting and responding effectively to alleged abuse or neglect when it occurs. This includes policies, procedures, training and raising awareness.
- Evaluation – learning and building on best practice in Safeguarding and having a competent workforce for prevention as well as protection. This includes serious case reviews, audits, evaluation of performance, monitoring and annual reporting.

4. Interface between DoLS and Safeguarding Adults Procedures

4.1 The deprivation of liberty safeguards (DoLS) were introduced with the amended Mental Health Act 2007, but the code of practice for DoLS was published under sections 42 and 43 of the Mental Capacity Act.

4.2 The deprivation of liberty safeguards were introduced to provide a legal framework around deprivation of liberty. The purpose was to prevent breaches of human rights legislation as in the "Bournewood" judgement which lead to the legislation.

4.3 . DoLS will safeguard individuals against the possibility of a deprivation of liberty. The Safeguarding procedures will only be triggered if there is a case of abuse to be considered.

4.4 The following are examples of circumstances where a safeguarding alert may arise:

- Where someone involved in a Best Interest Assessment becomes aware of abuse.
- Where a potential Deprivation of Liberty is seen by a person visiting or working in a care/hospital setting and after they alert the service manager the issue is not addressed /or an authorisation is not sought.
- Where a Deprivation of Liberty authorisation is refused and the service / organisation does not take steps to amend the way care or treatment is offered with the effect that a Deprivation of Liberty continues unlawfully.

4.5 DoLS introduces the statutory right of access to an IMCA for individuals and their representatives. There will also be access to the IMCA service within Safeguarding if there is a conflict of interest in a situation of alleged abuse.

4.6 The Adults and Community Directorate staff will have access to a DoLS procedure manual to assist them in identifying unlawful deprivations and in planning for the authorisation of lawful deprivation. The process and procedures for the safeguards will provide a legal framework to protect individuals who may be subject to a deprivation of liberty.

5. Conclusion

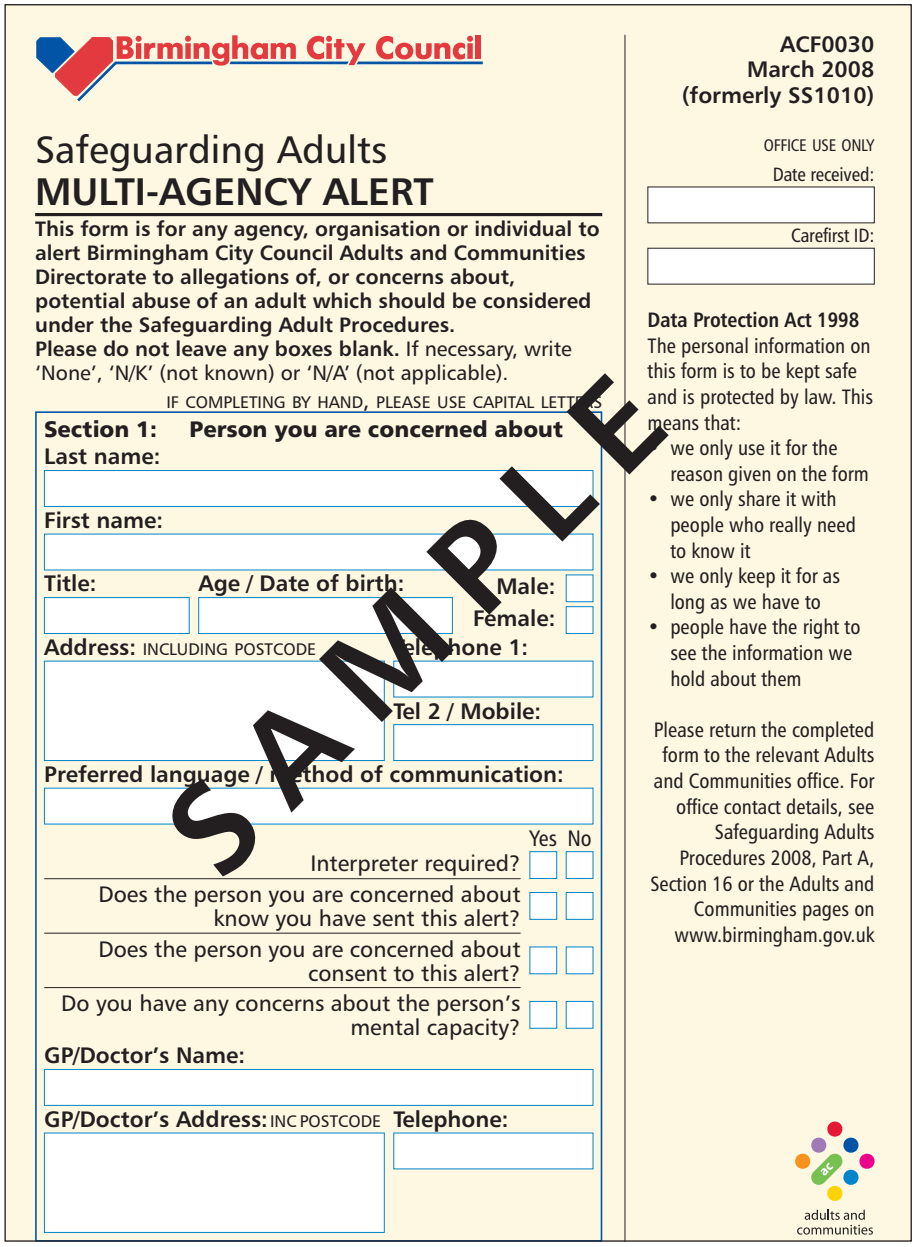
5.1 The procedures for the MCA and DoLS will assist all Adults and Community Directorate staff in pursuing best practice in their daily professional task of providing the best quality service for, and safeguarding the rights of, the adults of the city.

Appendix 6

(Form ACF0030)

This form is available from Birmingham City Council's website:

www.birmingham.gov.uk/safeguardingadults



Birmingham City Council

ACF0030
March 2008
(formerly SS1010)

Safeguarding Adults
MULTI-AGENCY ALERT

This form is for any agency, organisation or individual to alert Birmingham City Council Adults and Communities Directorate to allegations of, or concerns about, potential abuse of an adult which should be considered under the Safeguarding Adult Procedures.
Please do not leave any boxes blank. If necessary, write 'None', 'N/K' (not known) or 'N/A' (not applicable).

IF COMPLETING BY HAND, PLEASE USE CAPITAL LETTERS

OFFICE USE ONLY
Date received:
Carefirst ID:

Data Protection Act 1998
The personal information on this form is to be kept safe and is protected by law. This means that:
- we only use it for the reason given on the form
- we only share it with people who really need to know it
- we only keep it for as long as we have to
- people have the right to see the information we hold about them

Please return the completed form to the relevant Adults and Communities office. For office contact details, see Safeguarding Adults Procedures 2008, Part A, Section 16 or the Adults and Communities pages on www.birmingham.gov.uk

Section 1: Person you are concerned about

Last name:

First name:

Title: **Age / Date of birth:** **Male:** **Female:**

Address: INCLUDING POSTCODE **Telephone 1:**

Tel 2 / Mobile:

Preferred language / method of communication:

	Yes	No
Interpreter required?		
Does the person you are concerned about know you have sent this alert?		
Does the person you are concerned about consent to this alert?		
Do you have any concerns about the person's mental capacity?		

GP/Doctor's Name:

GP/Doctor's Address: INC POSTCODE **Telephone:**

adults and communities

SAMPLE

See the Good Practice Guide section on how to complete this form.

SAFEGUARDING ADULTS
GOOD PRACTICE GUIDE

SAFEGUARDING ADULTS GOOD PRACTICE GUIDE

The Safeguarding Adults Good Practice Guide is part of the Safeguarding Adults Multi-Agency document. It will provide additional and more practical guidance to support the implementation of the Safeguarding process.

This section will be published in stages with regular up-dates being added. The first stage of this Good Practice Guide section is due to be published in late 2009 and will be added to the on-line Policy and Procedure sections of the Safeguarding Adults document.

For more information, please contact:

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June 2009