Bournemouth University

The National Centre for Post-Qualifying Social Work

LEARN TO CARE
Supporting workforce development across the Social Care Sector

Safeguarding Adults at Risk of Harm

Staff Group C & D Workbook: Operational and Strategic Managers

Michael Lyne

Safeguarding adults at risk of harm

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About the Author

Mike is a Registered Social Worker and Registered Mental Nurse with over 25 years' experience in health and social care. He now is a lecturer at the National Centre for Post Qualifying Social Work. His current interests are in capacity, mental health legislation, consent to treatment issues, end of life care and substituted decision making in health and social care.

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Who should use this book

Safeguarding adults is everyone's business (Bournemouth University, 2010). This workbook is designed to meet some of the needs of staff in groups C & D as outlined in the National Capability Framework for Safeguarding Adults (2010).

As described in the Competence document, these groups include in group C, Service Managers, Independent Chairs, Operational Managers, Heads of Assessment and care management and in group D, Executive and Senior Managers, Chief Executives, Owner/Managers and Heads of Service. This is not an exhaustive list and the workbook should be of use to other senior staff as appropriate. The workbook deliberately does not concentrate on one group of staff as it is contended that an overall strategic and practice based knowledge of safeguarding issues is a requirement of good quality management and supervision, regardless of seniority.

As mentioned in the first paragraph, this workbook cannot seek to meet the whole needs of all readers. It is acknowledged that staff of this seniority should and will seek further information about issues with which they have a specific interest or difficulty and this is encouraged. In this sense, the value of the workbook is in promoting excitement in the field and a desire for further personal research.

It is also hoped that the workbook might serve as a prompt to those whose responsibility is to commission training and development for all grades of staff. All staff should be assessed as competent within their own specific role as outlined in The National Competence Framework for Safeguarding Adults. Suggestions of competency evidence can be ignored and replaced by appropriate evidence taken from the individual's own practice.

> "The broad definition of a 'vulnerable adult'…is a person, (18 or over) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (DH 2000).

In 2011 the Law Commission recommended that the term 'vulnerable adult' be replaced by 'adult at risk' (para 9.21, p114). However, at the time of writing this change has not been universally adopted and indeed, there remains some disquiet at this change in term as the question could be asked, "adult at risk of what?" Accordingly, the phrase "vulnerable adult" will continue to be used in this publication.

Foreword

We at the National Centre for Post-Qualifying Social Work are proud to present the final workbook in the Safeguarding series produced by Bournemouth University on behalf of Learn to Care, the professional association of workforce development managers in local authorities.

This series has been the outcome of many years of research and collaboration between practitioners, managers and organisations that provide health and social care services.

The National Centre for Post-Qualifying Social Work is committed to the Safeguarding of all vulnerable people and we endeavour to support staff to improve their professional practice through developing the skills and capabilities as outlined in the National Capability Framework for Safeguarding Adults.

I would like to extend my thanks to Mike Lyne and Lucy Morrison from The National Centre for Post-Qualifying Social Work for developing this helpful tool.

All of the National Centre publications, including the Safeguarding Workbooks for Staff Groups A and B, and the National Capability Framework for Safeguarding Adults are available for purchase from our website: www.ncpqsw.com.

I trust that this workbook will be an efficient and useful resource for those involved in the operational and strategic management of staff working with adults at risk.

Professor Keith Brown

Director of the National Centre for Post-Qualifying Social Work

Anne Connor

Chair of Learn to Care

May 2013

Introduction - Why safeguarding?

A number of recent events have appeared in the broadcast and written media which have highlighted issues in relation to vulnerable adults. In some senses, there is a tension in the phrase 'vulnerable adult'. 'Adults' are supposed to be able to support themselves, live a life to the full, make their own decisions and so forth. It can be difficult to reconcile the facts that some adults are unable to achieve some or all of these things without assistance.

In our society we accept that children are in need of care and support from parents and other carers and we embrace this concept. There is a legal framework including statute laws, The Children Act 1989, The Children Act 2004 and The Children and Young Person Act 2008 for protecting the safety and interests of children. Each subsequent childcare Act has sought to build on and reinforce the previous one. There is no single statute which works to protect the needs of vulnerable adults.

Activity:

Consider why the above statement is so. What are the societal, emotional, financial, political or other arguments or issues which allow this situation?

One of the most publicised events of recent months in relation to abuse has been the activities of staff working at Winterbourne View Hospital, a care home for adults with Learning Disabilities near Bristol owned by a private operator Castlebeck Ltd. In 2011 the BBC's Panorama programme secretly filmed support workers slapping patients, pinning them under chairs and giving them cold punishment showers. 11 members of staff were prosecuted for the ill-treatment of patients; six were given jail sentences under section 127 Mental Health Act 1983. A Serious Case Review by South Gloucestershire Council and investigations by both the Department of Health and the Care Quality Commission followed. This is, of course, the extreme end of the spectrum which constitutes safeguarding vulnerable adults but there is no doubt that much less extreme incidents of neglect and ill-treatment happen every day, often without anyone knowing about it.

The Law Commission (2011) expressed some disquiet regarding terminology, noting that there is a distinction between 'safeguarding' which it considers to be a *"broad concept that extends to all aspects of a person's general welfare*" and adult protection which concerns *"the investigation and intervention where it is suspected that abuse may have occurred."* (Para 9.1)

Activity:

Look at your organisation's policy documents.

- Is the terminology used clear, concise and accessible to all who may need it?
- Does your organisation separate 'adult protection' from 'safeguarding'?
- What is your personal view of the approach taken?
- How could your policies be improved?

As mentioned above, safeguarding adults is everyone's business. This workbook seeks to assist you to benchmark your current knowledge and understanding of the topic and stimulate you into further investigation as appropriate. The starting point is a fairly straight forward reminder of what might constitute abuse and the current legal framework for dealing with this. Findings from inspections and serious case reviews identify the themes and issues which are common and underpin the remainder of the workbook which investigates the strategies available to deal with these issues.

Abuse

> "*Abuse is the violation of an individual's human and civil rights by any other person or persons*"

(Department of Health, 2000)

'Abuse' within the context of adult safeguarding can mean a number of things. The following is provided in order to refresh the reader's memory but note that this does not constitute an exhaustive list of "man's inhumanity to man" (Burns, 1785). Note that the indicators suggested below may not be seen at all or may be seen in connection with an alternative form of abuse from that suggested. The indictors are also not exhaustive.

Remember that a person exhibiting one or more of the indicators mentioned may not actually be a victim of abuse but unless there is an alternative explanation then abuse should be suspected. Some of the behaviours described below may also be criminal offences.

Physical abuse

Physical abuse is non-accidental harm to the body.

It can range from careless rough handling to direct physical violence. This can include hitting, slapping, shaking, pushing, dragging or kicking. It can include medication given inappropriately i.e. without regard to the prescription, giving someone else's medication or with-holding medication. It can include misuse of restraint or locking a vulnerable person into a room or vehicle. It can include causing physical discomfort through inappropriate treatment or with-holding care.

Indicators of physical abuse can include a history of unexplained falls or minor injuries. It can include bruising which is often characteristic of non-accidental injury for example hand slap marks, pinch marks, bruising to buttocks, lower abdomen. Patterns of bruising may occur where colouration indicates different stages of healing from repeated incidents. It can include burns, scalds or bite marks or unexplained ulcers or pressure sores. The person may flinch at personal contact and/or may be reluctant to undress or uncover parts of the body.

Sexual abuse

Sexual abuse is the involvement of people in sexual activities for which they have not given consent or do not fully understand or were pressured into consenting to.

Sexual abuse can include vaginal or anal rape, being touched or being forced to touch another person in a sexual manner, being forced to watch pornography, being subjected to sexual innuendo and harassment and not having a choice of male or female carer for intimate personal care.

Indicators of sexual abuse are many and varied and different people will react in different ways. Disclosure may be direct or by means of hints and veiled comments. Partial disclosure may include the use of repeated phrases such as ‘‘it’s a secret’’.

Physical signs may include urinary tract or vaginal infections or Sexually Transmitted Diseases. There may be difficulty walking or sitting with no apparent explanation, torn, stained or bloody underclothes or bedding, bleeding, bruising, torn tissues or injury to the rectal and vaginal areas, bruising to thighs and/or upper arms. Pregnancy in females unable to give informed consent to sexual intercourse.

Behavioural changes may be evident including uncharacteristically sexually explicit or seductive behaviour which may include promiscuity or use of sexually explicit language, self-harm, obsessions with washing and cleanliness and an exaggerated fear of pregnancy.

Psychological or emotional abuse

Psychological abuse is any action which adversely impacts on an individual’s emotional well-being, causing distress and affecting the quality of their life and ability to function to their full potential.

Psychological abuse can include depriving an individual of the right to choice and privacy, being humiliated, ridiculed or bullied, being denied access to social activities or services, having opinions continually disregarded or ignored, living in a culture of fear and coercion, disregarding personal history, life experience or ethnicity and having opinions and behaviour attributed solely in terms of a person’s age, gender, disability, sexuality, ethnicity or religion.

Indicators of psychological or emotional abuse can include, loss of interest, withdrawal, anxiety and depression, appear to be frightened, fearful or avoiding

eye contact, irritability, aggression or challenging behaviour, unexplained sleep disturbance, poor concentration, self-harm refusal to eat, deliberate soiling, eating problems, weight gain or loss.

Financial abuse

Financial abuse is the theft or misuse of money, personal belongings or property of a vulnerable adult without proper authority.

Financial abuse may include theft of money or possessions, denying the right to access personal funds or benefits, misappropriation of money without the individual's consent, money being 'borrowed' by staff or volunteers who have a responsibility to provide a service, unauthorised disposal of money or possessions and being asked to part with money under false pretences.

Indicators of financial abuse may include unexplained or sudden inability to pay bills, Lasting Power of Attorney (Mental Capacity Act 2005) being obtained when a person lacks mental capacity, unexplained withdrawal of money from accounts with no known subsequent benefits, person lacking goods and services that they have bought and paid for, extortionate demands for payments for services i.e. building work.

Neglect and acts of omission

Neglect and acts of omission include repeated deprivation of medical o physical care needs including the failure to intervene in behaviour which is dangerous to the vulnerable person or to others.

Neglect and acts of omission may include failure to provide food, shelter, heating, clothing, hygiene or personal care, failure to respond to a person's needs or preventing someone else meeting their needs, withholding medical care or preventing access by medical professionals and inappropriate use of medication, over medicating or withholding medication.

Indicators of neglect and acts of omission may include poor physical and/or environmental presentation, inadequate heating and lighting, neglect of accommodation, poor physical condition i.e. ulcers or untreated bedsores, clothing in poor condition including being wet or soiled, failure to ensure access to health and social care professionals, weight loss or gain through inadequate or unsuitable food, medication not given as prescribed and failure to ensure adequate privacy and dignity.

Institutional abuse

Institutional abuse involves the collective failure of an organisation to provide safe, appropriate and acceptable standards of service to vulnerable people. Institutional abuse can occur in routines and systems, attitudes and behaviour that amount to discrimination through prejudice, thoughtlessness, ignorance, stereotyping or malicious intent. Institutional abuse can take place in any agency or organisation.

Institutional abuse may include failure to ensure adult protection policies and procedures are in place and complied with, failure to provide appropriate levels of awareness and training on adult protection and failing to meet acceptable standards of care.

Indicators of institutional abuse may include unacceptable practices being encouraged tolerated or left unchanged, organisational standards not meeting those laid down by legislation, regulatory bodies or contracting authorities, service users not being treated with respect and dignity, diverse needs not being recognised and valued i.e. age gender, disability, ethnicity or sexuality, services being inflexible and the organisation not promoting choice and individual focus, communication between the vulnerable person, their carers and family being discouraged, whistle blowing policies not being in place and accessible and insufficient staff training and development.

Discriminatory abuse

The principals of discriminatory abuse are provided by legislation including

- Race Relations Act 1976 (amended 2000)
- Disability Discrimination Act 1995
- Sex Discrimination Act 1975 (amended regs 2003)
- Human Rights Act 1998
- Carers (Equal Opportunities) Act 2004

Discriminatory abuse exists when the values, beliefs and culture of the dominant ideology results in a misuse of power that denies equal opportunities to marginalised groups and individuals.

Discriminatory abuse may include lack of respect for an individual's beliefs and cultural background, lack of provision to support cultural needs for example in

diet, religious observance not anticipated or accepted, isolation due to unresolved language barriers, provision of a sub-standard service to marginalised groups and individuals and repeated exclusion from rights afforded to citizens such as health, education, employment and criminal justice.

Other forms of abuse which sit outside the traditional pantheon but which still require knowledge and awareness of include,

- Professional abuse
- Domestic abuse
- Honour Based Violence or Killing
- Forced marriage
- Female Genital Mutilation
- Hate crime
- Mate crime
- Bullying and harassment.

Legal framework

The Law Commission (2011) states:

> The existing legal framework for adult protection is 'neither systematic nor coordinated, reflecting the sporadic development of safeguarding policy over the last 25 years'. Unlike in Scotland there is no single or coherent statutory framework for adult protection in England and Wales. Instead, it must be discerned through reference to a wide range of law including general community care legislation and guidance, the Mental Health Act 1983, the Mental Capacity Act 2005, the Safeguarding Vulnerable Groups Act 2006, the inherent jurisdiction of the High Court, and the civil and criminal justice systems. (Para 9.1)

The primary framework for safeguarding adults, although not a statute law is *No Secrets* (2000), subtitled *guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* This will remain in force until at least 2013 although other consultations and intentions have been published (DH 2011).

The Conservative/Liberal Democrat coalition government is intent on less central government control and more control being placed within society and communities. An example of this is the new directly elected Police and Crime Commissioners. Following this policy, the Government believes that communities should play a central part in the prevention and detection of abuse with the State's role being that of providing "vision and direction" (DH 2011).

No Secrets concentrates on safeguarding processes such as the roles and responsibilities of agencies, the development of multi-disciplinary procedures for responding to concerns, contract monitoring with independent providers, information for service users, carers and the public and the development of monitoring and training systems. As guidance, *No Secrets* carries no statutory weight.

Partly as a response to this, in 2005 the Association of Directors of Adult Social Services (ADASS) produced *Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work.* This document sets out standards for practice on the front line and importantly, suggests some timescales for response. ADASS suggest that the framework was developed with the purpose of promoting the "development of consistent, high quality adult protection work across the country." (ADASS 2005)

As mentioned in the introduction, The Children Act 2004 places local safeguarding boards for children on a statutory basis. By contrast, *No Secrets* only suggests that "*agencies may consider there are merits in establishing a multi-agency management committee (adult protection)…*" (DH, 2000, p15). This has led to some criticisms that safeguarding adults has become a 'poor relation'. The Law Commission recognised this and proposed a range of adult protection provisions in its proposed single statute for adult social care (The Law Commission, 2011).

Government has confirmed that local adult safeguarding boards will become mandatory in future legislation, "*making existing Boards statutory, while maintaining their freedom to operate in locally flexible ways, will secure a transparent and locally accountable mechanism for local communities to ensure the protection of vulnerable adults*." (DH, 2011, p.4)

The Mental Health Act 1983 contains two main provisions in relation to safeguarding. The first is section 7 guardianship. This allows for situations where 'mentally disordered' individuals need to receive care outside hospital which cannot be provided without the use of compulsory powers. Assuming that the individual is aged 16 or over and is suffering from a mental disorder "*of a nature or degree which warrants their reception into guardianship*" and that this is necessary in "*the interests of the welfare of the patient or for the protection of other persons…*" an application for guardianship may be made. (MHA 1983) There are extra requirements for people with a Learning Disability.

The guardian, either an individual or local authority has three main powers: the power to require the patient to reside at a specified place; to require the patient to attend at specific places and times for medical treatment, occupation, education or training; and to require access to the patient to be given to certain individuals. It has to be noted that these powers are really only operable with the compliance of the individual concerned. However, it is contended that "*the structure imposed by guardianship may assist relatives, friends and professionals to help a mentally disordered person manage in the community*" (DH 2008 Para 19.3).

The second major provision is the prosecution of offences under section 127 which states:

> It is an offence for any of the managers of a hospital or care home, or any officer on its staff or otherwise employed in it, to ill-treat or wilfully neglect a patient (whether or not detained) who is for the time being receiving treatment for mental disorder there as an in-patient. (DH 2008 Para 38.5)

> The same applies to a person receiving out-patient treatment for mental disorder when they are on the premises of the hospital or care home, or on premises of which the hospital or care home forms a part. (Para 38.6)
>
> It is also an offence for individuals to ill-treat or wilfully neglect a mentally disordered person who is for the time being subject to their guardianship under the Act, or otherwise in their custody or care (whether by virtue of a legal or moral obligation, or otherwise). (Para 38.7)

The maximum penalties as they stand are imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum, or both on summary conviction (usually in a magistrate's court) and imprisonment for a term not exceeding five years or a fine of any amount, or both on conviction on indictment (usually in crown court).

Prosecutions under section 127 need the permission of the Director of Public Prosecutions but this section was used in the recent Winterbourne View prosecutions mentioned elsewhere.

The Mental Capacity Act 2005 does not contain specific powers in relation to the protection of vulnerable adults but is frequently cited as being the closest to safeguarding legislation that is currently in existence. It has a number of provisions which directly relate to adults without capacity including the guiding principles (MCA 2005 section 1) which commence with an assumption that adults over 16 have the ability to make their own decisions unless proven otherwise.

The Act sets out the legally required test for assessing capacity which is undertaken in two parts. Firstly the identification of "*an impairment of or disturbance in the mind or the brain*" (section 2) and secondly, the ability or inability to understand information given, use the information in order to make a decision, retain that information for as long as it takes to make that decision and communicate that decision (section 3). It is important to note that capacity is time and decision specific so professionals and others should no longer make such statements as "*Mrs X has dementia and has no capacity*". Mrs X may very well have dementia but she may also be able to make various decisions even if these are of a minor nature.

Section 4 of the Act embeds the principle of making decisions on behalf of people who lack capacity in their best interests and the Code of Practice sets out the process to be used to arrive at such a decision. The Care Quality Commission notes that this "*needs to be embedded in everyday practice when safeguarding decisions are being considered*." (2010)

Other provisions of the Act which offer some protection for vulnerable people include the Office of the Public Guardian and its powers to investigate cases of abuse (section 58), the power to appoint deputies to take social welfare decisions in addition to financial decisions to ensure that the incapacitated person is adequately protected (section 16) and the creation of a criminal offence of wilful neglect or ill-treatment of someone lacking capacity (section 44). The defence against conviction under section 44 lies in being able to prove that the alleged perpetrator was acting in the incapacitated person's best interests.

A later addition to the Mental Capacity Act 2005 was the Deprivation of Liberty Safeguards (DoLS). These safeguards which only apply within hospitals and nursing and care homes provide protection for vulnerable people who might otherwise be deprived of their liberty in breach of their rights under Article 5(1) European Convention on Human Rights 1950. DoLS has been subject to a number of criticisms including that the system is too cumbersome; it doesn't offer the protection for vulnerable people that it sets out to and that it is not being used enough. By far the major difficulty with the system is the lack of a single definition as to what constitutes a deprivation of liberty. The definition is continually being developed and defined by case law and as such, it can be difficult for professionals to decide whether the person is in need of the protection that the Safeguards offer.

Activity:

Compare the following two pieces of case law from the European Court of Human Rights:

DD v Lithuania [2012] ECHR 254

DD is admitted to a social care home upon the request of her guardian without court involvement. Management in the home "*exercised complete and effective control…over her assessment, treatment, care, residence and movement for over 7 years with negligible prospects of leaving*."

The rules of the institution meant that she was not free to leave without management's permission. On occasion, she was brought back by police when she tried to leave without permission. The care home director had full control over whom she could see and from whom she could receive telephone calls. On one occasion she was placed on a secure ward, given drugs and tied down for 15-30 minutes.

She unequivocally objected to the situation throughout her entire stay; requested discharge on a number of occasions; and twice attempted to escape.

The European Court of Human Rights decided that the state of Lithuania was guilty of depriving DD of her liberty in breach of her rights under Article 5 European Convention of Human Rights.

Litwa v Poland [2001] 33 EHRR 53

Mr Litwa who was seriously visually impaired was found to be "causing a public disturbance" and was deemed to be intoxicated.

He was taken to a Sobering-up Centre by police (who left his guide-dog on the street), was detained for 6 ½ hours and not allowed to leave until sober.

Mr Litwa argued that these circumstances amounted to a deprivation of liberty in breach of his rights under Article 5. Would you agree?

In fact, the Court did agree that Litwa was deprived of his liberty against his rights.

On the surface, the two cases seem remarkably different. One outlines circumstances lasting for years whilst the other, circumstances lasting a matter of hours. Both amounted to a deprivation of liberty in breach of Article 5(1).

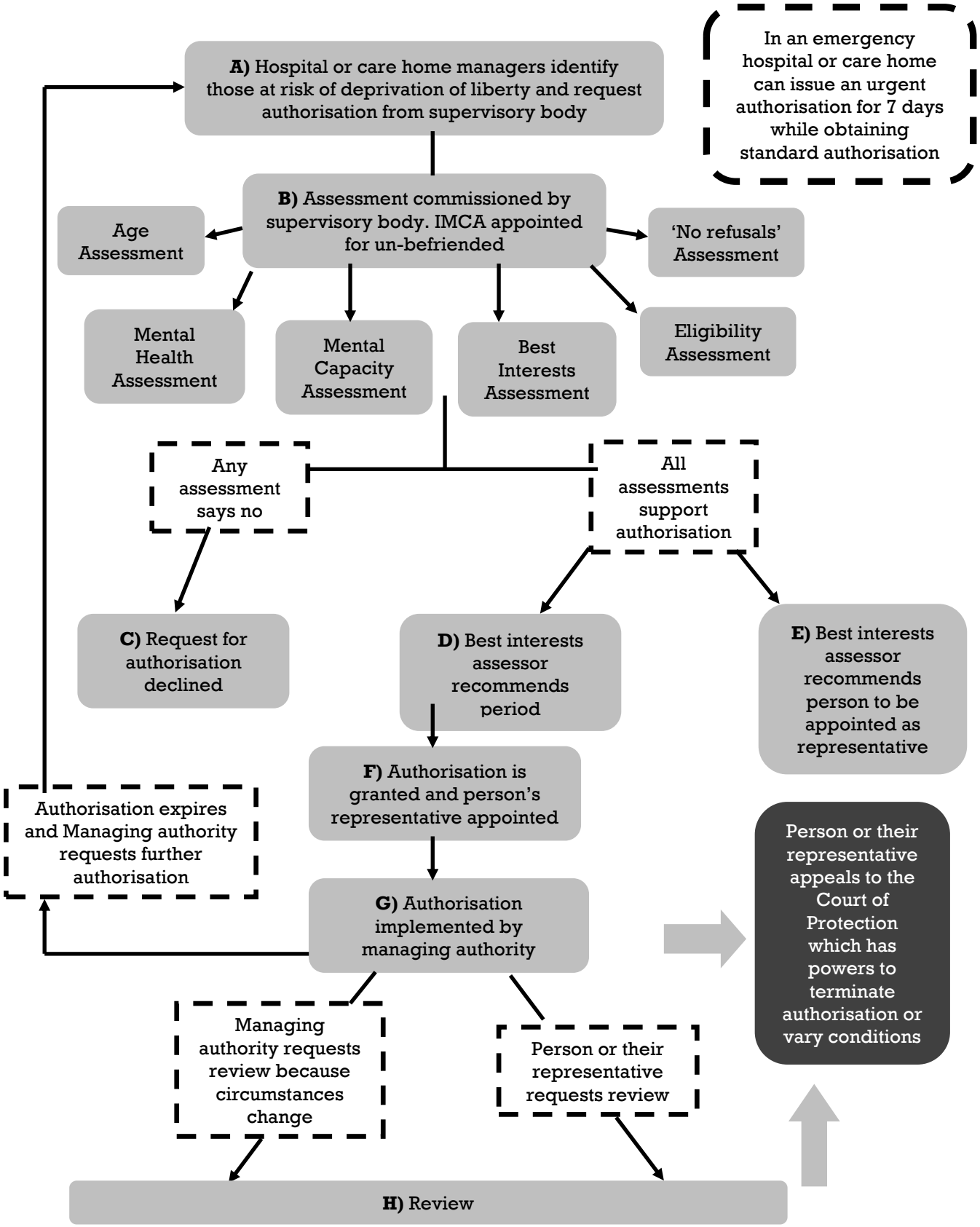
Consider a third case:

C v Blackburn with Darwen BC [2011] EWHC 3321
C was required by guardian local authority to reside at care home where there were locked doors. C was subject to 1:1 supervision both inside and outside the home. Staff used distraction techniques if he otherwise tried to leave. C did not like care home and wanted to live elsewhere.

The High Court decided that this was not a deprivation of liberty in breach of Article 5. And yet all three cases contain similarities in relation to the control and treatment of the individuals. Thus it can be seen that the professionals, known as Best Interest Assessors, who are charged with deciding this crucial question, are not helped by the legal framework itself.

The flowchart outlining the Deprivation of Liberty Safeguards process is reproduced below. For further information regarding DoLS contact your local MCA and/or DoLS Lead or see http://www.dh.gov.uk search 'deprivation of liberty'. You can also find information in the Code of Practice (Ministry of Justice 2008).

Deprivation of Liberty Safeguards



The Safeguarding Vulnerable Groups Act 2006 was to have provided an extensive 'vetting and barring' scheme for protecting vulnerable children and adults by stopping those who pose a known risk working with them. However, this Act has been significantly scaled back following the recent Protection of Freedoms Act 2012.

The major protective element which is not to be implemented is the provision which would have required individuals wanting to work with vulnerable groups to be registered and monitored to ensure their suitability. This was not without criticism including the issue that this would have meant the registration of approximately nine million people (and a fee was expected to be payable).

The Protection of Freedoms Act 2012 has caused the merger of the Criminal Records Bureau and the Independent Safeguarding Authority into a new 'Disclosure and Barring Service'.

The government's thinking behind this is clear.

> The UK Government is committed to protecting vulnerable groups including children. We want to see a focused and effective safeguarding system, where harm or risk of harm is identified, acted upon effectively and ultimately prevented. We also want a better sharing of responsibility for safeguarding between the state, on the one hand, and your organisations, on the other. We think that arrangements up until now over-emphasised protection by the state and did not sufficiently emphasise the vital role which you play.

(Home Office 2012)

It is also very clear that government wants to significantly alter responsibilities in relation to this and is placing the onus on providing safe and effective employees and services fairly and squarely on employers.

> Clear, well managed arrangements for safeguarding are important, whether in a large hospital, a school or a small local charity. This includes ensuring that all staff are appropriately recruited, trained and managed. Vigilant, on-going, day-to-day management is crucial, in order that unusual or concerning behaviour is picked up at the earliest opportunity. Safe, careful recruitment makes an important contribution. You are best placed to decide if someone is suitable for the role that you have and in doing so it is crucial that you take all sensible steps to identify the right person – including undertaking reference checks and conducting face to face interviews. All of this is just as important as a CRB check.

(Home Office 2012)

There is still a requirement on employers and others to provide information to the Independent Safeguarding Authority on an individual working with vulnerable adults where they consider that person to have caused harm or pose a risk. Anyone who is placed on the ISA's 'barring list' would then be prohibited from working in a ''regulated activity''. The full, legal definition of regulated activity is set out in Schedule 4 of the Safeguarding Vulnerable Groups Act 2006. Regulated activity excludes family arrangements, and personal, non-commercial arrangements.

The new definition of regulated activity relating to adults no longer labels adults as 'vulnerable'. Instead, the definition identifies the activities which, if any adult requires them, lead to that adult being considered vulnerable at that particular time. This means that the focus is on the activities required by the adult and not on the setting in which the activity is received, nor on the personal characteristics or circumstances of the adult receiving the activities. There is also no longer a requirement for a person to do the activities a certain number of times before they are engaging in regulated activity.

There are six categories of people who will fall within the new definition of regulated activity (and so will anyone who provides day to day management or supervision of those people). A broad outline of these categories is set out below.

1. Providing health care
2. Providing personal care
3. Providing social work
4. Assistance with cash, bills and/or shopping
5. Assistance in the conduct of a person's own affairs
6. Conveying (Home Office 2012)

Declaratory relief

The MCA 2005 preserves the right of interested parties to apply to the Court of Protection for a declaration of 'best interests', known as declaratory relief. The Court of Protection, as an arm of the High Court can make declarations on a range of issues including financial or welfare matters in relation to people who do not have the capacity to make their own decisions in these areas.

Declaratory relief previously only applied to people lacking capacity to make their own decisions. More recently, case law highlights the fact that the Court still retains 'inherent jurisdiction' and can intervene in the affairs of individuals who retain capacity. The landmark case in this area is *A Local Authority v DL, ML and GRL [2011] EWHC 1022 (Fam).* A local authority wished to safeguard elderly parents from the threatening and abusive behaviour of their son who lived with them. It was accepted that the parents had capacity to make the relevant decisions but Mrs Justice Theis DBE concluded that the court could intervene as long as the individuals were considered to be 'vulnerable'.

> If there is evidence to suggest that an adult who does not suffer from any kind of mental incapacity that comes within the MCA but who is, or reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors they may be entitled to the protection of the inherent jurisdiction (Para 53.4)

This case is important as the issues involved are not uncommon and may offer an indication that local authorities are able to consider offering protection to vulnerable people even if they do not, on the surface, appear to engage any of the other protective mechanisms mentioned above.

Activity:

Obtain a copy of Mrs Justice Theis' case transcript for the above. Compare the case to cases you know of and/or have worked with. Are there lessons in this case which could have been applied to yours? What are those lessons? Would the outcome of your case have been any different if the inherent jurisdiction of the Court had been engaged?

Tip: try http://www.bailii.org/ for access to freely available and downloadable case law.

Roles and responsibilities

Your role and responsibilities within the safeguarding process will, to a certain extent, depend on your everyday work and position. Regardless of position though, all staff should remember that the primary responsibility is to the person at the centre of any alleged or proven abuse – the victim.

Operational staff obviously have a key part to play in the process by virtue of the fact that they will often be the people who are raising any alarms, raising alerts and investigating issues. The quality or otherwise of your safeguarding policy and procedures will either help or hinder their work. A clear, well written and accessible policy will doubtless assist operational staff in their duties.

Some partner agencies of course will have specific roles within the process as a whole. The police and Crown Prosecution Service for instance will have a specific remit to investigate and deal with any criminal offences for which evidence can be gathered. Again, a good quality multi-agency policy which clearly delineates each agency's responsibilities will be invaluable.

No Secrets (2000) suggests that those with supervisory line management responsibilities are primarily ''responsible for ensuring that all appropriate agencies are involved in the investigation and provision of support and that good standards of practice are maintained'' (3.11). There is no suggestion though, as to what constitutes good standards of practice and it may be that supervisors and managers then need to turn to ADASS' *Safeguarding Adults* (2005).

Whilst not directly addressed in this publication, supervision plays a crucial role in the safeguarding process. It allows managers to monitor the progress of staff competency in the area and also to monitor the progress of on-going investigations or issues. Supervision also though has a sometimes overlooked role in providing emotional and practical support to the practitioner.

By its very nature, abuse can range from actions or inactions which appear to be relatively mild on the surface through the range of human experience to actions which may amount to wilful neglect or ill-treatment as described in section 44, MCA 2005 or even a breach of Article 3, HRA 1998 if perpetrated by a public authority. The nature of abuse at this end of the scale is likely to require emotional support for the practitioner. A valuable immediate function for the supervisor can be to provide a 'debrief' so that the practitioner is not left to deal alone with feelings of distress, failure or even abject horror at ''man's inhumanity to man'' (Burns 1785). Hawkins and Shohet (2007) argue that distress, if not acknowledged and dealt with can undermine the practitioner's practice and health. Further referral may then need to be made to appropriate sources of

support to ensure that the practitioner's mental and physical health is protected and promoted, which may include, in the extreme cases, counselling.

The supervisor themselves though, also needs to be able to seek debriefing as even though they may only be accessing the distressing issues second hand, there is still an emotional response possible which needs to be recognised and dealt with and not ignored.

Activity:

- Do you provide support for practitioners faced with distressing issues?
- Can you protect the time necessary so that the practitioner feels supported and valued?
- Do you know what mechanisms are available to refer distressed practitioners to suitable further support?

Think about situations where you have provided support to practitioners.

- What have you done with your own thoughts and feelings?
- Could you have done anything different?
- Do you have a good support mechanism and systems in place?

No Secrets goes on to suggest (3.12) that senior managers should take the lead in developing policy and strategy, promoting good practice and negotiating with colleagues in other agencies. This may also be devolved to a Safeguarding Lead if one exists. However, senior managers may also find themselves offering support to more junior members of staff as outlined above and so they also need to have strategies in place in order to protect their own mental and physical health. Whilst it is acknowledged that these strategies will be needed less often than staff in other groups, it is easy to overlook this aspect of senior managerial role and the importance of such needs to be recognised and understood.

Government would like Chief Officers and Chief Executives to take part in national debates and developments (*No Secrets* 3.14). In order to achieve this, this group of staff have a responsibility to understand the issues behind safeguarding vulnerable people and recognise learning from Serious Case Reviews. Senior management have a role to play here and can be pivotal in ensuring that such staff are briefed regarding local and national issues on a regular basis.

No Secrets (2000) and Safeguarding Adults (2005) both provide information aimed squarely at protecting and promoting the health and welfare of the victim(s) of alleged or proven abuse. Undoubtedly, this is as it should be as the document's primary concern should be in addressing their needs. *No Secrets* sets out a list which it entitles contents of procedures (6.5). This list includes "a full list of points of referral indicating how to access support, advice and protection at all times" and "a list of sources of expert advice". However, it is not clear whether this applies to staff in distress as a result of safeguarding activity. Safeguarding Adults also doesn't mention staff support.

Activity:

Examine your available human resources policies especially those in relation to staff support.

- Is safeguarding activity recognised as a potential risk?
- If not, should it be?
- Does your authority have an easily accessible corporate risk register?
- If so, again is safeguarding activity highlighted?
- If it isn't, should it be?

Training

Training is essential to the successful operation of any safeguarding vulnerable adult's policy and procedures, no matter how well any such policy is written. Training should not happen in isolation but rather should be an integral part of any safeguarding strategy.

Training can take place in any number of ways and indeed variation is to be welcomed as meeting the educational needs of individuals can be counted as best practice. Regardless of what model or format the training takes there are a number of occasions when training needs to happen. As a supervisor, manager or senior participant in the safeguarding process, you have a number of different responsibilities in relation to training.

1. Firstly is your responsibility to your own training needs. In order to be effective in your role as part of the safeguarding partnership you need to have an understanding of the issues and a good grasp of your policy and procedures including but not limited to what the process actually requires following an abuse incident or report.
2. Secondly, you have a responsibility to ensure that any junior staff you supervise or manage have also received training which is regularly reviewed and on-going.
3. Thirdly, you need to ensure that the training you are providing for staff is fit for purpose and designed to enable staff to carry out their individual functions in a more effective and understanding way.

The best safeguarding training is multi-agency in profile with a mix of professions, partners and grades to enable a good understanding of others roles and responsibilities in the process although there also needs to be a good understanding of roles and responsibilities within individual organisations. Standard 5 of Safeguarding Adults relates to a multi-agency training strategy which is appropriately resourced.

For your own staff, there are a number of times when it is suggested that safeguarding training should be offered and promoted. Obviously there needs to be something in any induction training that new members of staff or volunteers receive. As was stated at the beginning of this publication, safeguarding is everyone's business so it is contended that all new members of staff and volunteers, regardless of their role is introduced to the importance of the safeguarding process as soon as possible after employment. This does not just apply to 'clinical', social care or housing staff. This induction training can be fairly basic in nature and perhaps touch on types of abuse and the duty to report.

More detailed training can be provided for those whose roles involved face to face contact with members of the community. This may well include detailed training for health and social care staff. This training should highlight roles and responsibilities in more detail and should be a regular item on the training calendar. It should not be seen as a 'one-off', a box to tick to prove that the practitioner has received training. It should be offered in such a way that professionals attend perhaps yearly or two yearly depending on your organisation and the partnership's training requirements and provision. This training might well be best delivered in a single agency format to ensure that practitioners gain a good understanding of the specific requirements that their own organisation places upon them.

There also needs to be specialist training for investigators and managers. A multi-agency approach is recommended here partly so that these staff can get to know partners in other agencies and share ideas and knowledge.

As mentioned above, training can take many formats and need not be restricted to 'classroom' based sessions. Education can take place as part of the supervision process for instance or could occur within a particular professional group's practice forums. Undoubtedly for reasons of economy of scale some training will have to be delivered in formal sessions. This does have the advantage of allowing you to assess the training requirements for your staff and understand who has and who has not attended relevant training. It can be harder to capture this information from less formal processes such as mentioned above.

A useful tool for practitioners which may also have some value to more senior staff is the Safeguarding Adults Framework Evaluation (SAFE) tool developed by Diane Galpin at Bournemouth University. The tool which is freely available online at www.ncpqsw.com/SAFE is designed to support the improvement of practice in this area. Participants respond to eight questions about a case they have worked on and on completion receive a report based on the answers they have given. Further information can be gathered from the website above.

A further aspect of training which needs to be considered is the provision of training for supervisors to ensure that the supervisory process is effective. As mentioned elsewhere, supervision has a vital role to play in the safeguarding process but often, staff are moved into supervisory positions without attention being paid to how the supervisory relationship works. As mentioned elsewhere, supervision should be more than a discussion of case loads and work related issues. Ideally it should encompass room for the supervisee to explore issues and develop in their role. There is also sometimes an emotional support role for the

supervisor and it is important that the supervisor feels empowered to provide this.

Within the safeguarding process itself there is obviously a need to focus on policy and process but equally importantly is staff ability to make coherent and justifiable decisions and take and justify risks, both important practice skills.

If you are in a position where you are called upon to chair safeguarding strategy meetings there is also a responsibility on you to ensure that you have the necessary skills in order to carry out this task. It can be useful, with this in mind, to develop a partnership approach to any training calendar so that training in this area can be cost effective and reach the maximum amount of participants.

Activity:

Consider the amount of safeguarding training of all types that you have attended in the last two years.

- What is the balance between formal training and other informal education sessions?
- Do you learn more productively by attending formal sessions or do you prefer the informal or self-learning settings?
- Are there any gaps in your knowledge or competencies?
- How can you address those gaps?

Multi-agency working, policies and procedures

Safeguarding procedures can only be successful if the process is widened from the individual organisation and partner organisations all invest in and value the process. *No Secrets* (2000) suggests that,

"…all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern…" (*No Secrets*, 2010, p.6)

No Secrets goes on to list the organisations and individuals who it believes should be involved in a multi-agency framework.

Activity:

Compare your local framework to the suggested list in *No Secrets*. How do they compare? Are there any significant omissions from your framework? The list is set out below.

- Commissioners of health and social care services
- Providers of health and social care services
- Providers of sheltered and supported housing
- Regulators of services
- The police and other relevant law enforcement agencies including the Crown Prosecution Service
- Voluntary and private sector agencies
- Other local authority departments i.e. housing and education
- Probation departments
- Benefit Agency
- Carer support groups
- User groups and user led services
- Advocacy and advisory services
- Community Safety Partnerships
- Services meeting the needs of specific groups experiencing violence
- Agencies offering legal advice and services.

Of course it may be that not all of the above services will be particularly relevant all of the time but each has its own part to play and brings its own knowledge and experience to the framework which may very be valuable each and of itself. Some agencies may be more willing or able to participate than others. Some might not recognise that they have a role to play or may be reluctant to engage for other reasons.

Strategic leadership can be extremely valuable in this area. If the leadership is positive and enthusiastic about the framework, something which is not always easy to achieve bearing the purpose of the framework in mind, then that enthusiasm can be used to generate enthusiasm and engagement in the rest of the group. This can then be reinforced by any positive outcome that the framework achieves, especially if this equates to improved outcomes for service users.

Activity: Reflective Task

If you are a strategic leader or member of the framework with leadership or supervisory responsibilities consider your approach to the group.

- Are you able to enthuse and excite the group?
- How do you do this?
- Could you approach this in a different way to increase engagement?

One of the key issues in any framework is the quality of the communication. This is even more important when it is happening in the context of an interagency organisation where sharing information can be fraught with difficulty.

Underpinning good quality communication is a good interagency policy which deals with communication as well as the wider issues in relation to safeguarding vulnerable adults. In effect, two policies are necessary, one on interagency information sharing and the other which sets out the roles and responsibilities of all concerned when an adult is alleged to be a victim of abuse.

A short investigation into the findings of Serious Case Reviews and other serious incidents where things have unfortunately gone wrong often highlights poor communication as fundamental to the reason for the failure. Agencies having relevant information but failing to share this are often cited as a major reason for things going wrong. Sometimes the relevance or importance of information is not immediately apparent or only becomes important or relevant when linked to other pieces of information which is held by other parties. This is where a clear interagency information sharing policy demonstrates its worth.

The interagency safeguarding policy itself can then be operated with confidence in the knowledge that all relevant information is known to the appropriate people concerned.

The policy itself should be written in partnership and requires senior input and 'sign up'. Consultation needs to occur with frontline staff, service users and carers and members of the public. There needs to be clear delineation between the roles and responsibilities of all concerned and responses to issues of safeguarding needs to be consistent and timely. The policy needs to be written in such a way as to be easily accessible to all who may need to access and use them. They need to be free of professional jargon and 'in' phrases. There should be a list of appropriate definitions so that there can be no misunderstandings or arguments about the meaning of words which may mean one thing to one group and another to partner groups.

It needs to be freely available to service users, carers and the public. Internet only based policies will fail this test for the simple reason that not everybody is internet knowledgeable or has access. The argument that people can access the internet in libraries or internet cafes is not watertight as it does not allow for individuals who either cannot or refuse to access such places. Despite the prevalence of social media and society's dependence on the internet, there remain groups of individuals who cannot or will not use a computer. Hence, paper based copies of the policy need to be easily available.

Polices should be 'live'. By this we mean that they cannot or should not be written, placed on a shelf and forgotten about. They need to be regularly reviewed and have a mechanism which guarantees the quality of any changes that are made. They need to be able to respond to changes in legislation, case law or Serious Case Reviews.

An organisation's other policies should be written in conjunction with or reference the safeguarding adults policy. This is particularly important when writing policies which deal with contractors or other purchased services. External organisations providing services must be made aware of the importance of the safeguarding policy, especially if their usual business is not fundamentally health or social care in nature.

The policy needs to be widely promoted and every opportunity should be taken to bring it to public and professional attention. Training is obviously vital in this respect.

Activity:

- Is your safeguarding adults policy 'live'?
- When was it last reviewed and how regularly is this done?
- Has your partnership looked at it following the Winterbourne View issues or as a result of CQC's review of services following the scandal?
- Does this need to be done?

Activity: Reflective Task

Find another authority's safeguarding adult's policy on the internet or in hard copy. Compare and contrast your policy with theirs.

- Is there anything in the other policy which isn't in yours and yet which would be a useful or valuable addition?
- Is there anything in yours which detracts from its usefulness or is inappropriate or unnecessary?
- How would you go about amending your policy to add new or remove unnecessary information?

Audit and record keeping

Record keeping is an essential tool in the safeguarding process. In many respects, the partnership process is underpinned by and is only as good as the record keeping systems available. It is recommended that partnerships adopt common documentation for the process.

Record keeping needs to be clear, detailed and free of jargon. Records to be kept include alerts (reporting of concerns), referrals (making appropriate information available to partner agencies), decisions (deciding whether safeguarding policies are the correct mechanism to deal with the alleged issues), assessment strategies (formulation of the plan), assessment (collecting information which may or may not include criminal investigation), planning (providing a multi-agency response to the issues) and reviewing (assessing the effectiveness of that response and making any changes necessary).

Effective record keeping assists with the communication process which is often highlighted as being a regular barrier when things go wrong. Records can also be required by courts and coroners should the worst happen. Thus it is essential that the paperwork adopted is as straightforward as possible and strikes a balance between detail and overburdening the practitioner using it.

Detailed minutes of safeguarding strategy meetings or training development meetings are another valuable way in which to improve and maintain good communication within the partnership.

It can be useful if the paperwork adopted for the safeguarding process allows for participants to demonstrate the decision making process. Often in court cases it is not necessarily the decision that is criticised but the way in which it was arrived at.

Consider the case of The London Borough of Hillingdon v Steven Neary (by his litigation friend, the Official Solicitor) & Mark Neary & The Equality and Human Rights Commission [2011] EWHC 1377 (COP). This well-known case in relation to deprivation of liberty and the MCA 200 Deprivation of Liberty Safeguards concerned a vulnerable young man with Learning Disabilities who was taken into respite care for what he and his father thought was for a fortnight and kept him against his and his father's wishes for a year. Once in court, the judge criticised the local authority and its staff for what he termed ''misjudgements''. The paperwork provided by the authority was insufficient to justify the decisions that staff were making and to offer the correct level of protection that Steven needed.

Activity:

Obtain and read the case transcript for the above case. Consider the actions of the local authority and its staff.

- Are there any concerns that a similar problem could arise in your organisation?
- What steps would you need to employ in order to prevent a Neary in your partnership?

Linked to record keeping and also to partnership working and multi-agency policies and procedures is the need for audit.

An audit is basically an evaluation of a person or process in order to identify its strengths and weaknesses. Audits can identify targets achieved or missed and can verify that the standards set within your partnership framework have been achieved. Audits highlighting areas of good practice can be used as part of training in order to share such practice to a wider population.

There are a number of tools widely available in order to carry out an audit but organisations often design their own based on the specific areas of interest that they are seeking to report on.

At a basic level, an audit can act as a monitoring tool to check on the efficacy of the policies and process or perhaps the training programmes in place. As mentioned above audits should be used to highlight good practices and properly shared, can be used to publicise the safeguarding policies and work.

Staff at all levels can be encouraged to self-audit. This is most usually done in relation to training and development of knowledge and competencies. Again, this can be formally led by the partnerships' or organisation's training and development service or could be done at a less formal level by the individual themselves. In this way staff can be encouraged to own their own part of the process and this sort of activity can be used as learning activity in its own right for the purposes of Continuous Professional Development or contributing towards the training required by most professional regulation bodies.

Audits can be carried out by operational or managerial staff but should not be used as a means of criticising individuals. Poor practice which is highlighted should be dealt with by other means, perhaps by further training or disciplinary process if necessary.

Serious Case Reviews and Inspections

The purpose of having a Serious Case Review (SCR) is not to reinvestigate or to apportion blame, it is:

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults
- To review the effectiveness of procedures (both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To 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.
  (ADASS, 2010)

Manthorpe and Martineau (2010) carried out an analysis of 22 Serious Case Reviews following instances of death or harm. The research offered a reflection on the purpose, process and usefulness of SCRs as a way of learning retrospectively from serious incidents. They drew a number of conclusions including a lack of clarity in terms of the threshold for a review and the conduct of reviews which resulted in difficulties when considering system failings and difficulties in generalising learning for agencies and practitioners, a stated aim of the SCR process.

Other issues identified included: considerable variation on the issue of thresholds that make any particular case or incident deserving of a review; lack of co-operation from other agencies; inaccessibility of reports making learning difficult; limited resources for staffing adult safeguarding services; records being lost; limited attention to data collection.

The major issues identified though are deficits in inter-agency communication and the need for further training.

A number of practice implications are drawn including for policymakers:

- Consideration should be given standardising the approach to SCRs in adult safeguarding.
- Greater clarity is required in setting thresholds for SCRs.

- Lessons to be learned from SCRs should be analysed and more widely circulated.
- Guidance is required in relation to inter-agency co-operation, information-sharing and data protection.

For managers:

- Investigation of "near misses" that occur below the threshold will inform good practice generally.
- Communication between agencies is required to identify failing services.
- Adequate resources are needed to monitor and disseminate findings from adult safeguarding referrals.

Another issue highlighted was the lack of a central repository of SCR results, something this author found in writing this chapter. A simple internet search leads to a list of links of most, if not all, of the local authorities in England and Wales. Some of these results are local authority policy and procedure and some are SCR results. For instance, Cornwall County Council's public facing website offers Executive Summaries on two local cases, a full review of a further case and a link to a case from Warwickshire County Council. It is highly unlikely that anyone attempting to draw conclusions and threads together from different cases will have the time to trawl through a list of local authority links.

Even the Care Quality Commission does not assist with this task, information being diffuse and not easy to gather.

Some SCRs are more well-known than others. Perhaps the most infamous case of recent times is that of Winterbourne View Hospital near Bristol. A member of staff had tried to 'whistle-blow' by sending an email listing his concerns about poor care to senior managers of the company which owned the hospital. In May 2011, an undercover investigation by the BBC's Panorama programme revealed criminal abuse by staff of patients. Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients and was registered as a hospital providing assessment, treatment and rehabilitation for people with learning disabilities. It closed in June 2011 after the Panorama investigation. Following the television programme, South Gloucestershire Safeguarding Adults Board began a Serious Case Review, the police launched an investigation leading to 11 criminal convictions and the CQC inspected all hospitals and homes operated by Winterbourne View's owners and conducted a wider "health check", inspecting 150 learning disability services across England.

Findings include:

- No overall leadership among commissioners who, amongst other issues, did not receive detailed accounts of how Winterbourne View Hospital was spending the weekly fees on behalf of its patients.
- Continued placement of patients even though the hospital was not meeting its contractual requirements in terms of the levels of supervision provided to individual patients
- Families could not influence the placement decisions.
- Limited use of the Mental Capacity Act 2005.
- Although some commissioners funded advocacy services, the hospital controlled patients' access to these.
- The whistleblowing notification was not addressed by the hospital or by wider company management. The final response to the issues raised by the whistle blower was ineffective.
- Patterns of concern were not identified by South Gloucestershire Council Adult Safeguarding who had only an edited version of events at Winterbourne View Hospital. Other forms of alert, both to the local authority and the regulators that might cause concern where not shared and discussed between the two bodies.

  "Had both been aware of: patients' limited access to advocacy; notifications to the Health and Safety Executive; the hospital's inattention to the complaints of patients and the concerns of their relatives; the frequency with which patients were restrained and the duration and authorisation of these; the police attendances at the hospital; and the extent of absconding; then both may have responded appropriately in terms of urgency and recognition of the seriousness."

  (Flynn 2012)

- The role of the Care Quality Commission as the regulator of in-patient care at Winterbourne View Hospital was limited since light-touch regulation did not work. Although all agencies assumed that management of the Hospital would be honest in reporting incidents, this did not happen.

South Gloucestershire Council is further criticised for its unwillingness or inability to lead the safeguarding process as the lead agency. Indeed, they are criticised for being too deferential towards police.

Recommendations from the SCR included outcome based commissioning for hospitals detaining people with learning disabilities and autism; rationalising notifications of concern; establishing Registered Managers as a profession with a

code of ethics and regulatory body to enforce standards; NHS commissioning organisations prioritising patients' physical health and safety; and discontinuing the practice of t-supine restraint i.e. restraint that results in people being placed on the ground with staff using their body weight to subdue them in hospitals detaining people with learning disabilities and autism.

Case study:

Laurie described his history of moving from one home to another…he recalled that there was 'nothing' that he liked about Winterbourne View Hospital. Laurie was concerned that because he had moved so far from his family it was difficult for them to visit him regularly… Laurie's family visited Winterbourne View Hospital twice before Laurie moved in. His mum had been positive about the move until the initial visit. She did not like either the staff she met or 'the feel of the place,' not least because she was not allowed to see what was to be Laurie's bedroom. It was explained that there was 'a patient off baseline.'...he did not enjoy what he saw as 'baby games.' Laurie said of one staff member that he was: 'a shit. He was horrible to the patients. He used to wind a few (patients) up deliberately.'

Laurie and his keyworker recalled an occasion when Laurie was placed under s.37 of the Mental Health Act 1983, having been restrained. He had bitten a staff member. Laurie's key worker expressed disquiet about the incident and the use of the MHA because it was so unlike Laurie whose behaviour, while occasionally difficult, was consistent. Laurie said that it was 'medication time' and he was asked to queue for his medication. He told the staff that the waiting area was 'too packed for me down there' and he went to the lounge waiting for the area to 'unpack.' The staff challenged Laurie: 'they told me to get down to the clinic room and I said 'I don't want to'. I ran to hide in the toilet. They came and forced me out. They came in pushing me down the corridor. They pushed me into the clinic area then [three staff members] tried to strangle me.' This happened after Laurie had been restrained, having been dragged to the ground. When Laurie became calm, they released him and he refused to have his medication.

Laurie said that when he was on duty one staff member would come into his bedroom and jump on him and tell him to get up. Also, during his placement at Winterbourne View Hospital, he phoned his family and key worker every week. The hospital staff did not like Laurie doing so. In turn, they locked him out of his bedroom and insisted that he made personal phone calls in communal areas so that staff could monitor his conversations: 'They banned you making phone calls in your bedroom and

made you do phone calls in the lounge.' Laurie's key worker explained that Laurie had told him that he felt that he was not as bullied as some of his friends because he could, and would, tell his parents. He does not want what he saw happen to some of his friends to happen to anyone else.

(Flynn 2012 section 4 3:23-3:25)

Points for reflection

- Could 'Winterbourne View' happen in any of the services you manage, operate or contract with?
- What is the most difficult aspect to manage?
- Thinking about a service which might now or in the past cause you concern, what were the specific indicators of that concern and what did you do about them?
- On reflection, could or should you have done anything differently?

Whistleblowing

Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'.

The Public Interest Disclosure Act 1998 is the main legislative framework providing legal protection for individuals who disclose information so as to expose malpractice and matters of similar concern. The Bribery Act 2010 includes a defence of having adequate procedures in place to prevent bribery and having a secure whistleblowing procedure in place has become necessary. Whilst the authority may have excellent internal reporting systems, on occasions, staff may feel uncomfortable using them.

Staff can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including:

- Someone's health and safety is in danger
- Damage to the environment
- A criminal offence
- The company isn't obeying the law
- Covering up wrongdoing

The way a worker can 'blow the whistle' on wrongdoing depends on whether they feel they can tell their employer. Often employees fail to report wrongdoing or concerns due to:

- Lack of anonymity
- Fear of reprisals
- Feelings that they may not be taken seriously
- Inadequate or inappropriate internal reporting procedures

It is impossible for senior management to know everything that goes on but they can mitigate that everything possible has been done if employees have access to a secure policy. Staff are the eyes and ears of any organisation

Activity:

Consider the whistleblowing policy in your organisation:

- Is it used? Is it reported on?
- Can employees report anonymously, if appropriate?
- Do they trust the system?
- How easy is it to raise concerns if all they have are suspicions?
- Are staff comfortable raising corporate/clinical governance matters when they may be reporting to those suspected of wrongdoing?
- Are management always aware of bullying, health & safety concerns, discrimination, racism etc.?
- Is it safe and confidential enough to comply with the 'adequate procedures' defence under The Bribery Act 2010?

How do people 'blow the whistle'?

1. The worker should first check their employment contract or ask human resources/personnel if their organisation has a whistleblowing procedure.
2. If they feel they can, they should contact their employer about the issue they want to report
3. If they can't tell their employer, they should contact a 'prescribed person or body'.

A worker can only tell the prescribed person or body if they think their employer:

- Will cover it up
- Would treat them unfairly if they complained
- Hasn't sorted it out and they've already told them

Dismissals and whistleblowing

A worker can't be dismissed because of whistleblowing. If they are, they can claim unfair dismissal – they'll be protected by law as long as certain criteria are met.

Types of whistleblowing eligible for protection

These are called 'qualifying disclosures'. They include when someone reports:

- that someone's health and safety is in danger
- damage to the environment
- a criminal offence
- that the company isn't obeying the law
- that someone's covering up wrongdoing

Who's protected?

The following people are protected:

- Employees
- Agency workers
- People that are training with an employer, but not employed
- Self-employed workers, if supervised or working off-site

A worker will be eligible for protection if they honestly think what they're reporting is true and they think they're telling the right person.

Workers aren't protected from dismissal if:

- They break the law when they report something (eg. they signed the Official Secrets Act)
- They found out about the wrongdoing when someone wanted legal advice ('legal professional privilege') - e.g. if they're a solicitor

Workers who aren't employees can't claim unfair dismissal because of whistleblowing, but they're protected and can claim 'detrimental treatment'.

Tribunals

If a worker is dismissed for whistleblowing, they can go to an Employment Tribunal. If the tribunal decides the employee has been unfairly dismissed, it can order that they are:

- Reinstated or
- Paid compensation

Blowing the whistle to a prescribed person

The prescribed bodies or persons

If staff decide to blow the whistle to a prescribed person rather than their employer, they must make sure that they have chosen the correct person or body for their issue.

Below is a list of the prescribed people and bodies who staff can make a disclosure to. If staff want to blow the whistle then they should write down the malpractice they have discovered and the evidence to support this and send it to the correct body.

- The Audit Commission for England and Wales about the following areas
- The conduct of public business
- Value for money
- Fraud and corruption in local government and health service bodies
- The Care Quality Commission about the provision of health care on the NHS or independent health care services

The Standards Board for England about breaches to a local authorities' code of conduct

The Care Quality Commission about social care services in England

In addition, staff could also blow the whistle to their legal adviser, in the course of obtaining legal advice, or to a government minister as they are public sector employees.

In December 2001 the Department of Health announced that a confidential helpline which had been set up for NHS staff was being extended to social care staff from 1 January 2012. The helpline operates on weekdays between 08.00 and 18.00 with an out-of-hours answering service available at weekends and on public holidays. A web-based service is also being developed.

Staff in health or social care can contact the helpline if they have concerns but are unsure how to raise them or simply want advice on best practice.

The government-funded service also changed to a free-phone service provided by the Royal Mencap Society. The helpline number is 08000 724 725

References

Association of Directors of Adult Social Services (2005) Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work. London. ADASS. Available from: www.adass.org.uk/images/stories/Safeguarding%20Adults/SAFEGUARDING%20ADULTS%20pdf.pdf (Accessed 13 January 2012)

Association of Directors of Social Services (2010) Vulnerable Adult Serious Case Review Guidance-Developing a local protocol. Available from: http://www.adass.org.uk/index.php?option=com_content&view=article&id=522:safeguarding-adults-key-documents&catid=125:safeguarding-adults-&Itemid=406 (Accessed 13 January 2012)

Bournemouth University (2010) National Competence Framework for Safeguarding Adults. Bournemouth: BU

Burns, R. (1785) From Man was made to Mourn: A Dirge. http://www.robertburns.org/works/55.shtml (Accessed 1 March 2012)

Care Quality Commission (2010) Our safeguarding protocol: The Care Quality Commission's responsibility and commitment to safeguarding. Available from: http://www.cqc.org.uk/sites/default/files/media/documents/20120523_800249_v1.0_cqc_safeguarding_protocol__for_external_publication.pdf (Accessed 10 January 2012)

Clements, L. & Thompson, P (2011) Community care and the law 5th ed. London. Legal Action Group.

Department of Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice. London. TSO.

Department of Health & Home Office (2000) No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. London: TSO.

Department of Health (2008) Reference guide to the Mental Health Act 1983. London. TSO

Department of Health (2009) Report on the Consultation: The Review of No Secrets Guidance. London. TSO.

Department of Health (2011) Statement of government policy on adult safeguarding. Gateway Ref. 16072. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126770.pdf

Flynn, M. (2012) Winterbourne View Hospital: A serious case review. South Gloucestershire Safeguarding Adults Board. Available from: http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx (Accessed 30th April 2013)

Galpin, D. (2010) Policy and the protection of older people from abuse. Journal of Social Welfare and Family Law 32:3, 247-255

Hawkins, P. & Shohet, R. (2007) Supervision in the helping professions (3rd Ed). Bucks. OUP.

Home Office. (2012) Changes to disclosure and barring: What you need to know. London. TSO. Available at http://www.homeoffice.gov.uk/publications/agencies-public-bodies/dbs/corporate-publications/disclosure-and-barring-changes/leaflet-england-wales?view=Binary (Accessed 1 September 2012)

Mandelstam, M. 2009. Safeguarding Vulnerable Adults and the Law. London. Jessica Kingsley Publishers.

Manthorpe, J. & Martineau, S. 2010. Serious Case Reviews in Adult Safeguarding in England: An analysis of a sample of reports. British Journal of Social Work 1-18.

Ministry of Justice. 2008. Mental Capacity Act 2005 Deprivation of liberty safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. London. TSO

The Law Commission. 2011. Adult Social Care (Law Com 326). London: TSO

Statutes

European Convention on Human Rights 1950

Human Rights Act 1998

Mental Capacity Act 2005

Mental Health Act 1983

Protection of Freedoms Act 2012

Safeguarding Vulnerable Groups Act 2006

Case law

A Local Authority v DL, ML and GRL [2011] EWHC 1022 (Fam)

C v Blackburn with Darwen BC [2011] EWHC 3321

DD v Lithuania [2012] ECHR 254

Litwa v Poland [2001] 33 EHRR 53

The London Borough of Hillingdon v Steven Neary (by his litigation friend, the Official Solicitor) & Mark Neary & The Equality and Human Rights Commission [2011] EWHC 1377 (COP)

National capabilities framework for Safeguarding Adults:

Strategic Management and Leadership of Safeguarding Services

Guidance

Whatever way you have decided to use these materials, central to this process is having regular contact/ discussions with your supervisor/mentor/manager; basically the person(s) allocated in your organisation as having the authority to confirm you have met the capabilities contained in the National Capability Framework for Safeguarding Adults.

To demonstrate you have met a specific capability you will require confirmation of how it was met and a signature to verifying this. The person verifying you have met the requirements of the framework should use the 'Verifiers Guidance' to guide any discussions you might have in this process, the guidance acts as a prompt for you both to reflect on the knowledge and skills you already have and one's you may wish to develop.

You might also have some supplementary evidence you wish to include in this workbook, for example anonymised reports, certificates of training and/or education.

Well done for completing this work, and good luck with your future professional development.

Professional capability: 13 Actively engage in supporting a positive multi-agency approach to Safeguarding Adults			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Demonstrate an understanding of the different roles and responsibilities of all agencies involved in investigations and ensure these are met	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Show awareness of updated protocols and follow/implement them	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Demonstrate application of learning from CQC inspections and Serious Case Reviews in service development	**Please tick, at least 3**		
	Observed in practice		
	Assessments/ Plans/ Reports		
	Supervision/ discussion		
	Completed training		
	Other – give details		

Show how multi-agency prevention strategies are being developed and used in practice.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Challenge poor practice at an intra and inter-agency level.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Professional capability: 14 **Support the development of robust internal systems to provide consistent, high quality Safeguarding Adults service**			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Demonstrate a clear understanding of national policy and procedures and how these relate to the development and application of local Safeguarding policy and procedures in a multi-agency context	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Carry out effective monitoring and auditing	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Demonstrate effective training and CPD activity is commissioned to support the development of Safeguarding Adult services	**Please tick, at least 3**		
	Observed in practice		
	Assessments/ Plans/ Reports		
	Supervision/ discussion		
	Completed training		
	Other – give details		

Ensure necessary policy and procedures are in place to support supervisory practice	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Ensure supervision is carried out regularly to support Safeguarding activity	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Ensure supervisors are suitably trained to carry out the supervisory role	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Support 'whistleblowing' policy and procedures	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Monitor Safeguarding systems	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Ensure workforce has necessary skills and knowledge to work effectively	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Ensure effective training, policy and procedures are in place to support effective risk and decision making in practice.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Professional capability: 15 Chair Safeguarding Adults meetings or discussions			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
In line with local policy and procedures chair strategy meetings where it is deemed a senior manager is most appropriate eg. large scale inquiries or sexual offences.	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Professional capability: 16 Ensure record systems are robust and fit for purpose			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Implement audit and inspection regimes	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Can demonstrate established systems to support good practice e.g. maintaining records, protection plan monitoring and time management e.g. investigators report.	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion	.	
	Completed training		
	Other – give details		
Ensure appropriate record keeping of Safeguarding Adults meetings e.g. minute taking.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/ Plans/ Reports		
	Supervision/ discussion		
	Completed training		
	Other – give details		

Professional capability: 17 Lead the development of effective policy and procedures for Safeguarding Adult services in your organisation			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Work with partner agencies to develop a consistent intra- and inter-agency approach to Safeguarding Adults	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Have strategic understanding of the scope of Safeguarding services across the whole organisation	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Work in partnership with a range of agencies to promote Safeguarding adult services	**Please tick, at least 3**		
	Observed in practice		
	Assessments/ Plans/ Reports		
	Supervision/ discussion		
	Completed training		
	Other – give details		

Provide leadership for the workforce stating clear aims and objectives in Safeguarding Adults	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Ensure contractual arrangements with service providers adhere to Safeguarding Adults policy and procedures	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Can effectively communicate a proactive approach to Safeguarding Adults within your organisation	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		
Be able to account for your organisations practice	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Ensure 'whistleblowing' systems are in place.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give details		

Professional capability: 18 **Ensure plans and targets for Safeguarding Adults are embedded at a strategic level across your organisation**			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Ensure internal audit systems are robust	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give detail		
Actively engage in and have comprehensive knowledge of CQC inspections and findings and how these will be implemented to support service development in your organisation	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion	.	
	Completed training		
	Other – give details		
Be aware of the findings from serious Case Reviews and any implication for service delivery in respect of Safeguarding Adults in your organisation.	**Please tick, at least 3**		
	Observed in practice		
	Assessments/ Plans/ Reports		
	Supervision/ discussion		
	Completed training		
	Other – give details		

Professional capability: 19 Promote awareness of Safeguarding Adults systems within your organisation and outside of your organisation			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Publicise and promote Safeguarding policy and procedures	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give detail		
Can identify systems and structures in place used to raise awareness of Safeguarding Adults at a local and national level.	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion	.	
	Completed training		
	Other – give details		

Professional capability: 20 **Promote awareness of Safeguarding Adults systems within your organisation and outside of your organisation**			
Name of individual **……**	**Supporting Evidence**		**Assessors signature, position & date**
Ensure service users, patients, carers and customers are supported and involved in all aspects of activity, and that their feedback impacts upon service plans, locality action plans and the delivery of Safeguarding	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion		
	Completed training		
	Other – give detail		
Provide evidence of how patients, service users, carers and customers are involved in Safeguarding activity.	**Please tick, at least 3**		
	Observed in practice		
	Recordings/Plans/Reports		
	Supervision/discussion	.	
	Completed training		
	Other – give details		

The National Centre for Post-Qualifying Social Work

Bournemouth University
4th Floor, Royal London House
Christchurch Road
Bournemouth
Dorset
BH1 3LT UK

+44(0)1202 964765
+44(0)1202 962025
pqsw@bournemouth.ac.uk
www.bournemouth.ac.uk/hsc/pqsw
Follow us on twitter @researchpqsw

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