LBWF

Practitioners Guide - ADULT SAFEGUARDING

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Adult Care and Quality Standards

Adult Safeguarding

Practice Guide

Adult Social Care

Peoples Services

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Contents

1. Introduction

This guidance aims to support practitioners in further developing their values, skills, and knowledge to work confidently alongside adults who may be experiencing abuse and or neglect.

The guidance is underpinned by the values of Making Safeguarding Personal (MSP). It explores how we should work together with adults experiencing or at risk of abuse or neglect, to keep them safe and free from harm and to achieve the outcomes that they want.

It is not a definitive guide but seeks to support practitioners to navigate issues that we know from experience can cause difficulty and generate dilemmas for our practice.

The guidance is designed to be easy to read and enables a quick reference to vital areas of knowledge and give context to safeguarding work in Waltham Forest.

Waltham Forest adheres to The London Safeguarding Procedures. This guidance is supplementary to the PAN LONDON SAFEGUARDING PROCEDURES. The London Safeguarding Adults procedures should be considered as definitive, and all practitioners should familiarise themselves with the Safeguarding Procedures. The practitioner must consult their managers or the Safeguarding Adults Team when more guidance is required.

2. Aims of Adult Safeguarding

The Department of Health, in its summary of statutory guidance in the 2014 Care Act, describes safeguarding as "protecting an adult's right to live in safety, free from abuse and neglect".

It is important to consider that Safeguarding duties must be carried out alongside the other duties of the Care Act. For example, the duty to promote individual well-being, the duty to prevent or reduce the likelihood of further Care and Support needs developing, and the duty to provide good information and advice.

In practice, and where provision is already in place, this means it is often necessary to consider the effectiveness of any current care package and or provision provided by the local authority when undertaking safeguarding duties. It may be necessary to organise a review or reassessment of the person's needs with a focus on how the care package and/or support can work together with the person to keep them safe.

Safeguarding duties apply to all adults with care and support needs, regardless of whether the local authority provides any services for them. Therefore, in circumstances where we are working with adults who are not in receipt of services and it appears such services may be of benefit, it is necessary to consider if a Care Act Assessment, to identify care and support needs, is necessary.

3. Principles of Adult Safeguarding

Under the Care Act 2014 the Six Principles of Safeguarding are:[1]

1. **Empowerment**:
   People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention**:
   It is better to act before harm occurs.
3. **Proportionality**:
   The least intrusive response appropriate to the risk presented.
4. **Protection:**
   Support and representation for those in greatest need.
5. **Partnership**
   Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
6. **Accountability**
   Accountability and transparency in safeguarding practice.

4. Making Safeguarding Personal

> All safeguarding partners should "take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances, and lifestyles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised."
>
> Safeguarding "should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety."
>
> Care Act Statutory Guidance (2016), Sections 14.14 – 15.

'Making Safeguarding Personal' (MSP) promotes practice in which the perspective of the person involved in the enquiry is at the forefront of our interventions and decision-making. It moves away from paternalistic safeguarding practice which views the 'professional' as the expert. It looks to help those we work with identify the outcomes that they want, and which will help keep them safe.

[1] https://www.scie.org.uk/safeguarding/adults/introduction/six-principles

MSP is about full engagement with adults at risk. It means working successfully alongside them, and, as far as possible, being accountable to them and the people they may have asked to support them through the process.

In Practice, MSP means that:

- Conversations to figure out what the person wants to achieve should be evident from the start of the safeguarding interventions.
- Desired outcomes are negotiated, agreed, and clearly identified.
- We work with adults at risk (and their representatives where appropriate or advocates if they lack capacity) to understand how best outcomes might be realised.
- Desired outcomes are recorded and assessed at the end of our interventions.
- We consider, in the end, the extent to which desired outcomes have been realised.

The Care Act can be seen to have close alignment with the core values and principle of making safeguarding personal.

The table below explores and gives examples of how the principles enshrined within the Care Act can actively promote MSP.

Principle Enshrined in the Care Act	In Practice - How This Principle Can Inform MSP
1. Empowerment People being supported and encouraged to make their own decisions and give informed consent.	Conversations to determine what the person wants to achieve should be evident from the start of the safeguarding interventions and this directly informs interventions.
2. Prevention It is better to act before harm occurs.	Information should be shared about what abuse is, how to recognise the signs of abuse how to seek help and what to expect. Professionals working with the person should work in a preventive way to stop difficulties escalating and becoming a safeguarding issue. For example, a person who struggles with daily living who is self-neglecting.
3. Proportionality The least intrusive response appropriate to the risk presented.	Professionals should work in the person's interests, as they are seen, and will only get involved as much as needed. Decisions will not be made without consulting the person and or their representative.

4. Protection Support and representation for those in greatest need.	The person gets help so that they are able to take part in the safeguarding process as much as they want to.
5. Partnership Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.	Professionals will work with the person, their network, and the wider community to help find solutions to any safeguarding concerns that occur. Professionals will treat personal information sensitively and only shared when it is necessary and useful.
6. Accountability Accountability and transparency in delivering safeguarding.	Professionals working with the person will ensure that they are accountable by keeping them informed throughout the safeguarding process. Professionals will ensure accurate records are recorded. The person will be informed about the roles of everyone involved in my care. If a person refuses to cooperate with the safeguarding process but we proceed, the decision to override their wishes will be clearly

5. Carers and Safeguarding

Carers may be involved in situations that require a safeguarding response. This is not limited to but may include:

- Witnessing or speaking up about the suspected abuse or neglect of someone they care for.
- Experiencing intentional or unintentional harm from the adult they are trying to support.
- Concern of abuse or harm from professionals or organisations they are in contact with and who may support the cared-for person.
- Unintentionally or intentionally harming or neglecting the adult they support on their own or with others, the type of harm may fall into any of the categories of abuse discussed in later in this document.
- When risk increases in relation to the abuse of carers themselves.

When working with carers who are in situations where they are an alleged perpetrator, often a proportionate and caring approach is needed. This approach recognises that the risk of abuse increases when a carer is isolated and/or not getting the practical, emotional, or financial support they require. Professional judgement should always account for the cared-for person's situation, as well as the emotional and physical

impact of caring. If the cared-for person is the victim of alleged abuse, consideration should be given to the 3 point-test outlined in Section 7 (Who does adult Safeguarding apply to?).

If the threshold is met then a proportionate safeguarding response may be required, one which again considers the stress that both the cared-for person and the carer may be experiencing.

When a carer does not have care and support needs and is not eligible for a safeguarding response, a carer's assessment might be offered to help identify the needs of the carer. It is important to consider the carer support networks in the local area and what support may be available to the carer, in practice the emotional and practical support that can be offered by carers support networks can be invaluable in helping the carer cope with the stress of the caring role.

A needs or carer's assessment will enable us to explore the individual's circumstances and consider whether it would be possible to provide information or support that might reduce the chances of abuse or neglect from occurring.

Potential situations where abuse of carers is more likely include those where the person supported has health and care needs that exceed the carer's ability to meet them, and/or does not consider the needs of the carer or family members, further highlighting the importance of accurate assessment of care and support needs for the cared for person.

When working with a carer we should avoid stereotypes about the roles and responsibilities of the cared for person. It is important that our value base does not discriminate against a carer on the basis of gender, our own ideological beliefs, or attitudes towards the family. For example, we should not assume that it is a parent's role to look after their disabled sibling, that it is the partner's responsibility to look after their partner who is experiencing ill health.

It is important to recognise and be sensitive to the overwhelming worry stress and anxiety that the carer may be experiencing, this might be especially true when the caring role, developed from a progressive illness or disability and demands on the carer increase.

It is also important to recognise that the carer may be subject to complex behaviours and attitudes from the cared-for person. This may include:

- A belief that it is the carer's 'duty' and 'responsibility' to provide support. Such beliefs might have arisen out of personal and cultural beliefs and ideologies for example, a cared for husband may believe that it his wife's responsibility to care for him.
- Abusive and aggressive behaviour, this can often be in part caused by cognitive decline for example in the case of dementia.
- Control of the person's finances and financial resources.
- A rejection of help and support from outside, including respite
- Substance misuse.
- A cared-for person is angry about their situation and seeks to punish others for it.

6. Advocacy

Advocacy should always be discussed at the start of safeguarding interventions. Arrangements must be made for an independent advocate to represent and support the individual where they would have substantial difficulty in being involved in the process, and where there is no other suitable person to represent and support them. Consideration must be given to appointing an Independent Mental Capacity Advocate (IMCA) where an individual lacks capacity and it is alleged that he/she has been abused or neglected by another person, or he/she is abusing or has abused another person.

Our advocacy provider is POhWER. In LBWF, POhWER provide a range of mental health advocacy services. The services relevant to adults are:

- Independent Mental Health Advocacy (IMHA)
- Independent Mental Capacity Advocacy (IMCA),
- Care Act Advocacy (CAA)

Referrals can be made to POhWER via the following link: https://www.pohwer.net/waltham-forest

7. Who does adult Safeguarding apply to?

A Section 42 (Care Act 2014) Safeguarding enquiry relates to the duty of the local authority to make enquires or have others do so if an adult may be at risk of abuse or neglect. This happens whether the authority is providing any care and support services, or not, to that adult. It aims to decide what, if any, action is needed to help and protect the adult. These procedures also apply to people who pay for their own care and support services.

A Section 42 safeguarding referral may be progressed to an investigation when the council is satisfied that the person is eligible, and threshold is met.

It is important that Safeguarding thresholds are understood. [2]The Section 42 duty requires consideration of the following criteria under Section 42 (1) and (2) of the Care Act (2014):

S42 (1) Whether there is "reasonable cause to suspect" that an adult.

1. has needs for care and support.
2. is experiencing, or is at risk of abuse or neglect, and
3. as a result of their needs are unable to protect themselves

The is a referred to as the 'three-point test' throughout this guidance.

[2] s42-fwork-v-7-5-final-11-july.pdf (adass.org.uk)

The Responsible Authority

Where the three-point test is met the 'host' Local Authority is responsible for investigating safeguarding occurrences which are alleged to have taken place within the Local Authority regardless of the 'sponsoring authority' (If there is one) or place of residence.

Whilst guidance defines the Local Authority's responsibility for making safeguarding enquires, in practice there may be difficulties or issues that need to be resolved therefore some negotiation may be required between authorities. It is of importance that the safety of the individual is not compromised while these negotiations take place.

The table below explores which authority might be responsible for investigating Safeguarding concerns for an adult with care and support needs and highlights the sort of scenarios where difficulties or disagreements might arise.

Scenario	Authority responsible for progressing the Safeguarding Concern	Rationale	Case Example Learning
A young man with Learning Disabilities sponsored by Newham is subject to Hate Crime whilst traveling public transport in Waltham Forest	Waltham Forest	The incident took place in Waltham Forest; hence it is Waltham Forest Responsibility to progress the concern.	Close cooperation Should be sort with Newham in any subsequent investigation. With agreement elements of the Section 42 enquiry might be delegated to Newham, for example Newham might lead on a Making Safeguarding Personal conversation
An older person with care and support needs placed by Waltham Forest in supported living project in Essex has had money taken from their bank account.	Essex	Essex but please note If there is evidence that the fraudulent transaction took place in another borough for example, the alleged perpetrator visiting a bank in Waltham Forest to commit the fraudulent act, then there might be a compelling case for Waltham Forest to Investigate. Note this would also provide alignment with any Criminal investigation.	Sometimes it is necessary to negotiate the authority responsible, but agreement should always be sort

A young adult with a Physical disability is a resident in Waltham Forest, but not previously known, was subject to an assault by his brother whilst on holiday in Kent. Kent is refusing to accept the safeguarding referral, there are ongoing concerns about the safety of the young adult. Waltham Forest processed the initial referral	Kent, however, Waltham Forest until the issue regarding responsible authority is resolved.	The assault took place in Kent.	This example demonstrates disputes can occur. Until resolution is reached Waltham Forest should continue with the safeguarding process, as person should not be left at risk due to a dispute about the responsible body. Once Kent accept responsibility LBWF may be required to assess Care act need if required and/ or requested. It might be reasonable for Kent to request assistance with other elements of the Section 42 enquiry for example a making safeguarding personal conversation.

8. Safeguarding Roles

Enquiry Officer: An enquiry officer is responsible for undertaking actions under adult safeguarding. In some instances, there is a Lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional skills, and expertise is required.

Safeguarding Adults Manager (SAM): The SAM, or Lead, is the Local Authority member of staff who manages, makes decisions, provides guidance, and has oversight of safeguarding concerns that are referred to the Local Authority directly, or through the Mental Health team at the Northeast London Foundation Trust (NELFT)[3] where there are the above agreements in place.

[3] https://www.nelft.nhs.uk/

9. The Mental Capacity Act (2005) and Safeguarding

The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The MCA outlines five statutory principles that must underpin the work with adults who may lack mental capacity:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. 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.

At all stages of a safeguarding intervention, the adult's capacity to consent to any actions or decisions that are being made, must be considered. Where there is a concern that a person may lack capacity - and especially with important decisions - a Mental Capacity Assessment must take place by applying the two-stage test.

If the adult lacks capacity in relation to a decision(s) around the SA process or any actions that are proposed to be taken to safeguard the person (for example a change of accommodation, care plan amendments or restrictions on contact with others), then the Best Interests process must be robustly applied. A failure to apply the MCA appropriately, may result in an unlawful breach of the adult's human rights.

Please see the MCA code of practice for further guidance around applying the Act in Safeguarding Adults situations.[4]

[4] https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

10. Consent including Issues Around Mental Capacity

In almost all circumstances, consent should be established from the alleged victim if safe and practical to do so before progression from a safeguarding concern to a **Section 42 enquiry**.

When gaining consent there are there are four possible scenarios as follows:

Scenario 1 – There are no concerns regarding the alleged victim's capacity to consent to the safeguarding intervention and the person consents.

Case example - Mr Khan has referred himself to Adult MASH, expressing concerns that his son is stealing money from him. He is asking for help. He meets the 3-stage test, it is evident from conversation and records that he has capacity in respect of his referral.

Outcome – Proceed with the SA intervention/s42 enquiry.

Scenario 2 – There are no concerns regarding the alleged victim's capacity to consent to a safeguarding intervention, but the person refuses to give consent.

Case example – The neighbour of Ms Nowak is concerned that her daughter is using her mobility car for her own benefit. She reports this to the allocated social worker. Ms Nowak meets the 3-stage test. Ms Nowak is contacted by her social worker, but she does not consent to progressing the safeguarding concern, saying it is nobody's business. There are no concerns around the Ms Nowak's capacity.

Outcome – Follow Ms Nowak's request not to proceed with the SA intervention but emphasise that she may contact us again if she changes her mind about this situation.

Further guidance - Please note that in some cases where the person has capacity but refuses to consent, it may still be necessary to proceed with the safeguarding intervention. For example, if there is a public interest question as the allegation of abuse is against a paid staff member or a volunteer. In this instance, it is likely that the SA matter will need to progress even without the cooperation of the alleged victim as other service users could be affected. It is advised that the worker discusses these scenarios with their first line manager.

You should also be mindful that if a SA concern suggests that a crime may have been committed you should consider whether we have a duty to report it to the police. If in doubt, either contact the police for guidance or speak to your line manager.

Scenario 3 – There are concerns that the person lacks capacity to consent to the SA Process.

Case example – Mr Smith is known to Social Services and is in receipt of a care package. The home care agency that is working with him contact his allocated social worker regarding concerns of unexplained injuries (bruising). Mr Smith has been previously diagnosed with dementia. He is visited by his social worker, and he appears confused by the discussion and cannot explain how he got his bruises.

Outcome - The social worker assesses his capacity to consent to the safeguarding intervention using the two-stage test and concludes that, on the balance of probabilities, he lacks capacity to consent. She then uses

the Best Interests checklist/process and can demonstrate that it is in Mr Smith's best interests to investigate the matter further via the safeguarding process. Do not just assume that it is in the person's best interests to proceed without being able to justify how you reached this conclusion.

Please remember that if Mr Smith had an Attorney or Deputy for Health and Welfare, the Attorney or Deputy would make this decision.

Scenario 4 – It is considered not safe or appropriate at this stage of the referral to contact the alleged victim to gain consent.

Case example – Mr Chang has a physical disability. The police have contacted Adult MASH over fears that his flat has been taken over by local gangs for the purpose of selling and distributing drugs.

Outcome – Progress to a s42 enquiry and consult with multi-agency partners as appropriate. Develop a strategy for safe engagement with the alleged victim. Once safe contact has been made, consider consent to continue the process as in scenarios 1 to 3 above.

Adults should be encouraged to make their own decisions and should be provided with support and information to empower them to do so. This approach recognises that adults have a general right to independence, choice, and self-determination and that the alleged victim's wishes regarding the progression of a Safeguarding enquiry should be respected in most circumstances.

However, it is important to recognise that there may be genuine circumstances and concerns that prevent or discourage the victim from working with the practitioner. Examples might include:

- Concerns that an adult may be unduly influenced, coerced, or intimidated by another person and be frightened of reprisals.
- That adults may fear losing control of their own lives and they may not trust social services or other partners.
- That adults may fear that their relationship with the abuser will be damaged.
- That adults may fear that they will be put in care.

Where professional judgment indicates genuine concerns, reassurance, and appropriate support should be given. This may help to change the adult's view on whether to participate in the Safeguarding enquiry.

Where appropriate and where any attempted conversation is not putting the person at risk, it might be necessary for the practitioner to explore with the adult their concerns and what are they worried about. Such conversation could involve discussions around:

- Who you might be sharing information with and why? Reassuring them that in most circumstances the information will not be shared with anyone who does not need to know. Exceptional cases are discussed below.
- The possible benefits, to them or others, of participating. Could it help them access better help and support?
- The consequences of not participating in the process
- Reassure them that they are not alone, and that support is available to them.

11. Types of Abuse

There are ten categories of abuse described within the Care and Support Statutory Guidance. The 10 categories are:

1. Physical Abuse
2. Domestic Violence
3. Sexual Abuse
4. Psychological or emotional abuse
5. Financial or Material Abuse
6. Modern Slavery
7. Discriminatory Abuse.
8. Organisational or Institutional Abuse
9. Neglect and Acts of Omission.
10. Self-Neglect.

These categories cover a range of scenarios situations or behaviours. They are expansive and often involve scenarios where adults might be experiencing multiple sources of abuse. For example, an adult experiencing domestic abuse might also be subject to physical, sexual, and emotional abuse.

It is important to be knowledgeable that this list is the 10 categories of abuse recognised by the Care and Support Guidance. However, there are also other descriptions of abuse of adults which may fall into the above categories:

Female Genital Mutilation (FGM): is a specific form of physical (and psychological) abuse. FGM is a procedure where the female genitals are deliberately cut, injured, or changed, but where there's no medical reason for this to be done.

Honour Based Violence (HBV): is committed when families feel that dishonour has been brought upon them. It will usually be a criminal offence and referring to the Police should always be considered. Women are predominantly (but not exclusively) the victims, and the violence is often committed with a degree of collusion from family members and/or the community.

Mate Crime: The Safety Net Project define this as occurring "when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. It may not be an illegal act but still has a negative effect on the individual."

Radicalisation. Radicalisation is comparable to other forms of exploitation, such as grooming and Child Sexual Exploitation. It is the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups. Radicalisation is process rather than an event, and there is no single profile or pathway by which someone can be drawn into terrorism.

Cuckooing The practice of taking over the home of a vulnerable person in order to establish a base for illegal drug dealing, typically as part of a county lines operation.

In Appendix A to this document, you can find an expansive description of each type of abuse, accompanied by common signs and indicators. It is adapted from the Types and Instances of Abuse as listed by the Social Care Excellence Institute.

12. Timescales

Timescales for conducting safeguarding investigations are incredibly important.

We recognise the value of a personalised approach to protecting adults at risk, recognising that no two scenarios are the same and that complex enquires may take longer to conclude. However, it is critical that practitioners take timely action. There are few justifications for not addressing an initial safeguarding concern and deciding what pathway needs to take place to keep the person safe.

Timescales are monitored. Where times scales are not met, practitioners will be expected to provide evidenced justification for why this is so.

Circumstance where divergence from target timescales could take place might include where:

- Levels of risk may be high, which requires coordinated and complex multidisciplinary enquiry.
- Identified outcomes are not achievable within indicative time scales.
- A person's physical, mental, or emotional state may be compromised.
- The outcome is dependent on other processes. For example, NHS Serious Incidents, or the outcome of organisational enquires.

Please note, the closure of safeguarding interventions is not necessarily dependent on the outcome of other investigations, such as police enquires, organisational enquires and serious case reviews. Safeguarding interventions can be closed when we are satisfied that the person is safe and agreed outcomes are met.

Stage and Tasks	Indicative Time Scales	Notes
Concern Stage:		
1. Initial Risk Assessment	Immediate Action in case of an emergency, within one working day in other cases	
Section 42 Stage:		
1. Allocation to SAM and Enquiry Officer	Same Day Section 42 is sent to receiving team or raised to allocated Team.	If a dispute arises regarding Allocation, the receiving team must continue with the process whilst resolution is sort (See Section *Allocation of Safeguarding Work, the responsible team and dispute resolution).

2. Review of Immediate Safety Plan and additional Actions	To take place on the same day that the Section 42 is received.	Review of initial safety plan Triage of Section 42 should take place.
3. Initial Contact Enquiry officer to make Initial Introduction within 48 hours of Section 42 being received.	Within 2 working days of allocation.	Note where there are concerns regarding safety immediate action should be taken to address concerns.
4. MSP Conversation.		No Notes
5. Enquiry Plan, Safeguarding Plan	Within 3 working days of allocation.	Please note that the safeguarding Plan is an evolving document and may be modified and updated as the safeguarding enquiry progresses
6. Enquiry Actions	Within 5 working days of allocation.	
7. Review When Required	Within 20 Working Days of Allocation A review must take place for any safeguarding open more than 28 Calendar Days.	
Stage Three: Safeguarding Plan & Review		
1. Review and closure	Within 3 Calendar Months of allocation	Dispute Resolution

Allocation timescales process and dispute resolution

An adult safeguarding concern will normally be generated by concerns raised directly to Adult Mash or Via the Adult Front Door as a result of concerns that practitioners become aware of concerns in their day-to-day work.

With regards to concerns raised to the Adult MASH Team. If the person at risk is already open to a team, then the concern will be recorded and progressed to the relevant team at the concern stage to enable decision to be made to if the concern needs to be progressed to a Section 42 enquiry. In these circumstances the team to which the person is open to will progress the concern and make the decision regarding progression to Section 42 Enquiry. The exception here is the ACMT whereby Adults MASH will screen the Stage one concern.

Where the person at risk is not known to LBWF, or not open to a team then the safeguarding concern will be processed, and a decision will be made to if the circumstances require a section 42 enquiry by the adult MASH team. If eligibility is met for progression to a section 42, then the person at risk will be allocated to the team which most closely matches the persons presenting care and support needs. For example, if the person at risk primary support needs relate to the persons mental health, then the person will be allocated to the Relevant Mental Health Team. In all scenarios the concern should be progressed with a day of it being received.

Where a safeguarding concern is raised or generated directly to a team which the person is open to then the responsible team will process the safeguarding concern.

Where a person is in a hospital environment the Safeguarding concerns will be dealt with by the hospital either by the team the person is allocated to or if unallocated by the hospital team.

Dispute Resolution

It is recognised that sometimes there may be disputes regarding responsible team for Section 42 enquires. Such disputes should not in any circumstances delay safeguarding interventions and regardless of the dispute the receiving team should undertake a Review of Immediate Safety Plan and consider any additional Actions to address immediate safety within 48 hours of the initial referral. Where a dispute exists the responsible team managers should in the first instance try to agree local resolution, when it is not possible to agree resolution then the issues should be escalated to Service manager level for resolution to be made.

13. Reaching your Conclusion

When reaching your conclusion to the Safeguarding Enquiry you will need to complete the conclusion for authorisation by your manager. It is important that your conclusion is evidenced based, and fact and opinion are clearly highlighted. It is common that the safeguarding enquiry record is produced as evidence in Court and Criminal proceedings. In conclusion of the Safeguarding Enquiry, it is also accepted that the alleged perpetrator may also request sight of the outcome of the enquiry and rationale for the conclusions reached.

Outcome Definitions

Substantiated – A situation where "on the balance of probabilities" it was concluded that the allegation(s) made against the individual or organisation believed to be the source of the harm or neglect were proved.

Where there are several allegations of abuse raised in the one safeguarding episode/concern, all will need to be proved for it to be defined as fully substantiated.

Partially Substantiated - This refers to situations where there is more than one concern raised in a safeguarding referral, this can both be in relation to an individual or an organisation. An outcome of partially substantiated will be appropriate where 'on the balance of probabilities' it was concluded that one or more, but not all, of the alleged concerns where proven. So, for example, if a perpetrator was accused of stealing money and the physical abuse of an individual and the investigation concluded that 'on the balance of probabilities' only the theft was substantiated, then the conclusion would be Partially substantiated.

Inconclusive - This refers to cases where there is insufficient evidence to allow a conclusion to be reached. This will include cases where, for example, where there are no witness of an alleged abuse or alternative records which document the alleged abuse.

Not substantiated - This refers to cases where "on the balance of probabilities" the allegations are unfounded, unsupported or disproved.

Investigation ceased at individual's request- This refers to cases where the individual at risk does not wish for an investigation to continue. This conclusion is less likely if we give due consideration to Making Safeguarding Personal with the individual at the start of the process.

14. Working with Self Neglect

Under the Care Act (2014) statutory guidance – self-neglect is included as a category of abuse under adult safeguarding. Although it has no statutory definition, it might be considered as a serious lack of self-care. The National Institute for Health and Care Excellence (NICE) define self-neglect as a wide range of behaviours where a person neglects to care for their personal hygiene, health or surroundings. Self-Neglect is also often associated with hoarding, and also with an increased fire risk (see below). There may be a number of reasons why adults self-neglect and these include drug and alcohol addictions, mental health issues and physical health issues. Self-neglect can present a serious risk to an adult's health and safety as well as their mental and physical wellbeing.

A person who self neglects may be eligible for professional safeguarding intervention if they have care and support needs and as result of those care and support needs are unable to protect themselves.

Self-neglect can be a difficult area for practitioners to navigate and there is a fine balance to be achieved between respecting a person's self-autonomy and enacting or fulfilling statutory safeguarding duties. Successful interventions and outcomes are often only achieved after long and careful engagement. 'People skills' are of importance, and this often means adopting a down to earth, friendly, and caring approach to our work.

It is important to recognise from the onset that adults who self-neglect may be embarrassed by failures and/or the formalities of a safeguarding process. Subsequently, people may disengage and shy away from working with the practitioner and the wider network. It is therefore of great importance that care is taken to build the relationship with and trust of the individual, and to consider the value of safeguarding interventions and what they may achieve.

There are scenarios whereby a formal Section 42 process may not be conducive to engagement with the individual especially where an individual who self-neglects does not consent to the process. However, there are situations where practitioners may identify serious concerns when an adult refuses support of services but is viewed to be at great risk. They may need to be safeguarded through statutory interventions, while respecting the person's autonomy and empowering them to make choices in line with the Making Safeguarding Personal approach.

For people who do not consent, safeguarding interventions may not bring value. It is important that we do not abandon people or use the notion of having capacity as a justification for not intervening. Having capacity to decline safeguarding interventions does not mean that we walk away. If anything, it should make us focus more on how we might engage and work alongside the individual.

Working in collaboration with others in a multi-agency approach, sharing information, ideas and analysis can achieve better outcomes for the individual.

Waltham Forest's key principles and considerations for working with adults whom self-neglect are as follows:

1. **The Person is at the Centre of their Care and Support.**
    - The person's views and wishes must always be valued.
    - Listen to them and work towards the outcome they want.
    - They should be informed at every step of the process.
    - Be mindful of fluctuating capacity.

2. **Do Not Walk Away – Walk Alongside.**
    - People who self-neglect can find it difficult to engage with agencies. Keep persevering; take time to build a trusting relationship.
    - Work with them to help themselves.
    - Explore alternatives. Fear of change may be an issue so explaining that there are alternative ways forward may encourage the person to engage.
    - Always go back. Regular, encouraging engagement and gentle persistence may help with progress and risk management.

3. **Multi-Agency Approach**
    - Include other agencies and organisations at all points of support.
    - Who else is involved?
    - Who needs to be involved?
    - What information is held by others and/or is required?
    - Be guided by "A guide to thresholds and practice for working with adults, carers and families in Waltham Forest."

4. **Think Family**
    - What impact is the person's behaviour having on the people around them?
    - What impact are other people in the family having on the person self-neglecting.
    - Is there anyone else at risk?

5. **Think Family, Think Community and Wider than Statutory Services.**
    - Engage community, friends, and family.
    - Speak to neighbours or any one the individual may interact with.
    - Are there any voluntary/community organisations who could offer support?

6. **Build Trust**
    - Form a relationship, start conversations to get to know the person rather than immediately focusing on the issues.
    - Keep communication consistent.
    - Provide reassurance. The person may fear losing control, so it is important to allay such fears.
    - Agree to small steps.

7. **Respect**
    - Understand the persons background, it may be possible to identify underlying causes that help to address the issue.
    - Treat the person with respect and dignity.
    - Be non-judgemental – respect everyone.

Further guidance is available to practitioners in a document entitled Self-Neglect Multi-Agency Guidance published by Waltham Forest Safeguarding Adult Board (Nov 2019). This document offers detailed guidance to practitioners for working with people who are difficult to engage. The guidance emphasises the importance of multi-agency work, communication, escalation, risk assessment.

15. Fire Safety

Introduction

There are a number of Safeguarding Adult Reviews' involving death or serious injury by fire identified each year. The reviews often highlight common themes which may have contributed to the death or serious injury for example that practitioners are not always confident at understanding or recognising fire risk and/or that there is a lack of Multiagency policy and procedure specific to addressing Fire Safety. Self-neglect and hoarding are often contributory factors.

Recognising Fire Risk

Practitioner's whilst undertaking any social work duties should be alert to fire risk and know how to respond. For example if on a visit of you notice cigarette burns, a lack of fire alarms fitted, the person cared for is suffering cognitive decline and the person is on medication that might impede the ability to respond to a fire, then a fire risk would be indicated and a referral to LFB would be necessary. (See appendix 2

The Policy

The policy creates a process for:

- Identifying fire risk
- Responding to fire risk.
- Referrals to LFB.
- Sharing information about fire risk with LFB
- Monitoring of the referrals made.
- The Escalation of 'high risk cases.'

The Process

Identification of Fire Risk

In review, assessment and safeguarding forms constitute a simple risk assessment, which will help identify fire risk. The risk assessment takes less than 10 mins to complete.

Responding to fire risk - Referral to LFB

When a fire risk is identified, a referral will then be made to LFB, LFB will normally visit within 24 hours of the referral and offer fire safety advice and support.

Sharing information about fire risk with LFB Monitoring of outcomes.

Data collection points are being written into the Mosaic program which will capture the following details:

- Name of person at risk
- Social worker making the referral.
- Date of the referral.
- What triggered the referral, i.e., assessment review, safeguarding concern, etc.

This data will be shared with LFB and reviewed on a regular basis,

Escalation Policy

For cases where fire risk remains, and risk is judged to be high, further work should take place with the person at risk. The fire service, and other relevant authorities, attempt to lower or prevent risk of fire.

The nature of further work is not prescribed but should be guided by the adult at risk. However, in most circumstances where there is fire risk, self-neglect will be evident, self-neglect policy and guidance should be consulted and consideration given to instigating the adult safeguarding process.

Where risks are judged to be high, we need to be mindful that there are most likely to be 'wider public interests' - fire risks are likely to extend to those living with the person that presents the risk, those living in the vicinity of the risk, and to emergency services who might be called to attend a fire.

16. Organisational Safeguarding

Organisational safeguarding is usually a combination of contributory factors, such as:

- a lack of training and support for staff
- Inadequate processes and procedures.
- Insufficient supervision and management
- A lack of safer recruitment practices

There are many reasons why an organisation may move into a safeguarding process.

Threshold

Where there are 'Major' levels of risk which indicate that people who use the service are not protected from harm and/or the provision does not meet the quality and safety standards defined by the quality assurance team a decision may be made to initiate a formal organisational safeguarding process.

Major levels of risk might be indicated by such things as

- Multiple Safeguarding Alerts
- A Death or serious injury related to a service user.
- CQC enforcements or judgements
- Complaints

- Any combination of the above.

When the decision is made to instigate the organisational concerns process, intensive, and complex interventions take place following an organisation concerns process. The oversight of organisational safeguarding concerns is managed by the Adult Safeguarding Team.

The work involves four distinct phases and an optional review stage.

1. **The First Stage** involves a decision being made to initiate the provider concern process.

The first stage is typically triggered by concerns or issues of a serious nature where a high level of risk is identified. Non-exhaustive examples include:

- Continuous/multiple Safeguarding alerts.
- CQC concerns around practice and the safety and welfare of residents.
- Contractual compliance. For example, repeated missed visits, failure to provide double handed care and/or failure to provide services.
- Fraud allegations.
- Whistleblowing.
- Where a resident may be at risk of being made homeless.
- Complaints from neighbours, Councillors, and other stakeholders

At the first stage, consideration will be given to the immediate safety of residents and risk management. Section 42 work related to the organisational safeguarding concern is identified and work will begin to ensure that the any related section 42 work is co-ordinated to prevent duplication of work. At this stage coordination of individual fact finding starts to take place with integrated commissioning.

2. **The Second Stage** involves an initial Provider Concern Meeting.
   This meeting can be integrated into the High-Risk panel meetings or can involve a separate meeting where interventions cannot be delayed or there is a need for focused and/or large groups to meet.

   The purpose of an initial Provider Concerns Meeting is to start to evaluate the concerns and consider actions which may contribute and support fact finding enquires. Consideration will be given to communication and consultation with other partners such as CQC and health.

   A quality assurance strategy will then be developed. This is normally linked to a continuous improvement plan. Consideration is given regarding communication with people who use the service and how to ensure their safety.

   Examples of actions and fact finding enquires resulting from the provider concerns meeting may include:

   - Unannounced Visits
   - Announced Visits
   - Referral to other agencies
   - Staff Questionnaire
   - Interviewing Whistle Blowers

- Assessment of documents

3. The **Third Stage** involves Consultation with providers through a Findings Meeting.

   At this stage, fact finding enquires will robustly evidence issues of concern, and these will be incorporated into a continues improvement plan (CIP).

   The purpose of the Findings Meeting is to communicate issues of concern with providers with the instruction that the provider develop a plan to address the concerns.

   Other relevant organisations will be invited to the findings meeting typically this may involve sponsoring authorities, CQC and health.

   Findings Meetings may involve subsequent review meetings where issues are complex and there is a need to review progress.

   Findings Meetings always aim to seek consensus and agreement around issues and problems with the provider. Successful outcomes are most likely when there is broad agreement from all parties with regards to the nature of concerns what actions need to take place to mitigate the concerns and support improvement.

4. **The Fourth and Final Stage** of the process is Closure.

   Upon evidence of sustained and continued improvement through the quality assurance process, the process will come to an end.

   If improvement was not sustained, other actions such as suspension of services may result.

17. Feedback

This section considers feedback that should be given to refers, other professionals, and alleged perpetrators. It should be a given and a key principle that the adult at risk is given feedback throughout the whole enquiry.

Feedback gives assurance that actions have been taken to address concerns. It helps us be accountable for the actions we take and give those involved a chance to respond to any concerns that they may have about the safeguarding intervention.

Feedback needs to take account of data protection legislation. This legislation is expansive and beyond the scope of this guidance however some key points are considered.

A more in-depth guide can be found here.

https://www.scie.org.uk/safeguarding/adults/practice/sharing-information

Gaining Consent to share information.

If the adult at risk has capacity, their informed consent should be sought before sharing information with the person allegedly responsible. However, where the sharing of information to prevent harm is necessary, lack of consent to information sharing can be overridden.

It is important to be forthright with the adult concerned that whilst we will treat information sensitively and, on a need-to-know basis but we cannot ensure confidentiality.

Feedback to other Professionals

There are few grounds for not sharing information with other professionals, in most cases it will be essential in terms of the safeguarding process.

Where the person involved has the mental capacity to make the decision and does not want their information shared with others this would only be permitted in a number of circumstances

- Risk does not extend to others.
- No crime is alleged.
- No staff are implicated.
- No coercion or duress is suspected.
- The public interest served by disclosure does not outweigh the public interest served by protecting confidentiality.
- The risk is not high enough to warrant a multi-agency risk assessment conference referral.
- No other legal authority has requested the information.

Feedback to Referrers – Non-professionals

Feedback to referrers needs to take account of confidentiality and the requirements of data protection legislation. If the adult at risk has capacity, their informed consent should be sought before sharing information. It is worth being mindful that often all that is required is assurance that the concern will be taken seriously and investigated accordingly.

Feedback to persons that have alleged to cause harm.

Feedback to people who are alleged to have caused harm should follow the principles of natural justice. 'Natural justice' is a technical term for the rule against bias and the right to a fair hearing.

The principles of natural justice also need to be considered in line with the overriding aims of the safety of the individual and the requirements of GDPR and where the sharing of information to prevent harm is necessary, lack of consent to information sharing can be overridden. Tis accounts that is may be a necessary requirement of a safeguarding enquiry to put information to the person allegedly responsible, where it has not been possible to obtain consent to this.

An evaluation should be carried out as to whether it is safe to share information about the complaint with the person allegedly responsible.

Providing information on the nature and outcomes of concerns to people alleged to have caused harm also needs to be seen in the wider context of prevention. For example, information can be used to support people to change or modify their behaviour.

18. Safeguarding Reports and Returns

Within the Mosaic process, data from safeguarding intervention is gathered. The reasons for this are primarily related to the need to monitor safeguarding intervention and detect patterns of abuse. Secondly, it ensures that the council is able to fulfil its statutory obligations in relation to safeguard reporting.

It is essential that data that is recorded on Mosaic is accurate against data collection points. If this is not the case, not only could it lead to inaccurate reporting, but it could also prevent the council from spotting patterns of concern. This is especially true of safeguarding concerns against providers; without accurate records it is very difficult to identify patterns of abuse which may indicate provider failings.

Be aware that the data covers a wide range of statistics and information and can also be used to audit safeguarding interventions. For example, the length of time that work is taking.

Data collected includes monitoring of:

- Date of Concern.
- Date passed to Section 42.
- MSP Outcomes.
- Outcome of Section 42s.
- Name of Enquiry officer.
- Where there are fire safety concerns.
- Personal details of service user.
- Name of alleged perpetrator, if known.
- Details of any organisation for which organisational concerns are raised.
- Type of alleged abuse.
- Outcomes of alleged abuse.
- Time scales.
- Responsible team.

19. Proportionality and Extenuating Factors

Whilst in most circumstances eligibility should be clear, occasionally there may be extenuating factors or issues which might suggest that a safeguarding response would not be proportional or appropriate. In these circumstances it might be helpful to be mindful of the guidance given by the Care act Care and support guidance

14.14 In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances, and lifestyles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

This supports that safeguarding interventions should be person-led and outcome-focused and it engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances their life, accordingly in some scenarios a formal safeguarding enquiry may not be the most constructive approach or lead to the best outcomes.

Intent should be considered, where there is no intent to cause harm, it is often the case that dealing with the factors that led to the harm taking place will prevent future harm.

Level of risk is also an important consideration, where levels of risk are high then there would be a lesser justification for not following a formal process.

The following are examples where dilemmas might occur.

- Where a person self neglects and a safeguarding intervention might be seen as intrusive and be a distraction from working with the person to prevent self-neglect, in this scenario a more successful intervention might be achieved from intensive work with the individual, but this should account for levels of risk.
- Carer who are struggling to provide support for a cared for person resulting in concerns of neglect for the cared for person. In this case a Care act needs assessment (For carer and cared for person) person might be a more desired approach
- A cared for person is injured as a result of an informal carers dropping the person when transferring to bed. In this case an OT assessment and a carers assessment

Where there are extenuating factors that suggest a formal safeguarding approach is not desirable, this should be discussed and clear and defendable rational recorded on the SGA concern form, which clearly states alternative interventions and a review date. A line manager should always be involved in such decisions.

21. Appendix A: Types of Abuse

Abuse Definition	Types/Description	Signs and Indicators
Physical Abuse	Assault, Rough handling. Scalding and burning. Physical punishments. Inappropriate or unlawful use of restraint.	No explanation for injuries or inconsistencies within the account of what happened. Injuries are inconsistent with the person's lifestyle.

	Making someone purposefully uncomfortable (e.g., opening a window and removing blankets). Involuntary isolation or confinement. Misuse of medication (e.g., over-sedation). Forcible feeding or withholding food. Unauthorised restraint, restricting movement (e.g., tying someone to a chair).	Bruising, cuts, welts, burns and/or marks on the body or loss of hair in clumps. Frequent injuries. Unexplained falls. Subdued or changed behaviour in the presence of a particular person. Signs of malnutrition. Failure to seek medical treatment or frequent changes of GP.
Domestic Violence	Domestic violence and abuse include any incident and/or pattern of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been, between intimate partners or family members regardless of gender or sexuality. It also includes so called 'honour-based' violence, female genital mutilation and forced marriage.	Low self-esteem. Feeling that the abuse is their fault when it is not. Physical evidence of violence such as bruising, cuts, broken bones. Verbal abuse and humiliation in front of others. Fear of outside intervention. Damage to home or property. Isolation – not seeing friends and family. Limited access to money. Coercive or controlling behaviour is a core part of domestic violence. Coercive behaviour can include: Acts of assault, threats, humiliation, and intimidation. Harming, punishing, or frightening the person. Isolating the person from sources of support. Exploitation of resources or money. Preventing the person from escaping abuse. Regulating everyday behaviour.
Sexual Abuse	Rape, attempted rape, or sexual assault. Inappropriate touch anywhere. Non-consensual masturbation of either or both persons. Non-consensual sexual penetration or attempted penetration of the vagina, anus, or mouth. Any sexual activity that the person lacks the capacity to consent to. Inappropriate looking, sexual teasing or innuendo or sexual harassment. Sexual photography or forced use of pornography or witnessing of sexual acts. Indecent exposure.	Bruising, particularly to the thighs, buttocks and upper arms and marks on the neck. Torn, stained, or bloody under garments. Bleeding, pain or itching in the genital area. Unusual difficulty in walking or sitting. Foreign bodies in genital or rectal openings. Infections, unexplained genital discharge, or sexually transmitted diseases. Pregnancy in a woman who is unable to consent to sexual intercourse. The uncharacteristic use of explicit sexual language or significant changes in sexual behaviour or attitude. Incontinence not related to any medical diagnosis.

		Self-harming. Poor concentration, withdrawal, sleep disturbance. Excessive fear/apprehension of, or withdrawal from, relationships. Fear of receiving help with personal care. Reluctance to be alone with a particular person.
Psychological or emotional abuse	Types of psychological or emotional abuse. Enforced social isolation – preventing someone accessing services, educational and social opportunities and seeing friends. Removing mobility or communication aids or intentionally leaving someone unattended when they need assistance. Preventing someone from meeting their religious and cultural needs. Preventing the expression of choice and opinion. Failure to respect privacy. Preventing stimulation, meaningful occupation, or activities. Intimidation, coercion, harassment, use of threats, humiliation, bullying, swearing or verbal abuse. Addressing a person in a patronising or infantilising way. Threats of harm or abandonment Cyber bullying.	An air of silence when a particular person is present. Withdrawal or change in the psychological state of the person. Insomnia. Low self-esteem. Uncooperative and aggressive behaviour. A change of appetite, weight loss/gain. Signs of distress: tearfulness, anger. Apparent false claims, by someone involved with the person, to attract unnecessary treatment.
Financial or Material Abuse	Theft of money or possessions Fraud, scamming. Preventing a person from accessing their own money, benefits, or assets. Employees taking a loan from a person using the service. Undue pressure, duress, threat, or undue influence put on the person in connection with loans, wills, property, inheritance, or financial transactions. Arranging less care than is needed to save money to maximise inheritance. Denying assistance to manage/monitor financial affairs. Denying assistance to access benefits. Misuse of personal allowance in a care home.	Missing personal possessions. Unexplained lack of money or inability to maintain lifestyle. Unexplained withdrawal of funds from accounts. Power of attorney or lasting power of attorney (LPA) being obtained after the person has ceased to have mental capacity. Failure to register an LPA after the person has ceased to have mental capacity to manage their finances, so that it appears that they are continuing to do so. The person allocated to manage financial affairs is evasive or uncooperative. The family or others show unusual interest in the assets of the person.

	Misuse of benefits or direct payments in a family home. Someone moving into a person's home and living rent free without agreement or under duress. False representation, using another person's bank account, cards, or documents. Exploitation of a person's money or assets, e.g., unauthorised use of a car. Misuse of a power of attorney, deputy, appointee ship or other legal authority. Rogue trading – e.g., unnecessary, or overpriced property repairs and failure to conduct agreed repairs or poor workmanship.	Signs of financial hardship in cases where the person's financial affairs are being managed by a court appointed deputy, attorney, or LPA. Recent changes in deeds or title to property. Rent arrears and eviction notices. A lack of clear financial accounts held by a care home or service. Failure to provide receipts for shopping or other financial transactions carried out on behalf of the person. Disparity between the person's living conditions and their financial resources, e.g., insufficient food in the house. Unnecessary property repairs.
Modern Slavery	Human trafficking. Forced labour. Domestic servitude. Sexual exploitation, such as escort work, prostitution, and pornography. Debt bondage – being forced to work to pay off debts that realistically they never will be able to.	Signs of physical or emotional abuse. Appearing to be malnourished, unkempt or withdrawn. Isolation from the community, seeming under the control or influence of others. Living in dirty, cramped, or overcrowded accommodation and or living and working at the same address. Lack of personal effects or identification documents. Always wearing the same clothes. Avoidance of eye contact, appearing. Frightened or hesitant to talk to strangers. Fear of law enforcers.
Discriminatory Abuse.	Unequal treatment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, and belief, sex, or sexual orientation (known as 'protected characteristics' under the Equality Act 2010). Verbal abuse, derogatory remarks or inappropriate use of language related to a protected characteristic. Denying access to communication aids, not allowing access to an interpreter, signer, or lip-reader.	The person appears withdrawn and isolated. Expressions of anger, frustration, fear, or anxiety. The support on offer does not take account of the person's individual needs in terms of a protected characteristic.

	Harassment or deliberate exclusion on the grounds of a protected characteristic. Denying basic rights to healthcare, education, employment, and criminal justice relating to a protected characteristic. Substandard service provision relating to a protected characteristic	
Organisational or Institutional Abuse	Discouraging visits or the involvement of relatives or friends. Run-down or overcrowded establishment. Authoritarian management or rigid regimes. Lack of leadership and supervision. Insufficient staff or high turnover resulting in inadequate care. Abusive and disrespectful attitudes towards people using the service. Inappropriate use of restraints. Lack of respect for dignity and privacy. Failure to manage residents with abusive behaviour. Not providing adequate food and drink, or assistance with eating. Not offering choice or promoting independence. Misuse of medication. Failure to provide care with dentures, spectacles or hearing aids. Not taking account of individuals' cultural, religious, or ethnic needs. Failure to respond to abuse appropriately. Interference with personal correspondence or communication. Failure to respond to complaints.	Lack of flexibility and choice for people using the service. Inadequate staffing levels. People being hungry or dehydrated. Poor standards of care. Lack of personal clothing and possessions and communal use of personal items. Lack of adequate procedures. Poor record-keeping and missing documents. Absence of visitors. Few social, recreational, and educational activities. Public discussion of personal matters. Unnecessary exposure during bathing or using the toilet. Absence of individual care plans. Lack of management overview and support.
Neglect and Acts of Omission.	Failure to provide or allow access to food, shelter, clothing, heating, stimulation, and activity, personal or medical care. Providing care in a way that the person dislikes. Failure to administer medication as prescribed. Refusal of access to visitors. Not taking account of individuals' cultural, religious, or ethnic needs.	Poor environment – dirty or unhygienic Poor physical condition and/or personal hygiene. Pressure sores or ulcers. Malnutrition or unexplained weight loss. Untreated injuries and medical problems. Inconsistent or reluctant contact with medical and social care organisations. Accumulation of untaken medication.

	Not taking account of educational, social, and recreational needs. Ignoring or isolating the person. Preventing the person from making their own decisions. Preventing access to glasses, hearing aids, dentures, etc. Failure to ensure privacy and dignity.	Uncharacteristic failure to engage in social interaction. Inappropriate or inadequate clothing.
Self-Neglect.	Lack of self-care to an extent that it threatens personal health and safety. Neglecting to care for one's personal hygiene, health, or surroundings. Inability to avoid self-harm. Failure to seek help or access. Services to meet health and social care needs. Inability or unwillingness to manage one's personal affairs.	Very poor personal hygiene. Unkempt appearance. Lack of essential food, clothing, or shelter Malnutrition and/or dehydration. Living in squalid or unsanitary conditions. Neglecting household maintenance. Hoarding. Collecting a large number of animals in inappropriate conditions. Non-compliance with health or care services. Inability or unwillingness to take medication or treat illness or injury.

22. Appendix B - Recognising fire risk

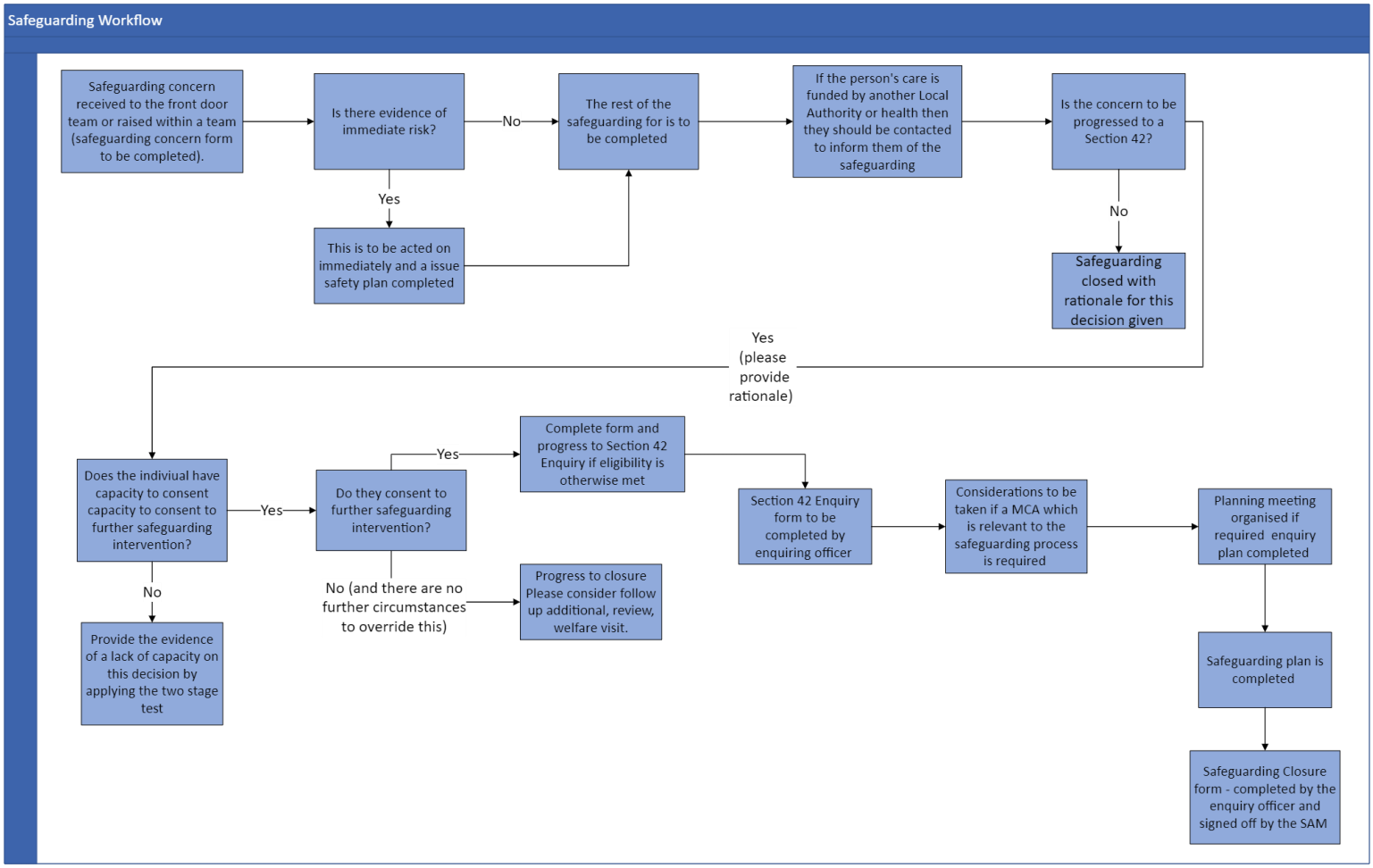
Recognising Fire Risk

Increased fire risk might be indicated by

- **Smoking**
- Signs might include:
- Burns on carpets, furniture, bedding and clothing Evidence of smoking in bed. Carelessly discarded cigarettes or matches. Overflowing ashtrays Lighters or matches within the reach of children.
- **Physical Impairment/Limited Mobility/Reduced Manual Dexterity**
- Whilst a person with a physical impairment may not be at greater risk from a fire if a fire should occur, they may be slow or unable to vacate the property in a safe and timely manner it is also likely that reduced manual dexterity may increase the likelihood of a fire, particularly from smoking or other.
- **Drug and Alcohol Dependency/Misuse**
- This Might impair the person ability to react to a fire or impair judgement which might lead to a fire occurring.
- **Use of prescribed medication**
- Prescription medication such as sleeping pills and certain antidepressants can increase the risk of a fire starting particularly if the individual is a smoker.
- **Mental Ill Heath**
- More serious diagnosed conditions may lead to stronger medication, and more propensity to consume alcohol, non-prescription drugs and smoking. In some more serious conditions symptoms can include fire setting behaviours.
- **Dementia**

- Dementia is a progressive brain disease that means a person's ability to recognise fire saft or risk is reduced, may increase the likely hood of devices being left on which may cause fire.
- **Hoarding**
- Hoarding in itself can often increase fire loading within a property, block exit routes which would reduce the ability to exit in a safe make it more difficult and dangerous to attempt a rescue by emergency personal.
- **Heaters and Open Fires**
- A number of injuries and fire deaths relating to inappropriate use of portable heaters and / or poor regard to being in close are known to the fire service.
- Proximity to an open fire, (gas, electric or solid fuel).
- **Learning Disability**
- A learning disability may inhibit a person's ability to make safe decisions they may not remember or retain safety information which could affect their ability to respond to fire and exit in a safe and timely manner.
- **Sensory Impairment**
- A person with a sensory impairment may require specialist equipment to ensure that they are able to respond to fire risk for example flashing strobes and vibrating pillow pads.
- The need for clear escape routes is particularly important for people with visual impairments as they may not be able to see escape routes.
- **Inappropriate use of or unsafe electrical appliances**
- Overloaded sockets and faulty electrical appliances are a major cause of fire.
- **Emollient creams**
- Many emollient creams are paraffin based and the use of such creams can result in bedding, dressings and clothing becoming impregnated with paraffin. These items can easily ignite when bought into contact with naked flames.
- i.e., smoking, candles, gas fires and cookers
- **Use of medical oxygen**
- Oxygen is highly explosive when exposed to naked flame or dirt and grease. The oxygen rich atmosphere stays within clothing and furnishings creating an increased risk of rapid fire spread which is a particular risk for smokers.
- **Living alone**
- Analysis of accidental house fires shows that people who live alone are more at risk from fire.
- **Does the property have a working smoke detector?**
- LFB recommend that all homes have a working smoke detector on each level.

22. Appendix C: Flow Chart Safeguarding Workflow



23. Appendix D: Flow Chart Organisational Safeguarding