Diogelu Gwent
Gwent Safeguarding

ADULT SAFEGUARDING

GUIDANCE

TO REPORT OR NOT TO REPORT

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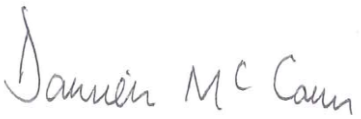
Preface

All statutory and non-statutory partners of the Gwent Safeguarding Boards are currently working in extremely challenging and unusual times during the Covid-19 pandemic. As such we recognise the need to support staff in fulfilling their roles and function with regard to safeguarding people. There will be many staff working in unfamiliar roles who will not have the knowledge and expertise that that role would normally hold.

This guidance is aimed at supporting staff in their decision making. This has been designed in a way that it can be added to as forms and risk assessments are developed and as such we ask that staff access this document via the Gwent Safeguarding page as this is liable to change.

https://www.gwentsafeguarding.org.uk/en/Home.aspx

Thank you to all for your commitment to safeguarding people during this difficult time.



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Torfaen

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Introduction

It is widely acknowledged that practitioners and service providers work tirelessly to support the most vulnerable people in our communities, sometimes in challenging situations. Unfortunately, during the course of this work there will be occasions that give rise to concerns about the safety of the adults they work with. It is crucial that all agencies know what to do when they identify or suspect that an adult is at risk of abuse or neglect and pro-actively contribute to preventing harm and abuse occurring or escalating. Deciding when a safeguarding concern should be referred to the Local Authority and understanding how concerns could or should be managed is not always clear.

In order to provide regional guidance and consistency, the following 'Adult Safeguarding 'To Report or Not To report' document' has been developed by Gwent Adult Safeguarding Board, in collaboration with partner agencies and in consultation with frontline staff.

The purpose of the threshold guidance document is to ensure our regional, collective response to keeping people safe is appropriate and proportionate to the abuse/neglect identified or the risk thereof. This means that formal safeguarding procedures will not always be the best or only way of addressing issues that arise. The guidance document provides examples to assist with professional judgement.

To supplement this document for further guidance please refer to Working Together to Safeguard People: Volume 6 – Handling Individual Cases to Protect Adults at Risk

Professional Judgement

There may be circumstances where a situation appears to be low risk but you are aware of similar incidents that have happened in the past. This will influence your decision to refer to the Local Authority and such detail should be made explicit on the Adult Duty to Report Form. The report maker will need to consider the views of the adult at risk, where appropriate, and seek consent for sharing information on a multi-agency basis.

The Wales Safeguarding Procedures (2019)
http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/
promotes use of reflective practice and encourages practitioners to exercise professional judgement where appropriate. In this respect these procedures reflect the ethos of the Social Services and Well- being (Wales) Act 2014
http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

If in any doubt, it is recommended that advice is sought from Aneurin Bevan University Health Board (ABUHB) staff should seek advice from their own specialist safeguarding team. Out of Hours enquiries should be made to Gwent Emergency Duty Team (EDT) – up to date contact details can be found on the Gwent

Safeguarding website
https://www.gwentsafeguarding.org.uk/en/Adults/Report/Report-an-adult-at-risk.aspx

Abuse versus Poor Practice

The difference between the quality of care or support (poor practice) and neglect is much contested (please see definitions of Neglect on page 11). If a person is totally dependent on others' assistance to meet basic needs, continual 'poor practice' can lead to serious harm or death.

Poor practice is a concern which relates to the quality and standards of service delivery. Useful elements in deciding if poor practice has occurred, which does not require action under the Safeguarding process should consider;

- is a 'one off' incident to one individual
- resulted in no harm
- indicated a need for a defined action

Incidents which indicate that poor practice is impacting on more than one adult, or that poor practice is recurring and is not a 'one off , must result in Safeguarding Adults procedures being initiated as these incidents can be good indicators of more widespread, institutional abuse.

Sometimes a 'one off' incident is an indication of a lowering of standards by health or care providers.

This proportionate approach to managing risk ensures the right action is taken by the right people at the right time. It also ensures that proper regard is given to the wishes and feelings of the individuals involved who should be empowered to make their own informed decisions.

Social Services and Well-Being Act Principles

The Social Services and Well-being (Wales) Act 2014 provides a sound legislative basis, supported by principles that ensure the adult remains in control of their own decisions, or decisions that are least restrictive and in the best interests of that person when they are unable to make decisions for themselves.

The fundamental Principles of the Social Services and Well-being (Wales) Act 2014 are:

- **Voice and control** – putting the individual and their needs at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.
  "*I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*

- **Prevention and early intervention** – increasing preventative services within the community to minimise the escalation of critical need.
  "I receive clear and simple information about what abuse is, how to recognise signs and what I can do to seek help".

- **Well-being** – supporting people to achieve their own well-being and measuring the success of care and support.
  "*I feel happy in the support I receive and empowered that I was part of the process".*

- **Co-production** – encouraging individuals to become more involved in the design and delivery of services.
  "I get help to take part in the decision making process to the extent to which I want and to which I am able".

Local Authority Duty

When a safeguarding report is made to the Local Authority it has a legal duty to make (or cause to be made) enquiries and adequately protect and investigate in cases where abuse or neglect has occurred or there is a risk thereof. The purpose of a safeguarding enquiry is for the Local Authority to clarify matters and decide what course of action (if any) is required in order to protect the adult in question from abuse and or neglect. If any action is necessary, then it is for the Local Authority to take the lead in coordinating what action is appropriate and by whom.

Issues of Human Trafficking, Domestic Abuse including Forced Marriage, Honour Based Crime, Female Genital Mutilation, Sexual Exploitation (including sexting and indecent images) and Hate/Mate crime will often be referred to the Police who will lead the investigations and manage the multi-agency response. However, if care and support needs are identified, the Local Authority should be contacted so that initial enquiries can be made regarding the well-being of the individual concerned.

Partner Agency Duty to Report

Whilst all agencies are expected to report concerns to the Local Authority if they have **reasonable cause to suspect** that an **adult is at risk of abuse or neglect**, as defined in the Social Services and Well Being Act, this document acts as a reminder to Partner Agencies that they have a legal duty to do so.

Responsibility and Accountability

Safeguarding in its wider context is everyone's responsibility and whilst we will work together to support adults, we will expect professionals to **"own"** their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding report has been made.

Outcomes

Interventions to prevent and protect adults from abuse and or neglect must focus on the outcomes that people want and enable them to remain in control of their lives. Maintaining dignity, respect, choice and independence as autonomously as possible is a fundamental principle of any intervention including safeguarding.

Wishes and Feelings

Adults have the right to make decisions about their lives even if we think those decisions are unwise. Central to this approach is engaging the adult in conversation about how best to respond to their situation ensuring they have a voice, choice and control as well as improving quality of life, well-being and safety. There should be an honest conversation with the adult explaining the concern. Removing a person's decision making powers in such circumstances would be further perpetrating abuse.

Consent

Wherever possible, you must gain consent of the individual and seek their views unless doing so is likely to increase the risk to them or put others at risk. Information should be presented to the individual in such a way that there is informed consent. If consent is not given to sharing information including raising a safeguarding concern then alternative action should be taken to reduce the risk to the adult. A lack of consent does not negate the need to take preventative action if and when appropriate.

Overriding Consent

When an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not always override a professional's responsibility to raise a safeguarding concern with the Police or Local Authority. In circumstances where others are at risk, including children or a crime may have been committed, or the adult is being coerced, controlled and intimated, a safeguarding concern should be raised.

Providing Information

The adult should receive clear information and feel informed about the support that is available, the reason for raising the concern and if action is taken against their wishes (i.e. without consent), the reason for this taking place. It does not preclude the sharing of information with relevant partners however it is good practice to inform the adult that this will happen unless doing so would increase the risk of harm. Consideration must be given to a person's specific communication needs when providing information and throughout any intervention.

Mental Capacity/Assessing Capacity

Where a safeguarding enquiry identifies capacity issues, an assessment of capacity must be undertaken by an appropriate and competent person. In the context of safeguarding, the capacity in question could relate to, for example, the adult's capacity to make specific decisions about their situation or to cooperate with the Local Authority in undertaking the safeguarding enquiry. A person must be assumed to have capacity unless it is shown that they lack capacity. The person must first be given all practical and appropriate support to help them make the decision for themselves. The appointment of an advocate should only apply if all practical and appropriate support to help the person make the decision has failed. It is noted that capacity is always fluid and decision specific.

Best Interests

Everything that is done for or on behalf of a person who lacks capacity will be in that person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. Also, carers and family members will be consulted. Due regard should always be given to the 5 Key principles of the Mental Capacity Act 2005.

Mental Capacity Act 2005 – 5 key principles

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes 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 his best interests.
5. Before the act is done, or the decision is made, regards 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.

Advocacy in Safeguarding

People should be active partners in any safeguarding enquiry. No matter how complex a person's needs, local authorities are required to involve people, to help them express their wishes and feelings to support them to weigh up options, and to make their own decisions. Professionals and individuals must ensure that judgements about the needs for advocacy are integral to the safeguarding process.

The Local Authority must initially consider the best way of involving the person in the safeguarding enquiry, which is appropriate and proportionate to the person's needs and circumstances. If it appears to the Local Authority that the person may have

care and support needs and considers that the person has substantial difficulty in engaging with the safeguarding process, then they must consider whether there is anyone appropriate who can support the person to be fully involved.

This might, for example, be a carer (who is not professionally engaged or remunerated), a family member or friend. If there is no-one appropriate, then the Local Authority must arrange for an independent advocate who must support and represent the person in the safeguarding enquiry.

Effective safeguarding seeks to promote an adult's rights as well as protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect. It enables the adult to understand both the risk of abuse and actions that she or he can take, or ask others to take, to mitigate that risk.

If a safeguarding enquiry needs to start urgently then it can begin before an advocate is appointed but one must be appointed as soon as possible. All agencies should be aware of how the services of an advocate can be accessed and what their role is.

Liberty Protection Safeguards (LiPS) https://socialcare.wales/service-improvement/the-mental-capacity-act-and-deprivation-of-liberty-safeguards-dols

There are times when a person's liberty may be restricted to prevent them from coming to harm.

For example we may prevent someone from leaving a care home by locking the front door, for fear they may get injured on a busy road.

The Mental Capacity Act allows us to do this in the person's best interests, but we must be authorised to do so.

Changes to the MCA introduced in 2019 will include a new scheme called Liberty Protection Safeguarding (LiPS) and strengthen people's rights in areas such as best interest decisions.

The Proposed LiPS scheme will apply:

- In any health care setting, not just care homes and hospitals
- Applies to anyone 16 and over, rather than 18 as it was with DoLS which this replaces
- Introduces a 2 tier system of protection

The implementation of LiPS will mean that a care home worker who accesses clients home using a key safe and locks the door behind them when they leave to prevent the client from coming to harm, will no longer be able to do this without authorisation.

A 'responsible body' (typically the local authority or health board) will need to provide authorisation. They would assess if the planned care arrangements were proportionate and necessary.

If a person is being deprived of their liberty without proper authorisation or safeguards, then a safeguarding concern should be raised.
(Online: Social Care Wales 2019)

Decision Making/Recording Actions

If a decision is made NOT to report to the Local Authority, the individual agency must make a record of the concern and any action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not reporting to the Local Authority does not negate an agency's responsibility to take relevant action where they can and should do so or to report internally and also to regulators and commissioners.

Before Making a Duty to Report

Before a report is made (as referred to below, the report maker should have considered all three elements described in the definition of an adult at risk and clearly communicate **why they have reasonable cause to suspect the adult is at risk of abuse and or neglect.** They must also provide clear detail of the action they have already taken to manage the situation**/**any associated risk and whether or not the adult has consented to the report. If consent has been overridden, the reason for doing this must be explicit on the Duty to Report form.

In responding to safeguarding concerns the Local Authority may provide advice and guidance to professionals to manage the safeguarding incident, to the person suffering or at risk of abuse, to Carers or relevant parties, rather than invoke adult protection proceedings. It is important to understand therefore that a safeguarding enquiry may not necessarily result in what is typically considered to be a "safeguarding response", such as an investigation by the Police, Regulatory Body or Local Authority, but it could result in other action to protect the adult concerned. If control measures have been put in place which effectively keeps the person safe, then the level of risk reduces. Such actions may be sufficient therefore to allow for ongoing management of the situation at agency level.

If the circumstances require more general information, advice and assistance, social work support or an assessment of Care & Support needs this must be requested via the local assessment and care management routes below. Do not refer such requests to safeguarding unless you have reasonable cause to suspect the person is an adult at risk of abuse or neglect as described above.

Making a Duty to Report

All safeguarding reports must be submitted on the regional Duty to Report form https://www.gwentsafeguarding.org.uk/en/Adults/Report/Report-an-adult-at-risk.aspx and forwarded to the Local Authority area in which the abuse or risk thereof

occurred. Contact details are available on the Gwent Safeguarding Board website: www.gwentsafeguarding.org.uk

Definition of an Adult at Risk

The Social Services and Well-being (Wales) Act 2014 defines an "adult at risk of abuse and or neglect" as an adult who:

- Is experiencing or is at risk of abuse or neglect;
- Has a need for Care & Support (whether or not the Local Authority is meeting any of those needs). *NB: Care and Support is not clearly defined in the Act, and*;
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk thereof

The inclusion of 'at risk' within the new Welsh Government definition enables **early intervention** to protect an adult at risk and prevent escalation. The decision to act does not require actual abuse or neglect to have taken place. The aim is to protect people who need it and to help them prevent abuse or neglect happening.

Definition of Care & Support

Care & Support is defined in the Social Services and Well-being (Wales) Act 2014 as:

- Care
- Support
- Both Care & Support

Care & Support needs may be obvious, but often they may not. However, establishing any Care & Support needs may become evident during a conversation with the adult.

The Care and Support Protection Plan

As set out in the Wales Safeguarding Procedures (2019), an adult at risk, where there is abuse or neglect should have a care and support protection plan. This should be devised by the practitioners participating in the strategy meeting (referred to in the procedures as the 'strategy group').

A care and support protection plan should:

- follow the requirements set out under Section 54 of the Social Services and Well-being Act (Wales) 2014;
- be subject to regular review. If an adult protection conference is subsequently held on the adult at risk, any existing care and support protection plan should

be reviewed by the conference to ensure that it is effective in protecting the adult at risk.

The care and support protection plan seeks to remove or reduce the risk of abuse or neglect. The plan should include care and support arrangements but particularly emphasize the protection or risk management to support the individual achieves their personal outcomes.

Definition of Abuse or Neglect

Abuse means physical, sexual, psychological, emotional or financial abuse. Neglect means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being.

Physical Abuse – includes but is not limited to: hitting, slapping, over or misuse of medication, undue restraint or inappropriate sanctions.

Neglect – includes but is not limited to: a failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of feed, shelter, clothing; emotional neglect.

Financial Abuse – includes having money or other property stolen, being defrauded, being put under pressure in relation to money or other property or having money or other property misused. Examples of such can include: unexpected change to their will; sudden sale or transfer of the home; unusual activity in a bank account; sudden inclusion of additional names on a bank account; signature does not resemble the person's normal signature; reluctance or anxiety by the person when discussing their financial affairs; giving a substantial gift to a carer or third party; a sudden interest by a relative or other third party in the welfare of the person; bills remaining unpaid; complaints that personal property is missing; a decline in personal appearance that may indicate that diet and personal requirements are being ignored; deliberate isolation from friends and family giving another person total control of their decision making.

Psychological Abuse – includes but is not limited to: threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks; coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim.

Sexual Abuse – includes but is not limited to: rape and sexual assaults or sexual acts to which the adult at risk has not or could not consent and/or was pressurised into consenting.

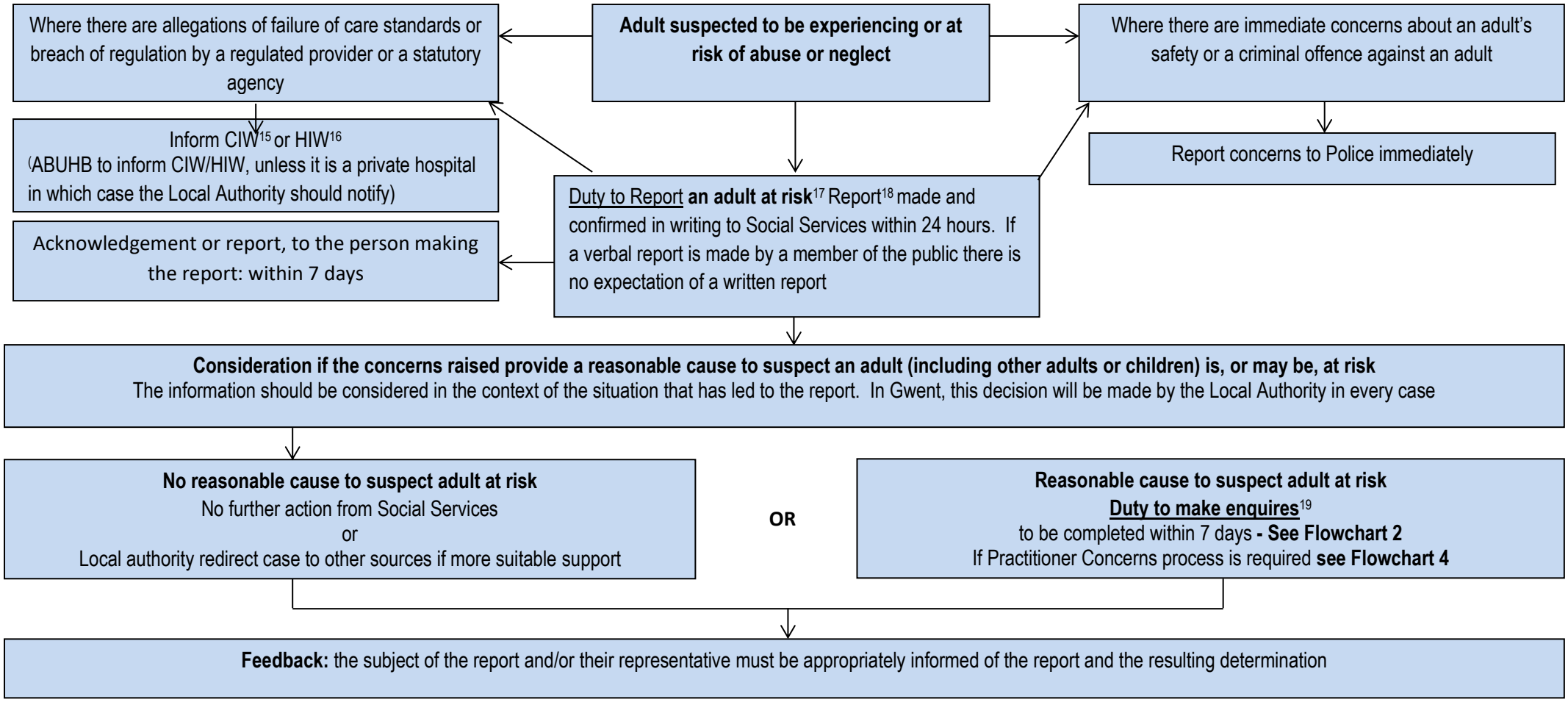
Determination

Whilst it is likely that some concerns may not progress beyond the initial enquiry stage of the safeguarding process, the report will still be recorded, assessed and

reviewed by the Local Authority who will consider whether appropriate action has been taken/is being taken or will be taken to manage the risks that have been identified. This may include checking if the report maker has provided information or advice, reported to another agency or professional or arranged for an assessment of Care and Support needs.

To supplement this document for further guidance please refer to Working Together to Safeguard People: Volume 6 – Handling Individual Cases to Protect Adults at Risk For regional guidance refer to the flowcharts that follow;

Flowchart 1: Reporting an Adult at Risk*



**An Assessment for Care and Support needs to be considered at any stage*

[15]Care Inspectorate Wales: www.CIW.org.uk

[16]Healthcare Inspectorate Wales: www.HIW.org.uk

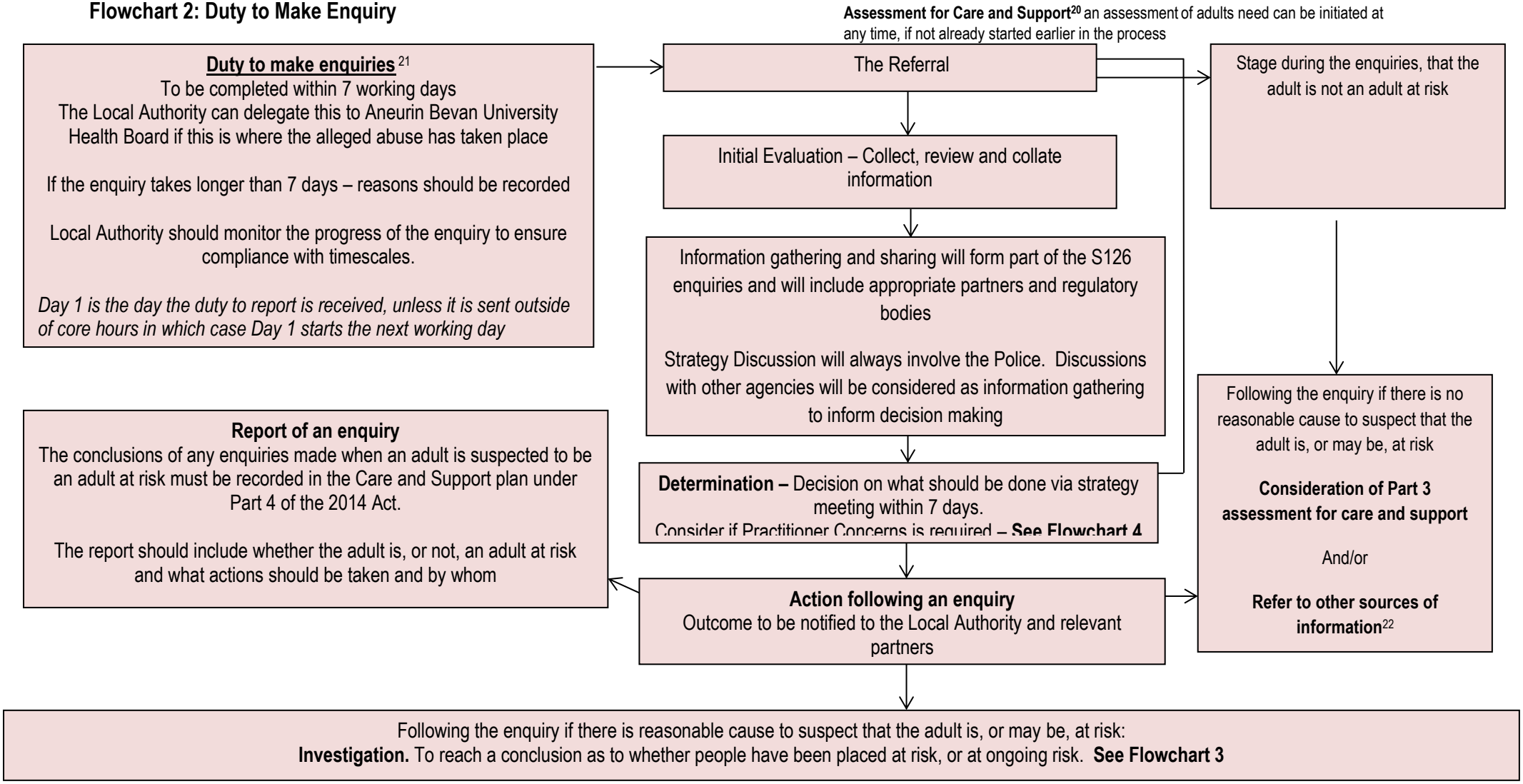
[17]Social Services and Well-being (Wales) Act 2014, s128 (1) Duty to report adults at risk

[18]A **report to Social Services will be taken to also mean a referral**

[19]Social Services and Well-being (Wales) Act 2014, s126 (2) Duty to make enquires

The consent and capacity of the adult, as well as public interest must be considered when deciding at all points what action to take in response to concern or allegation.

Flowchart 2: Duty to Make Enquiry



[20]Social Services and Well-being (Wales) Act 2014, S19 Duty to assess the needs of an adult for care and support
[21]Social Services and Well-being (Wales) Act 2014, s126 (2) Duty to make enquiries
[22]Social Services and Well-being (Wales) Act 2014 s17 Duty to secure information, advice and assistance service
A strategy meeting may also be known as a strategy discussion but they should be taken to have the same meaning

Flowchart 3: Strategy discussion/meeting and what happens after a strategy discussion/meeting

Criminal Investigation: Takes Priority: May run concurrently with Social Services Investigation

Strategy discussion/meeting[23]. Within 7 working days of the completion of the enquiry – Multi-agency to agree the response and action to be taken.
Where it is clear that there should be a Police investigation – a strategy meeting should be the forum for deciding what action should be taken:
NB – A criminal investigation by the Police, takes priority over all other enquiries, although may run concurrently with them

Determination of action to be taken.
Outcome of S126 enquiry is one of the 3 determinations or No Further Action (NFA)

Determination 1: Immediate Protection

Safeguard the adult from immediate risk
v
Further strategy discussion/meeting
(as needed)
v
Case Conference
Agree Care and Support
v
Part 4 Care and Support Protection Plan
(as needed)
v
Review and Closure

Determination 2: Adult not at risk but may have other needs for care and support services

Advise individual that duties under section 126 of the Act come to end
v
Assessment under Part 3 of the 2014 Act (as appropriate)
v
Part 4 Care and Support Plan
v
Review

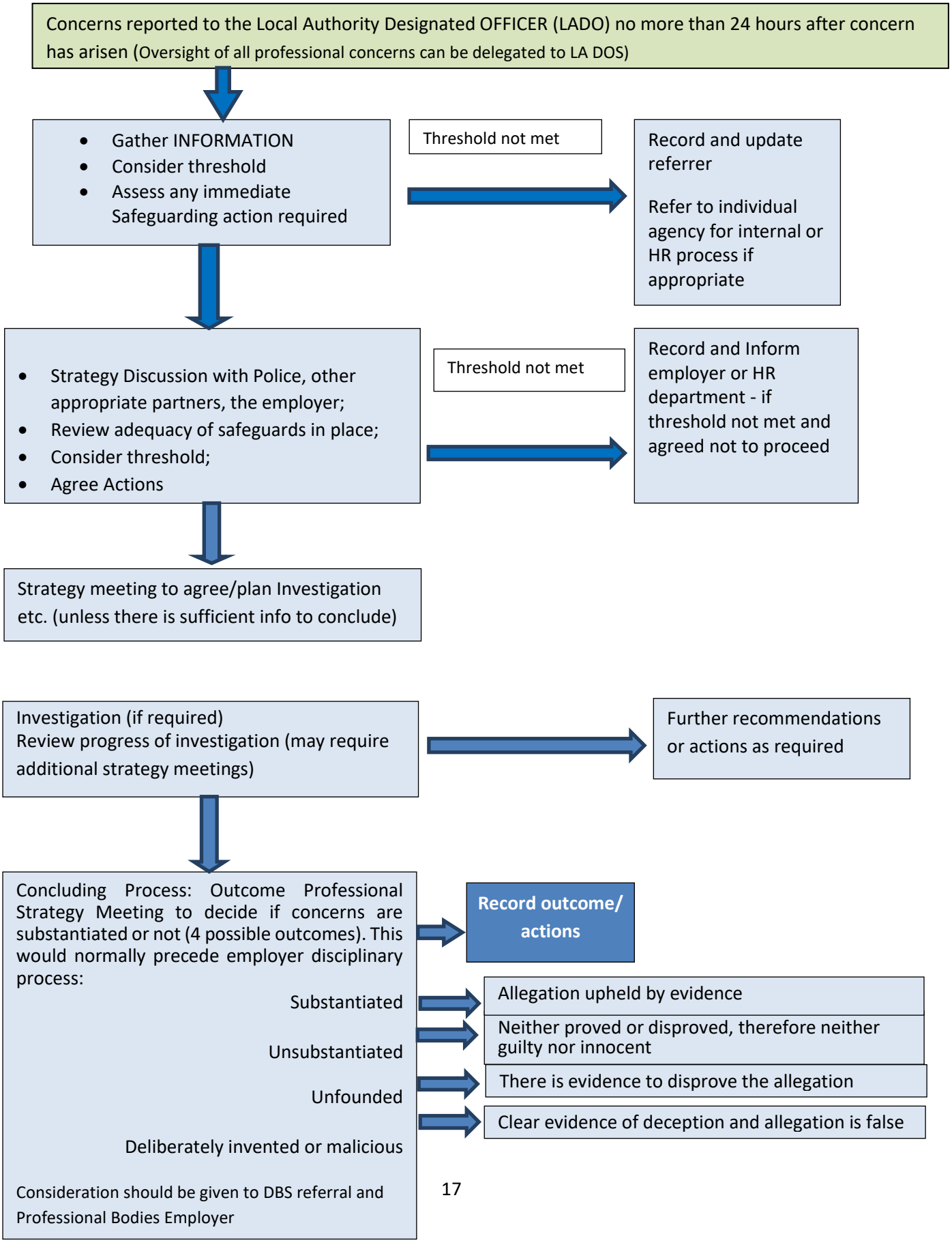
Determination 3: Adult at risk and action to protect needed

Further strategy meetings
(as needed)
v
Case conference
Agree Care and Support
v
Part 4 Care and Support Protection Plan
(as needed)
v
Review and Closure

[23] A strategy meeting may also be known as a strategy discussion, but they should be taken to have the same meaning.

Flow Chart 4 **PROFESSIONAL CONCERNS PROCESS MAP**

Reports of concerns about people whose work brings them into contact with children or adults at risk (may run concurrently with the child or adult protection process)



Poor Practice/Service Standard Concerns

There are well established routes within each agency which address poor practice. If advice is required please consult with your Safeguarding Team or Commissioners.

Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust

The policy for Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust sets out arrangements for responding to safeguarding concerns about those whose work, either in a paid or voluntary capacity, which brings them into contact with children or adults at risk. It also includes individuals who have caring responsibilities for children or adults in need of care and support and their employment or voluntary work brings them into contact with children or adults at risk.

For further guidance refer to section 5 of the Wales Safeguarding Procedures and the Gwent Guidance/Protocol Safeguarding Allegations/Concerns about Practitioners and Those in a Position of Trust

Institutional Abuse

Institutional abuse is the mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting. It occurs when the individual's wishes and needs are sacrificed for the smooth running of a group, service or organisation.

In formal settings institutional abuse is more likely to occur where staff are:

- Inadequately trained
- Poorly supervised
- Not supported by management
- Have poor communication skills
- Part of a 'closed' culture, for example a care setting where new ideas, visitors, care management or other professional involvement is discouraged

Institutional abuse can involve more than one abuser, and there might also be a number of people experiencing the same abuse. Every organisation that works with adults should have clear whistleblowing/raising concerns procedures and all staff should understand the procedure for making a report about the organisation or another member of staff.

All staff/practitioners have a duty to be made aware that they can approach Social Services or the Police, independently, to discuss any worries they have about abuse, neglect or harm and that they should do so if;

- They have concerns that their manager, designated practitioner or proprietor may be implicated;

- They have concerns that the manager, designated practitioner or proprietor will not take the matter seriously and/or act appropriately to protect the adult; or
- They fear intimidation and/or have immediate concerns for the service users' or they own safety

Concerns of <u>significant, escalating or recurring</u> Institutional/Organisational Abuse should be treated as a safeguarding issue and reported to the Local Authority using the adult Duty to Report Form (DTR).

Violence against Women, Gender Based Violence, Domestic Abuse and Sexual Violence (VAWDASV)

Violence and abuse in any form is unacceptable. The Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 outlines a legislative framework and long term strategy and vision in Wales to tackle such issues. This will help ensure anyone who experiences abuse as outlined in legislation is provided with an effective and timely response by relevant authorities.

A key component of the VAWDASV Legislation and framework is "Ask and Act". This is a process of targeted enquiry to be practiced across the Public Service to identify violence against women, domestic abuse and sexual violence. The term targeted enquiry describes the recognition of indicators of violence against women, domestic abuse and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues.

The VAWDASV Act and accompanying "Ask and Act" framework is one of the most significant practice changes in Wales in recent years.

Domestic Abuse and the Adult Safeguarding Process

Domestic Violence and Abuse is officially classed as "any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality". People presenting should always be signposted to specialist services.

If the person is an adult at risk and has needs for care and support, a Duty to report should be made.

It is important that throughout your conversation with the person, you identify with them which are the best services to assist them with the domestic abuse, their additional vulnerabilities and what they would like to do in order to seek a solution or help with decision making.

For specialist advice/help:

- **Live Fear Free Helpline:** 0808 8010 800
- **Text Service:** 078600 77333
- **Email:** info@livefearfreehelpline.wales

Interface with Safeguarding Children

If you are working with an adult and have concerns there is an unborn child or children/young people living with or in contact with that adult you must consider the safety and well-being of those children too and complete a Multi-Agency Referral Form (MARF). If unsure please seek advice from IAA or Safeguarding Lead.

How to Use the Threshold Guidance

Please note the following **Threshold Guidance** covers a broad spectrum of concerns that may occur within the context of safeguarding adults.

The examples identified are not exhaustive and do not cover every safeguarding situation and should not deter professionals and workers from exercising professional judgement on a case by case basis. Where possible, a person's views and wishes must always be taken into consideration before any action is taken. If a worker or professional is unsure or unclear about which pathway is the most appropriate they should seek advice from their Line Manager or Designated Safeguarding Advisor in the first instance. Additional advice and guidance can be sought from the relevant duty desk in each of the five Local Authorities.
Where significant harm has been caused or there is significant risk it is more likely for the safeguarding process to be invoked.

Please contact your local Safeguarding Team for advice or if you wish to discuss

Blaenau Gwent
Tel: 01495 315700
Email: DutyTeamAdults@blaenau-gwent.gov.uk

Caerphilly
Tel: 0808 100 2500
Email: povateam@caerphilly.gov.uk or IAAAdults@caerphilly.gov.uk

Torfaen
Tel: 01495 762200
Email: socialcarecalltorfaen@torfaen.gov.uk

Newport
Tel: 01633 656656
Email: firstcontact.adults@newport.gov.uk or pova.team@newport.gov.uk

Monmouthshire
Tel: 01873 735492
Email: MCCadultsafeguarding@monmouthshire.gov.uk

If it is an emergency and you need to contact us outside of office hours please call our Emergency Duty Team on 0800 328 443.

These are some examples to act as an aide in decision making and is not an exhaustive list.

PHYSICAL ABUSE – includes but is not limited to: hitting, slapping, over or misuse of medication, undue restraint or inappropriate sanctions

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Staff error causing little or no harm, e.g. friction mark on skin due to ill-fitting hoisting Isolated incident/dispute between service users with no harm, quickly resolved and risk assessment in place Adult does not receive prescribed medication, missed or wrong dose. No harm occurs Appropriate moving and handling procedures not followed on one occasion not resulting in harm Adult does not receive recommended mobility assistance on one occasion not resulting in harm Isolated incident of carer falling asleep on duty. No harm caused – remains a disciplinary/management issue Bruising caused by family carer due to poor lifting and handling technique. No harm intended. Immediately resolved when given correct advice/equipment Minor events that still meet criteria for incident notification	Inexplicable light/minor marking found where there is no clear explanation as to how the injury occurred Recurring missed medication or administration errors in relation to one service user that cased no harm Isolated incident involving service user on service user, harm occurs	Inexplicable injuries/marking or lesions, cuts or grip marks on more than one occasion Recurrent missed medication or administration errors that affect more than one adult and/or result in harm Predictable and preventable incident between two vulnerable adults where injuries have been sustained or emotional distress caused – the staff fails to prevent Adult is injured through common flouting of procedures. Harm occurs Accumulation or escalation of minor event that meet criteria for Reg 26/38 reporting	Withholding of food, drinks or aids to independence Covert administration without proper medical authorisation or outside the Mental Capacity Act Serious inexplicable injuries Deliberate maladministration of medicines, e.g. sedation Inappropriate physical restraint /over medication undertaken to manage behaviour outside of a specific care plan, or not proportionate to the risk	Pattern of recurring administration errors or deliberate maladministration that results in ill-health or death. Grievous bodily harm/assault with or without a weapon, leading to irreversible damage or death, including Female Genital Mutilation Physical assaults-injury/death Any potential physical criminal act against an adult at risk

These are some examples to act as an aide in decision making and is not an exhaustive list.

NEGLECT– NOT including self-neglect – includes but is not limited to: a failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of food, shelter, clothing; emotional neglect

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Isolated missed home care visit where no harm occurs Adults is not assisted with a meal/drink on one occasion and no harm occurs Poor transfers between services and no harm occurs, e.g. hospital discharge without adequate planning Adult is not bathed as often as they would like. No harm caused DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form not valid due to error/missing signatures and/or GMC number or, DNACPR decision not communicated effectively, or; DNACPR form and carbon copies not filed and/or distributed correctly and NO harm caused	Inadequacies in care provision that lead to discomfort or inconvenience and no significant harm occurs, e.g. being left wet occasionally Occasionally not having access to aids to independence. (If regular consider restraint) Adult at risk living with family carer who is failing with caring duties Temporary environment restrictions, but action to resolve is in place Occasional inadequacies in care from informal carers. No harm Care Plan does not address risk of harm and no harm occurs e.g. management of behaviour to protect self or other	Recurrent missed home care visits where risk of harm escalates, or one missed visit where harm occurs Poor transfers between services and harm occurs, e.g. hospital discharge without adequate planning Vulnerable adult who is susceptible to pressure ulcers is not formally assessed and harm occurs Care plan does not address risk of harm and harm occurs Management of behaviour to protect self or other	Ongoing lack of care to the extent that health and well-being deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence Mismanagement of wounds or pressure damage by professionals/paid carers DNACPR form not valid due to error/missing signatures and/or General Medical Council(GMC) number, or, DNACPR decision not communicated effectively, or, DNACPR form and carbon copies not filed and/or distributed correctly and harm caused	Serious injury or death as a result of consequences of avoidable pressure ulcer development, e.g. septicaemia Failure to arrange access to life saving services or medical care Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk Gross neglect resulting in serious injury or death

These are some examples to act as an aide in decision making and is not an exhaustive list.

SEXUAL ABUSE – including sexual exploitation – includes but not limited to: rape and sexual assaults or sexual acts to which the adult at risk has not or could not consent and/or was pressurised into consenting

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Isolated incident when an inappropriate sexualised remark is made to an adult with capacity and no distress is caused Isolated incident of low level, unwanted sexualised attention/touching directed at one adult by another, whether or not capacity exists. No harm or distress is caused	Minimal verbal sexualised teasing or harassment Two people who there is cause to suspect may lack capacity are engaged in a sexual activity or relationship (of which the legislation states you cannot make a best interests assessment). No distress to either	Sexualised attention between two service users where one lacks capacity to consent Two people whom there is cause to suspect may lack capacity are engaged in a sexual activity or relationship (of which the legislation states you cannot make a best interests assessment) and harm or distress occurs to either party Sexualised touch or masturbation without valid consent Being subject to indecent exposure Contact or non-contact sexualised behaviour which causes distress to the person at risk	Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent Being made to look at pornographic material against will/where valid consent cannot be given	Penetration by any means (whether or not is occurs within a relationship) without valid consent Sex in a relationship characterised by power imbalance, coercion or exploitation, e.g. staff and service user or service user and service user Sex without valid consent (rape) Voyeurism without consent

These are some examples to act as an aide in decision making and is not an exhaustive list.

PSYCHOLOGICAL/EMOTIONAL ABUSE – includes but is not limited to: threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks; coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim.

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined – NO distress caused Isolated taunt or verbal outburst – NO distress caused Isolated threat of abandonment e.g. threat to withdraw visits/social contact and support – NO distress caused	Occasionally repeated incident of denying or failing to recognise an adults choice or opinion Occasionally repeated treatment that undermines dignity and esteem Occasionally repeated threats of abandonment e.g. threats to withdraw visits/social contact and support Occasionally repeated taunts or verbal outbursts	Ongoing incidence of denying or failing to recognise an adults choice or opinion causing harm The withholding of information to dis-empower the adult at risk Ongoing threats of abandonment causing harm or distress Frequent humiliation of adult at risk	Persistent taunts or verbal outbursts which cause ongoing distress The persistent withholding of information to dis-empower and harm or distress is caused Persistent treatment that undermines dignity and damages esteem Persistently denying or failing to recognise an adults choice or opinion	Persistently intimidated and bullied causing distress and attempts to resolve this have failed Emotional blackmail e.g. persistent threats of abandonment/harm causing distress, coercive control Denial of basic human rights/civil liberties, overriding advanced directive, forced marriage, modern slavery Prolonged intimidation/victimisation Producing and distributing inappropriate photos via any social media means Vicious/personalised verbal attacks

These are some examples to act as an aide in decision making and is not an exhaustive list.

FINANCIAL ABUSE - Includes having money or other property stolen, being defrauded, being put under pressure in relation to money or other property or having money or other property misused. Examples of such can include: unexpected change to their will, sudden sale or transfer of the home, unusual activity in a bank account, sudden inclusion of additional names on a bank account, signature does not resemble the persons normal signature, reluctance or anxiety by the person when discussing their financial affairs, giving a substantial gift to a carer or third party, a sudden interest by a relative or other third party in the welfare of the person, bill remaining unpaid, complaints that personal property is missing, a decline in personal appearance that may indicate that diet and personal requirements are being ignored, deliberate isolation from friends and family giving another person total control of their decision making.

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Money is not managed safely or recorded properly – isolated incident and no harm caused Isolated incident of staff personally benefitting from the support they offer service users in a way that does not involve the actual abuse of money e.g. accrues reward points on their own store loyalty card Isolated incident of a person, who holds Lasting Power of Attorney for Property and Finances, has used the donor's finances inappropriately involving a small amount of money, where no harm has been caused. Advice and guidance in relation to the Code of Practice for Attorneys under the Mental Capacity Act 2005 (Chapter 7, specifically 7.50-7.74), should be re-enforced	Money is not managed safely or recorded properly on more than one occasion Adult not routinely involved in decisions about how their money is spent or kept. Capacity in this respect is not properly considered and no evidence of undue pressure or coercion Failure by relative to pay care fees/charges where no harm occurs Misuse of Adult at Risk's money by a 3rd Party	Adults monies kept in a joint bank account, unclear arrangements for equitable sharing of capital and interest Adult denied access to his/her own funds possessions Concerns exist that a person who holds Lasting Power of Attorney for a person's property and finances, may be consistently misusing the person's finances and are not acting in their best interests and/or may be benefiting financially from their position as attorney and seem not to be acting in accordance with the Mental Capacity Act's Code of Practice for Attorneys	Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control Personal finances removed from adult's control without legal authority or consent Ongoing non-payment of care fees/charges and adult at risk experiences distress or harm through having no personal allowance or risk of eviction/termination of services	Fraud/exploitation relating to benefits, income, property or Will Theft of money or property Doorstep crimes/financial scams

These are some examples to act as an aide in decision making and is not an exhaustive list.

EXAMPLES OF DISCRIMINATION – including Hate/Mate Crime

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Isolated incident when an appropriate prejudicial remark is made to an adult and no distress is caused	Isolated incident of teasing motivated by prejudicial attitudes- service user to service user Recurring taunts Care Plan fails to address an adults diversity and associated needs for a short period	Inequitable access to service provision as a result of a diversity issue Recurring failure to meet specific care/support needs associated with diversity Persistent and frequent targeting by others in the community who take advantage of adult at risk Teasing by person in a position of trust	Being refused access to essential services Denial of civil liberties e.g. voting, making a complaint Humiliation or threats on a regular basis Denial of individuals appropriate diet, access to take part in activities related to their faith or beliefs, or not using the persons chosen names Making an adult at risk partake in activities in appropriate to their faith or beliefs	Hate crime resulting in injury/emergency medical treatment/fear for life Hate crime resulting in serious injury or attempted murder and Honour Based Violence Exploitation of an adult at risk for recruitment or radicalization into terrorist related activity Female Genital Mutilation or Forced Marriage

These are some examples to act as an aide in decision making and is not an exhaustive list.

EXAMPLES OF CONCERNS RELATING TO DIRECT PAYMENTS

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Direct payment financial returns show payments for unauthorised expenditure. One off mistake – payment returned Isolated incident of direct payment recipient benefiting from interest from direct payment account Direct payment used flexibly to meet user needs but not as described on support plan Excess float in direct payment account is being used for purposes other than on support plan, e.g. utility bills or equipment. Possible misunderstanding or if fraud suspected then escalate as possible criminal offence Suitable person Personal Assistant found to be illegally working in the country. No harm caused but, suitable person responsibility removed. PA dismissed	Large excess in user accounts indicating care may not be being provided Direct payment not set up correctly despite advice and guidance e.g. Personal Assistant not set up with her Majesty's revenue and Customs (HRMC); no audit trail for payments (i.e. no authorised timesheets, no wage slip or proof of invoice payment); no liability insurance Cash payments made against advice with no evidence of payment and care not provided Information obtained that suitable person or Personal Assistant has criminal conviction which gives rise to concerns about their role suitability	Pattern of unauthorised expenditure by person acting on behalf of adult at risk with inadequate explanation Pattern of repeated non-payment of bills/personal assistant wages, meaning care is withdrawn Payments made from direct payment account for unauthorised expenditure by suitable person, not on support plan Suitable person not able to provide evidence to demonstrate they are managing the direct payment	Direct payment is not being spent on some or all care on support plan, leading to neglect Irregularities on financial returns leading to requests for further evidence which are continually ignored by suitable person or evasive action is taken, including avoidance of attempts to review person on direct payment	Misuse/misappropriation of direct payment by another including; person in a position of trust or suitable person e.g. suitable person is using some of the Personal Allowance or agency time for their own needs and person is neglected Creation of fictitious Personal Assistant where payment is actually going to suitable person Adult at risk is misusing/misappropriating direct payment by recipient, but under coercion by another

These are some examples to act as an aide in decision making and is not an exhaustive list.

CARE PROVIDER EXAMPLES

Any poor practice requires escalation to the appropriate Commissioning Team and may require a Duty to Report				
No harm or risk thereof Low risk of harm	**Possible harm or risk thereof Moderate risk of harm**	**Likelihood of Significant Harm or risk thereof Severe/Critical risk of harm**		
Lack of stimulation/opportunities to engage in social and leisure opportunities – no harm occurs In the short term, person not given sufficient voice or involved in the running of the service Service design where groups of service users living together are inappropriate – no harm occurs One off incident of low staffing due to unpredictable circumstances, despite management effort to address – no harm caused	Lack of stimulation/opportunities to engage in social and leisure opportunities – and no improvement after advice Denial of individuality and opportunities for service users to make informed choices and take responsible risks Care planning documentation not person centred Denying adult at risk access to professional support and services, such as advocacy. Poor ill-informed or outmoded care practice. No significant harm More than one incident of low staffing levels, no contingencies in place. No harm caused	Rigid or inflexible routines Service user's dignity is undermined, e.g. lack of privacy during support with intimate care needs; shared clothing, underclothing, dentures etc. Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted Failure to refer disclosure of abuse Inappropriate or incomplete DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) – see neglect thresholds page 20 Single incident of low staffing resulting in harm to more than one person	Ill treatment of one or more adults at risk, such as unsafe manual handling Failure to report, monitor or improve bad care practices Unsafe and unhygienic living environments Failure to support an adult at risk to access health and/or care treatments Punitive responses to challenging behaviours Repeated incidents of low staffing resulting in harm to more than one person	Staff misusing their position of power over service users Over-medication and/or inappropriate restraint used to manage behaviour. Widespread, consistent ill treatment Stark or sparse living environments causing sensory deprivation Deprivation of liberty not authorised by legal process Low staffing levels which result in serious injury or death to more than one person (corporate manslaughter)

OTHER EMERGING SAFEGUARDING TRENDS

MODERN SLAVERY

Limited freedom of movement, being forced to work for little or no payment, limited access or no access to medical and dental care, no access to appropriate benefits, limited access to food or shelter, be regularly moved (trafficked) to avoid detection, removal of passport or ID documents , Sexual exploitation, starvation, not control over movement/imprisonment, Forced Marriage, 'County Lines' exploitation.

ONLINE ABUSE & EXPLOITATION including SOCIAL MEDIA

All agencies need to be aware of the significance of social media in the exploitation of vulnerable people. People can be groomed by individuals or gangs via the internet and directly via mobile phones. The abuse can be in various forms such as human trafficking, sexual exploitation, radicalisation, financial abuse and obtaining and sharing indecent images on line.

Agencies need to be aware that these forms of abuse can take place without the victim leaving their home. All agencies are expected to report concerns to the Local Authority if they have reasonable cause to suspect that a person is at risk of abuse as defined in the Social Services and Well Being (Wales) Act, this includes abuse which may take place over the internet and social media.

COUNTY LINES

'County lines' describes situations where an individual, or more frequently a group, establishes and operates a telephone number (line) in an area outside of their normal locality in order to sell drugs direct to users at street level. This generally involves a group from an urban area expanding their operations by crossing one or more police force boundaries to more rural areas, i.e. a 'county' force. A 'county lines' enterprise almost always involves exploitation of vulnerable persons.

It is essential for a county lines enterprise to identify potential premises to operate from. Establishing these bases is achieved in a number of ways, most commonly by exploiting local drug users. This is achieved either by paying them in drugs, by building up a drug debt or by using threats and/or violence in order to coerce them; this practice is commonly known as 'cuckooing'. In other cases, group members have entered into relationships with vulnerable females in order to use their properties. If 'County lines' exploitation of an adult at risk is suspected, Police should be informed and a MARF submitted.