Safeguarding Vulnerable Adults Task and Finish Group

Notes of the meetings held on the 6 December 2011 and 10 January 2012

1. Plymouth City Council, Safeguarding Adults Manager

Kerrie Todd, Safeguarding Adults Manager provided the panel with an overview of the policies and procedures for making and dealing with a safeguarding alert.

A document detailing all of the policies and procedures within the city had been produced. The comprehensive document provided guidance for all providers and details of what processes would be undertaken should an alert be raised.

A copy was not distributed with the agenda. The document was tabled and members would also be sent a copy of the procedure note with appendices via email by the Democratic Support Officer.

In response to members of the panel it was reported that -

(a) guidance and procedures were reviewed and updated every year;

(b) all anonymous alerts would be assessed and investigated. Because of their nature it was impossible for anonymous alerter to receive feedback;

(c) the Safeguarding Manager outlined five stages to the alert procedure, detailed in the "Multi agency policy and procedures for Safeguarding Adults a complete working guide";

1. Alert – The safeguarding team would evaluate the risk and make a triage decision on what action was required immediately. A referral would be made to Adult Social Care (ASC) within one working day.

2. Referral received – Once the referral was received by ASC an evaluation of risk would take place. ASC would consider whether the referral is about a person who is or could be an adult at risk under the definition of "No Secrets". This initial evaluation would take place on the day the referral was received.

3. Gather information – A "hoovering" exercise would take place were information from all statutory agencies about the individual would be gathered. The exercise may identify further risks to the individual and the risk assessment would be adjusted to reflect the new information.

4. Decision – Information gathered would be used to determine whether abuse could be ruled out. If risk of abuse was identified interim protection plans would be put in place and the police would decide whether a criminal investigation would be required. If abuse could be ruled out then the case

would be referred for alternative action / services.

5. Strategy Meeting – The risk would be further evaluated at a strategy meeting where an investigation would also be planned. Any changes or extension to interim protection plans would take place and the responsible manager would feed back to the alerter. If the adult at risk was identified as lacking mental capacity the Independent Mental Capacity Advocate would be involved. Following the strategy meeting an action plan would be produced and sent within 24 hours.

In response to questions from the panel it was reported that –

(d) information gathering would generally take a few days, there would be flexibility if the suspected offender was suspended from the care setting;

(e) when an alert was raised there was an immediate triage assessment which would take into account current knowledge of the home, whether there had there been any recent concerns, was the manager capable, etc. An audit would be undertaken to look for triggers such as whether service users behaviour was affected when particular members of staff are on duty;

(f) if a suspect was identified that person or persons would be suspended, police would be contacted, conduct an investigation and pass evidence to the Crown Prosecution Service who would decide whether to prosecute;

(g) it was difficult to embed the procedures in care settings not used by the local authority. Local Authorities outside Plymouth commissioned care settings not used by Plymouth City Council (PCC) but PCC had responsibility for safeguarding the resident in them. It was difficult to assure safeguarding in these settings as the council did not send clients to those homes.

(h) free alerter training was offered to all care homes; it was a full day and was not an e-learning package. Attendees discussed value and belief systems and brave, courageous steps taken by those who report safeguarding issues when their jobs were on the line;

(i) regarding the care settings not used by PCC; other Local Authorities are advised not to use them, PCC is unable to contact families of clients and advise them that the settings do not meet PCC standards, the CQC may say that they are adequate but PCC would still not use them;

(j) some services that were being used as part of personalised budgets were beyond the reach of the safeguarding team. The team provided guidance on safeguards, criminal record bureau (CRB) checks and alerters training. However if service users did not want to insist on CRBs or train their staff there is no legal recourse, although PCC remains responsible for safeguarding issues;

(k) there was a non-restraint policy, PCC would not use a provider that

restrained those with challenging behaviour, unless in cases of risk to life and limb, for example if somebody attempted to run onto a busy road. There was a set of standards to cover such eventualities;

(l) if there was an alert the review team could be at a care setting within four hours. The first response was to improve services, such visits could take place during the day or night;

(m) the local involvement network can make unannounced visits although they had not informed the safeguarding team of any issues.

2. **Plymouth Age Concern**

The panel heard from Pauline Luxton of Plymouth Age Concern.

Pauline advised the panel that –

(a) day guests were referred to the day service through ASC, self referrals or family referrals. Some guests were not in receipt of social care services;

(b) Plymouth Age Concern was represented on the Plymouth User Safeguarding Hub. Discussions had taken place about the types of abuse vulnerable adults could be subject to. There was a great deal of financial abuse by clients own families, for example Plymouth Age Concern were aware of clients who were charged by their own family for the collection of pensions, shopping and housework;

(c) within the day centre many clients were seen every week, the service was able to note any changes in demeanor or physical capability. Plymouth Age Concern provided informal contact away from social services, many clients felt more comfortable talking to workers at the service rather then social services;

(d) all staff at the day centre had received the free alerter training provided by the city council;

(e) the day centre was not officially regulated but there were regular visits by social care commissioners and there was also a board of trustees. There was a residential care unit attached to the day centre which was regulated by the CQC;

(f) there was an advocacy team available for service users.

In answer to questions from members of the panel it was commented that –

(g) Plymouth Age Concern worked closely with the Citizens Advice Bureau and the Police. As older people tended to be more private, Plymouth Age Concern were able to keep their approach informal and friendly;

(h) the procedure and timescales for the alert process were appropriate and Plymouth Age Concern had always received feedback on alerts raised. Many cases were complex and could not be resolved in a day;

(i) Plymouth Age Concern were keen to reach more older people in Plymouth and intended to expand in order to provide more services and information to older people in the future;

(j) small day service providers such as lunch clubs were run by volunteers, there were good and bad providers;

(k) the Plymouth Age Concern Advocacy Team had carried out work to help older people into extra care settings in order to help with loneliness. Plymouth Age Concern also provided a telephone service to call the vulnerable and lonely at least once a week;

(l) Plymouth Age concern also provided a Home Care Department. Carers in the community would be able to raise safeguarding concerns pertaining to domiciliary care;

(m) if Plymouth age concern had a safeguarding concern they would alert the safeguarding team via the published route.

3. **Devon and Cornwall Police**

Detective Constable Karen Anderson of Devon and Cornwall Police provided evidence to the panel. It was reported that –

(a) the Safeguarding Team at Devon and Cornwall police worked within the Public Protection Unit. It was made up of three Detective Constables and a Detective Sergeant who were responsible for safeguarding alerts that had a criminal aspect. Generally cases that were accepted by the team focused on professionals who had abused, although the team also took on cases of family and domestic abuse where workloads allowed;

(b) Plymouth was the first area in the region to have identified officers for this kind of work and there were 12 officers force wide;

(c) alerters would remain anonymous for as long as possible, it was often the case that initially an alerter would be reluctant to talk to the Police, a safe place for discussion could often be agreed on; However some people did not want to speak to the police and did not wish to progress with criminal proceedings;

(d) theft could be dealt with in different ways depending on the circumstances, if the offender was unknown the theft would be dealt with by local officers;

(e) there was financial abuse taking place throughout the city and this was expected to rise. The Police had made a number of successful prosecutions.

In response to questions from the panel it was reported that -

(f) the personalisation agenda was a great opportunity for people to have control over their own care but it was important that there was a safe place a service user could go to get independent advice. There needed to be improved advocacy across the City;

(g) it was important that service users were aware of all of the routes available to them to make themselves safe;

(h) if people did not want to enter the criminal process it was important that there was positive action on cases of domestic abuse and that protection plans remained under constant review;

(i) alerters could never remain 100 per cent anonymous, particularly when criminal proceedings began. It could not be overestimated how difficult it was for some people to make an alert. All alerters would be supported by the Police in making criminal complaints;

(j) it was felt there were enough Independent Mental Capacity Advocates to deal with the need in the city, what was needed was more general advocacy provision;

(k) if any witnesses were intimidated the Police would prosecute the perpetrator.