



Derby and Derbyshire Safeguarding Adults Boards Practice Guidance (April 2024)

"Derby Safeguarding Adults Board and Derbyshire Safeguarding Adults Board are committed to promoting equality. The SABs aspire to remove the barriers of institutional discrimination and oppression in safeguarding adults practice across the city and county.

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Safeguarding adults is everybody's business. Everybody is different and diversity will be celebrated and respected. Everybody will be treated fairly, with accessible information, advice and support to help stay safe and maintain control of their lives."

Navigating your way around this practice guidance document

Using hyperlinks

The table of contents uses hyperlinks to the relevant sections and subjects – just click or tap the on the section or subject you would like to read.

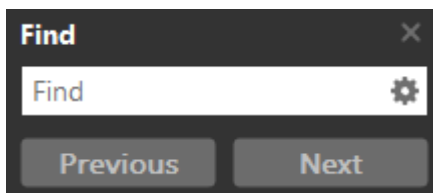
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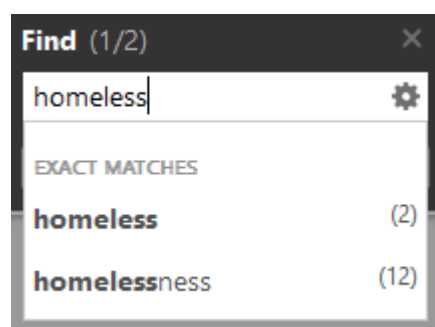


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As an example, we have used the word homeless. You can see there are two occurrences of the word “homeless” and there are also twelve occurrences of the word “homelessness” – you would just click or tap the one you want.

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Introduction

The Derbyshire Safeguarding Adults Board (DSAB) has agreed the overarching use of the term "adult at risk" in line with the recommendation of the Law Commission.¹

Adults at risk of abuse and neglect

This operational guidance is for all agencies, staff and volunteers who have a responsibility for the care, support and protection of adults at risk.

Every person has the right to live a life free from abuse, exploitation and neglect and every agency has a responsibility to keep adults safe – *"Safeguarding is everyone's business"*.

Abuse occurs in all sections of society and there should be no discrimination because of assumptions about class, gender, age, disability, sexual orientation, race, religion, culture or eligibility for service.

Some people are more vulnerable to abuse than others because they are disempowered within society. People may be additionally vulnerable because of disability, age, impairment or illness.

The [Care Act 2014](#) legislates that people need to be involved from the outset in the safeguarding process. This develops the Making Safeguarding Personal protocol, which has been implemented within local authorities to ensure that clients are involved and participate throughout the safeguarding meetings.

The Care Act is explicit in its message in that all agencies have a responsibility to support, refer and partake in **Section 42 enquiries** where necessary. People who refer into the local authority are expected to have the initial conversations as to what the person's wishes and outcomes are.

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¹ ["Reforming the Law for Adult Care and Support: The Government's Response to Law Commission report 326 on Adult Social Care"](#)

Their wishes consent and capacity should also be considered at this stage and the local authority will need to consider these carefully in all their responses. It is important to balance choice against risk and human rights in all cases.

There will be in a minority of cases where information may not be shared openly due to the placing individuals at higher risk. The local authority can override consent in some cases if they think a person is at serious risk of death or there are public safety issues.

Adults at risk of abuse must be made aware of their rights and given information, advice and support. They should be encouraged and enabled to access protection from the law and legal processes.

Every effort must be made to promote the well-being, dignity, security and safety of adults at risk of abuse consistent with their rights, mental capacity and personal choices.

In most cases the adult at risk of abuse should be the person who decides on the chosen course of action, whilst being given all possible support. In a proportion of cases, an adult with mental capacity may choose to remain in an abusive environment or situation. In these cases, it is still extremely important to consider what advice and support can be offered to reduce their risk from harm.

The Care Act promotes the involvement and inclusion of the person in the process and looks at involving the adult in the safeguarding meetings. Many adults are not able to participate in the meetings due to lack of capacity or understanding, and the Care Act instructs the local authority to provide an adequate advocacy service.

Many people choose to have a friend or family as a supporter or advocate and the Act is clear that advocacy should be provided where there is no family available. Also, if the family are implicated in the abuse the Local Authority can approach the Independent Mental Capacity Advocate (IMCA) service if the person lacks capacity.

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The involvement of the person is not complicated, but it can be time consuming, and arranging person centred meetings, which may involve a range of accessible services.

The Care Act makes it clear the approach should be personalised and aimed at people participating in the meetings as far as possible.

The adult's views are paramount, and every effort should be made to establish, record and review the adults identified outcomes within all stages of the safeguarding process.

Definitions of abuse

- **Discriminatory abuse.** One person, or a group of people, being treated less favourably on the grounds of their protected characteristics in line with the [Equality Act 2010](#). This includes racial or ethnic origin, religion or belief, disability; age or sexual orientation (direct discrimination), or where an apparently neutral provision is liable to disadvantage a group of persons on the same grounds of discrimination, unless objectively justified (indirect discrimination).
- **Domestic abuse.** A single incident or continuing incidences of abusive behaviour by a person to another person, each aged 16 or over who are personally connected: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional abuse; stalking, harassment, 'honour-based' violence including forced marriage, female genital mutilation.
- **Financial abuse.** The misuse of a person's funds and assets including theft and fraud, internet scamming, coercion in relation to an adult's affairs or arrangements, including in connection with their Will, property and inheritance or the misuse or misappropriation of property benefits and possessions.
- **Modern slavery.** The recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. It is a crime under the [Modern Slavery Act 2015](#) and includes holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after.

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- **Neglect.** The failure to meet an individual's basic physical, psychological, social and/or health needs. This may include but is not limited to a failure to provide food; clothing and shelter; protection from physical and or emotional harm; provide adequate supervision/interaction with others; provide and/or access appropriate medical care and treatment; to fulfil caring responsibilities and/or interventions.
- **Organisational abuse.** Repeated instances of poor care of individuals or groups of individuals through neglect or poor professional practice because of structures, policies, processes, practice and/or culture within an organisation.
- **Physical abuse.** An act causing injury, trauma, bodily harm or other physical suffering such as hitting, slapping, pushing, kicking, misuse of medications, etc.
- **Psychological abuse.** This includes emotional abuse and takes the form of threats of harm or abandonment, deprivation of contact, humiliation, rejection, blaming, controlling, intimidation, coercion, indifference, harassment, verbal abuse (including shouting or swearing), cyber bullying, isolation or withdrawal from services or support networks.
- **Self-neglect.** Where an individual neglects their basic needs. Reasons for this may include depression, illness, bereavement, finding achieving these tasks difficult or simply because they choose not to. It is important to consider mental capacity of the individual when determining if someone is making an informed choice to live in a certain way.
- **Sexual abuse.** Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, teasing or innuendo, photography, subjection to pornography or witnessing sexual acts, indecent exposure and assault or acts without consent.

Your practice and preventing abuse

You can help to prevent abuse

- Acknowledging that 'it could happen here'
- Being alert to signs of distress or intimidation
- Reporting concerns at the earliest opportunity to your manager
- Completing the safeguarding adults referral form
- Being assertive in ensuring that the referral is passed on to the local authority, who will take the lead on safeguarding adults at risk
- Taking opportunities for training and development

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- Asking for help if you feel you are 'out of your depth' with a particular issue
- Being a Dignity in Care Champion:
 - A Dignity in Care Champion is someone who believes passionately that being treated with dignity is a basic human right, not an optional extra. They believe that care services must be compassionate and person-centred, as well as efficient, and are willing to try to do something to achieve this.

Recognising abuse or neglect – your responsibility

It is vital to recognise abuse or neglect as early as possible and to take effective and proportionate action.

The practice guidance contains information about some possible causes, signs and symptoms that may help alert you to the fact that abuse or neglect is taking place. They may be relevant to any adult at risk, whether living in a domestic home, residential or nursing home, or who is receiving services in other community settings, hospitals, or in a custodial setting.

Every type of abuse is serious, and you must deal with it in an appropriate way. This means reporting your suspicions to your manager or agency Safeguarding Lead. Do not investigate it on your own. This is unacceptable and may result in the loss of vital evidence.

Situations of increased risk

Research indicates the following factors can make abuse more likely to occur:

- Abuse of alcohol or drugs
- Have stopped work specifically to provide care
- Have moved in with the adult at risk, specifically to provide care
- Have a history of abuse as a perpetrator or a victim
- Are under additional stresses such as illness, financial or marital problems
- Feel very lonely or isolated

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- Habitually lose their temper, or have previously admitted to roughly handling the person for whom they are caring
- Are dependent on accommodation on the person for whom they are caring
- Are financially dependent in the person for whom they are caring or financially reliant on their estate
- Have expressed that they cannot cope or continue to provide care for the person
- Perceive the person they are caring for as being deliberately awkward, or lacking insight into certain illnesses like dementia
- Feel that the person they are caring for has failed to fulfil the carer's own needs in former years

The following factors for the adult at risk, may lead to an increased risk from abuse:

- Has a recently increased level of dependency because of behavioural difficulties such as restless wandering, confusion and incontinence, especially faecal
- Disturbs the carer at night
- Lacks purposeful activity
- Exhibits behaviours perceived to be odd or embarrassing
- Is not helpful or co-operative, is rejecting or ungrateful or will accept care only from a particular person
- Has a difficulty in communication; for example, through visual or hearing impairment, loss of or difficulty with speech, or a difficulty with memory and concentration
- Change in behaviour or deteriorating illness

Some adults are particularly targeted due to their disabilities. It may be easier for an abuser to approach someone who appears more isolated for financial or sexual gain. Victims of cybercrime and scamming are often people who are targeted online or mail scams due to someone approaching them at times when they are vulnerable, e.g., an elderly person being bereaved. Younger people can also be targets of grooming online for radicalisation and sexual exploitation.

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See separate guidance on these areas on the [Safer Derbyshire website](#), the [Derbyshire Safeguarding Adults Board website](#) and the [Derby Safeguarding Adults Board website](#).

The lists above are not exhaustive.

Dignity in care

Dignity should be at the heart of everyone's practice, whether care is given in a person's own home or another care setting.

Social care and health agencies are responding actively to ensure that they meet the Dignity and Respect challenge, the principles of which underpin this adult safeguarding policy, procedures and practice guidance. The '[Dignity Challenge](#)' states that high quality services that respect people's dignity should:

- Have a zero tolerance to abuse
- support people with the same respect you would want for yourself or a member of your family
- Treat each person as an individual by offering a personalised service
- enable people to maintain the maximum possible level of independence, choice and control
- Listen and support people to express their needs and wants
- Respect people's right to privacy
- Ensure people feel able to complain without fear of retribution
- Engage with family members and carers as care partners
- Assist people to maintain confidence and a positive self-esteem
- Act to alleviate people's loneliness and isolation

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Adult exploitation risk assessment

Introduction

This document provides guidance about assessing and responding to an adult who may be at risk of exploitation across Derby and Derbyshire. The guidance has been developed as part of the multi-agency work of the Derby and Derbyshire Safeguarding Adults Boards (DSAB) and should be used with reference to the:

- [Joint Derby and Derbyshire Practice Guidance for responding to Adults and Child Victims of Modern Slavery](#)
- [Derby and Derbyshire Safeguarding Adults Policy and Procedures](#)

Definition of exploitation

“Exploitation involves being groomed, forced or coerced into doing something that you don’t want to do for someone else’s gain.” – Torbay & Devon Safeguarding Adults Partnership

Exploitation and criminal exploitation include the following (see also [Joint Derby and Derbyshire Practice Guidance for responding to Adults and Child Victims of Modern Slavery](#) section 8.1):

- Drug cultivation, e.g., cannabis farm
- Drug distribution, e.g., County Lines
- Shoplifting, pickpocketing, begging
- Forced/sham marriage
- Sexual exploitation
- Financial/identity fraud
- Organ harvesting

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- Gang violence and related activity
- Extremism and radicalisation
- Female genital mutilation (FGM)
- Honour based abuse and violence

Vulnerability to exploitation

Being vulnerable to exploitation does not mean the adult is being exploited. There are many reasons why adults will not, or feel they cannot, speak about their experiences or seek help and support. It is important to build trust with the adult to enable this to happen.

- Always be alert to the possibility of exploitation, regardless of age or gender, and be prepared to offer support.
- When it is difficult to contact/maintain contact with the adult, the person with the best relationship with the adult should lead discussions and contacts.
- Using a professional interpreter is best practice where exploitation is known or suspected.
- Adults may lack the capacity to make decisions for themselves (Mental Capacity Act, 2005) or may be threatened / coerced into behaviours that pose a risk to themselves and/or others. Grooming, coercion and control are known to have an impact on mental capacity, particularly where sexual exploitation is a factor. The adult may become so dependent on the alleged perpetrator(s) they see criminal behaviour as something to survive and keep themselves safe.
- Only ask questions about exploitation when victims are on their own or with trusted individuals and in a place they consider to be a safe space. Perpetrators of exploitation come from diverse backgrounds, working in groups or alone and may or may not be connected personally to the adult (North Tyneside Safeguarding Adults Board, 2017). People from countries in which the authorities are perceived as corrupt can be more readily controlled. Criminals build on the mistrust victims harbour towards the police to ensure that even if identified by the police, victims will be unlikely to disclose the circumstances of their exploitation (Hestia, 2020).

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Risk assessment

The Exploitation Risk Assessment (ERA) identifies risk indicators and factors to be considered to help professionals to assess exploitation risk. The ERA should be used with reference to the context and understanding of the adult's circumstances, factual information and, where relevant, information provided by other agencies and/or third parties (from another source) which should be identified, and source referenced where possible.

Exploitation Risk Assessment (ERA)*
A. Are potential risk indicators evident? Include third party information where relevant
1. Subject to violence/threat of violence and/or evidence of physical injuries appear to be from an assault
2. Shows signs of emotional/psychological trauma; shows fear/anxiety
3. Sexual violence: sexual assault, rape, indecent images taken/shared as part of initiation / revenge / punishment / internally inserting drugs (plugging)
4. Evidence of forced labour / domestic servitude / criminal exploitation and/or victim/their family 'in debt' to the exploiters: debt bondage used to control the victim
5. Neglect and basic needs not being met
6. Living in unclean, dangerous and/or unhygienic environments
7. Tiredness and sleep deprivation: victim is expected to carry out criminal activities over long periods and through the night
8. Poor attendance and/or attainment at school/college or not attending employment

9. Living in a property which is being used by others for criminal activity
10. Physical / learning disability or learning difficulty / neuro diversity
11. Mental ill health / self-harm / significant changes in emotional well-being
12. Acquisition of money, clothes, mobile phones etc. without plausible explanation
13. Gang-association and/or isolation from peers/social networks, visibility in gang related videos
14. Carrying weapons
15. Looked after child or care leaver
16. Leaving home/care without explanation
17. Persistently going missing or returning late, and/or being found in areas away from home
18. Suspicion of physical assault/unexplained injuries
19. Excessive texts/phone calls received or having multiple handsets
20. Returning home under the influence of drugs/alcohol, increasing drug use/possession of large amounts of drugs
21. Using sexual, drug-related or violent language you wouldn't expect them to know
22. Relationships with controlling or significantly older individuals or groups
23. Being arrested with older individuals
24. Multiple callers (unknown adults or peers)

B. Professional assessment: Consider the adult’s circumstances e.g. role as a carer, care and support needs, culture, ethnicity, language barriers and their contact with services

- What are the views of the adult about the ERA?
- Have they consented to information sharing and/or referral?
- Capacity: is the adult able to make a decision for themselves?
- What are the primary risks?
- Are there any protective factors?

C. Risk level: using the information from the risk indicators and professional assessment will help to identify whether there is evidence:

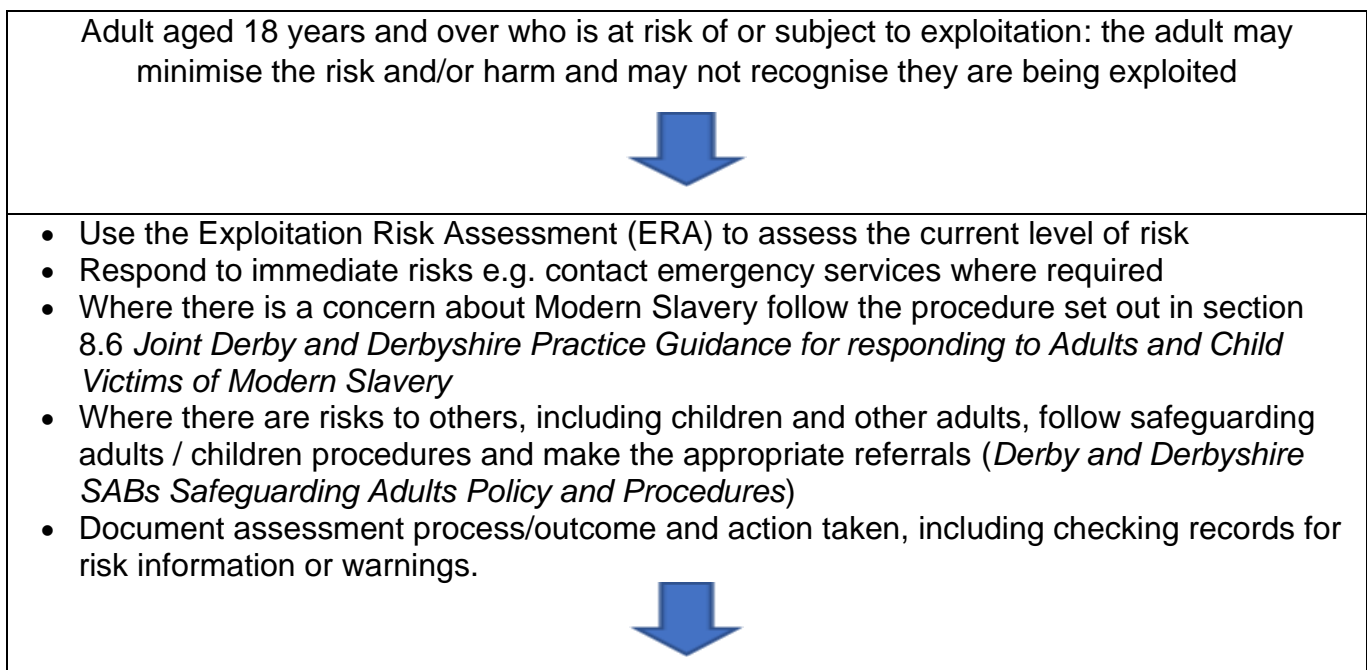
- Of vulnerability to exploitation
- Of grooming or targeting for the purposes of exploitation
- That the person is being exploited

N.B. Where there is evidence of critical risk, take immediate action to safeguard the adult

*The ERA is adapted from the Exploitation Assessment Guidance (Walsall Safeguarding Partnership, 2020); Sexual Exploitation Guidance - Adults (North Tyneside Safeguarding Adults Board, 2017) and Criminal Exploitation of children and vulnerable adults: County Lines guidance (Home Office, 2018).

Intervention

The flow chart below sets out the process to be followed where adult exploitation is suspected.



Seek advice and support from manager and consider:

- Outcome of the ERA
- Progress with referrals made and/or planned within safeguarding procedures
- Information sharing with the police see Appendix 1 Derbyshire Constabulary Information Sharing Form for Professionals
- Other safeguarding procedures that may be appropriate e.g. the Vulnerable Adult Risk Management (VARM) process (Derbyshire).

N.B. Do not close the case based on non-contact or intermittent contact or where the adult refuses support

References

- Derbyshire Constabulary (2022) Missing and Exploitation Investigation Team SOP
- Hestia (2020) Underground lives: criminal exploitation of adult victims
- Home Office (2022) Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-Statutory Guidance for Scotland and Northern Ireland
- Home Office (2018) Criminal Exploitation of children and vulnerable adults: County Lines guidance
- North Tyneside Safeguarding Adults Board (2017) Sexual Exploitation Guidance - Adults
- Walsall Safeguarding Partnership (2020) Exploitation Assessment Guidance

Derbyshire Constabulary Information Sharing Form (ISF) for professionals: Operation Liberty/Operation Blofeld

This ISF offers a multi-agency system of sharing information with Derbyshire Police to aid keeping vulnerable adults and young people safe and to identify any existing or emerging risks in relation to their potential exploitation. Identifying place-based risks, as well as specific risks around individuals, will support the contextual safeguarding of our communities.

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Where there is an immediate concern relating to a child or adult, this information should be reported through recognised safeguarding referral processes within your organisation. Partners and colleagues should not delay in providing information which could assist in the immediate safeguarding of an individual.

Criminal offences or concerns requiring a police response should be reported via **101** or **999**.

This form is to be used to raise concerns and share information relating to concerns of child or adult exploitation, using the categories below as a guide. This includes potential County Lines, Child Sexual Exploitation and other forms of Criminal Exploitation.

Efficient sharing of information may assist in the early identification of exploitation related risk and threat; providing opportunities for intervention by **preparing** our services to respond, informing action to **protect** individuals and communities from exploitation, **preventing** the exploitation or continued exploitation from occurring and informing a police response to **pursue** those responsible.

Prior to completing the form, practitioners may seek advice and support from a manager in their respective agencies.

If the information is about significant harm to a child or young person then Social Care referral systems must be used to report those concerns. Please see [Derby and Derbyshire Safeguarding Children Partnership's \(DDSCP\) safeguarding children procedures](#).

The information can also include low level, soft “whisperings” and gut feelings, something that does not sit well with you or co-workers. The information need not be corroborated or contain full identities of persons, vehicles, etc.

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Descriptions, nicknames, partial number plates **should still be submitted**.

Where known please provide full names and details of:

- Victims
- Potential victims and
- Potential exploiters.

Once completed send this form to: schadultenquiries@derbyshire.police.uk

NEVER assume someone else has passed on the information you have.

Duplicate information is better than none.

Persons of interest
<i>(People who may pose a risk to children or vulnerable adults, now or in the future, whether their full identity is known or not, for instance nicknames, addresses, descriptions. This can include peer on peer abuse)</i>
Locations of interest
<i>(Geographical area, residential premises, school, hotel etc)</i>
Business of interest
<i>(Taxi companies, take-aways etc)</i>
Online Spaces
<i>(Social media platforms, apps, etc)</i>
Other <i>(phone numbers, vehicles, upcoming events)</i>

If your report is in relation to a specific incident, please detail it below, including as much detail as possible, date, time, location, nicknames, descriptions, registration plate (even if only partially known), potential risks (weapons etc):

Adult Social Care and Health commissioning, contracts and safeguarding

Commissioners and Officers in the Contracts team should ensure that all documents such as service specifications, invitations to tender and service contracts reflect the Derbyshire and Derby City Safeguarding Adults Procedures and specify how they expect service providers to meet the requirements of these procedures.

Compliance with Derbyshire and Derby City Safeguarding Adults procedures will be included in the monitoring arrangements for contracts.

Adult Social Care Staff such will be responsible for notifying the relevant member of the Contracts Team in the event of a safeguarding referral concerning an Independent Sector contracted provider.

The Contract Manager responsible for the specific service subject to a safeguarding referral should attend any relevant strategy or planning meetings concerning a contracted provider if necessary to do so and will carry out any actions agreed to at the meetings.

The Contract Manager will where applicable follow this up with a monitoring visit to ensure that any changes required in the management, staffing or practices of the service in question are undertaken.

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It is noted that although a client subject to a safeguarding referral might be supported by an independent provider it does not automatically mean that the provider is at fault. It is, therefore, likely that there is no requirement to undertake a contract monitoring visit in such circumstances. Other forms of monitoring would then suffice.

The performance management of care provision for Independent Sector providers is the joint responsibility of Adult Social Care and Health Commissioners and Contracts Team. Recent Ombudsman's judgements have gone against councils where they have failed to protect people in unsatisfactory or poorly performing care homes. Adult Social Care and Health Commissioners and Contracts Team are required to have robust procedures in place to deal with concerns and complaints, including safeguarding concerns.

The commissioners of care, i.e., those Health and Social Care organisations who contribute financially towards the care of individuals, have a duty of care to ensure the care they purchase is of good quality and is safe and effective. They will make links with other organisations including Care Quality Commission, care providers and other responsible bodies. This work is done on a regular basis by the Contracts Team

As commissioners for care services, NHS Derby and Derbyshire Integrated Care Board and Adult Social Care take their duty of care very seriously and aim to engage in a positive and supportive way with all independent providers of care.

Role of the Adult Social Care and Health Contracts Team

Derbyshire Adult Care have a Contracting and Compliance Team responsible for the management of all contracts between Adult Social Care and independent care providers. This includes residential and nursing care homes, community support providers, day care and a range of other contracted services.

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A Contract Monitoring Framework is in place for each service type, which allows the Contracting Team to be involved in the assessment of providers to promote safe and quality care services and, where applicable, helping providers with developing plans to make improvement.

The team's activities are complimentary to the Care Quality Commission (CCQ), working closely with the local NHS and other partner agencies such as Derbyshire Fire and Rescue Service, the Police, Healthwatch and Skills for Care in respect of monitoring the performance of care homes and home care providers. The team's focus is on positive relationship management so that the link between contractor and provider is one of respect where the contractor looks to offer support and guidance to make improvements and the provider is open and transparent about difficulties and accepting of support and guidance.

However, if performance is not satisfactory, then the team use contract sanctions appropriate to the situation. Any use of sanctions needs to be carefully considered as this would usually mean restricting placements whilst improvements are undertaken and sustained. Typically, the Contracting Team find that the primary reason for poor performance is the lack of continuity in staffing due to recruitment and retention problems in the care industry. Successful care providers are very much reliant on strong effective leadership to maintain and develop a good service. During monitoring visits, the team look for evidence of a good service in recruitment practice, training, support planning, as well as the safe and effective management of medication.

In exceptional circumstances the Council with its partners will look to provide alternative support for people where there is a lack of confidence in a provider's ability to supply safe and appropriate services.

Role of the Adult Social Care and Health Commissioning Team in Derbyshire

Commissioning is the process of arranging services to meet an identified service need. Commissioning can be at a strategic level where services and functions are arranged to meet the needs of many people for example commissioning a Carers Service for Derbyshire.

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Commissioning can also be at a more individual or 'micro-commissioning' level; for example, a person, often a social worker, may 'commission' a provider to help with the support needs of a client.

Who are the commissioners?

Details of the various commissioners and their areas of responsibility are available from the [Adult Social Care and health Commissioning Team's website](#).

Role of the commissioner in the safeguarding process

A Commissioner would become involved where there is a deficiency/failure in the service specified. Commissioners would not routinely get involved in regular safeguarding audit work. They like to be hands-on with the service, including safeguarding concerns. Commissioners are involved with nurturing positive relationships with service providers. Some of the services commissioned do not involve personal care and as such are not regulated by the CQC.

Fundamentally, the commissioner would have a preventative role in designing-out/reducing the risk of a safeguarding incident occurring by the use of a high-quality service specification. An example is shown below:

- People can say when things are not quite right
- Staff understand people well enough to know when things are not right for them
- Staff pick up on issues that indicate potential problems/safeguarding concerns (relationships/health issues)
- People know what to expect so they can say when this is not happening. They know what "good" should look like
- People have contact with the outside world
- People feel valued and happy (service users and staff)
- If safeguarding concerns are picked up, the individual is asked at the beginning what they want to happen and why

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Developing and measuring a service against these areas can then be designed/recorded.

Role of the Contract Manager regarding safeguarding in relation with Care Providers and Service Managers

In response to a safeguarding alert where there is a concern about the performance of a provider, the link Contracts Manager would endeavour to attend any strategy or planning meetings concerning the provider. The Contract Manager in partnership with other relevant stakeholders would, if applicable, carry out a targeted monitoring visit to carry out checks on performance that might have been identified as a weakness as part of the safeguarding investigation. The officers involved would ensure that any weakness in practice is highlighted to the provider and that there are agreed actions with timescales to make necessary improvements to ensure safe and quality care services are provided.

Where systemic poor performance is identified and there is no coherent action plan to quickly address any shortcomings the Council and its partners may sanction a Provider until improvements are evidenced and sustained. In circumstances where provider performance is of on-going/urgent concern, a request would be made for clients of the services (including self-funders) to receive an urgent targeted 'safe and well' review from a Social Worker or Continuing Health Care Nurse. These reviews would consider the concerns highlighted in any safeguarding investigation linked to any other evidence about poor performance, e.g., there could be a focus on management of medication, weight loss, skin integrity, etc. During these conversations, clients and/or their representatives would also be given the opportunity to consider alternative provision if they so wish.

Role of the Contracts Manager when recording safeguarding information

The Contracting Team maintain a record of all safeguarding alerts by provider that have been shared with the team. This record includes, where available, any outcome of the investigation, whether it is related specifically to the provider and or its staff or a third party that the provider had no influence over (e.g., financial abuse by a family member).

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This information is used to help identify patterns and trends alongside other intelligence gathered at an individual service or with a provider group. This information will then be used to either bring forward a full monitoring visit, or for a targeted visit, with requests being made to other key stakeholders to check key activity.

Terms and conditions of a service contract with a provider

Compliance with the Safeguarding Adults procedures is routinely included in all contract documentation between the Council and providers undertaking activity with clients of Adult Social Care.

It would typically state that the provider shall comply with Derbyshire and Derby City Safeguarding Adults Policy and Procedures as amended periodically at all times and must take appropriate action in compliance with this on all occasions.

During a monitoring visit to a service a Contract Manager would consider any recent safeguarding referrals and outcomes, check that the provider's safeguarding policy is satisfactory and up-to-date and ensure that the provider staff are aware of how to report a safeguarding incident.

The Contracting Team also promote the understanding of whistleblowing so that provider staff feel supported to let others know if they are aware of unsafe practice, risk or wrongdoing which they are unable to influence towards a positive outcome. Such alerts can help identify systemic poor performance that has become the norm in a service.

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Assessing and supporting people with multiple and complex needs

Introduction

This guidance has been developed from East Sussex Safeguarding Adults Board document of the same name dating from December 2020. It was recommended by panel members as a document promoting best practice during Derbyshire Safeguarding Adults Board (DSAB) Homelessness Audit in March 2023. It meets audit actions around improving practice when working with adults who are defined as having multiple and complex needs (MCN). East Sussex Council has kindly given permission for the document to be adapted by DSAB. It is designed to provide guidance to professionals in identifying, assessing, and supporting people with multiple and complex needs.

The focus of this guidance is on outlining best practice pending national guidelines (April 2022 from the Department of Health and Social Care and NICE) and should be read in conjunction with the [Derby and Derbyshire Safeguarding Adults Policy and Procedures](#) and the [Derbyshire Information Sharing Agreement](#).

This guidance does not replace single agency assessment, care planning and risk management arrangements. Instead, it should be used to complement these and support agencies' assessments. It should also inform and guide practice and support development of practice knowledge.

This guidance should be viewed and applied in the context of the general provisions of the [Care Act 2014](#) which are intended to promote and secure health and wellbeing.

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Purpose of the guidance

The purpose of this guidance is to help people with MCN, and the professionals who work with them, to focus on the impact multiple needs have on a person's ability to achieve positive outcomes.

It also recognises that professionals are often managing behaviours which require a commitment to a longer term, solution-based approach which depend on building trust and rapport with the person.

It is acknowledged that professionals across different organisations may have a greater or lesser role in each of the seven areas of practice highlighted in this guidance. For example, building trust and rapport, and exploring trauma and adverse life experiences indicates therapeutic interventions, whilst assessment of need points towards adult social care. Professional judgement should be used to identify and involve agencies that can respond to aspects of complex need that are beyond your organisational remit.

The guidance aims to inform practice to facilitate the following:

- The adult's involvement
- Identification and holistic assessment of need and risk
- Timely information sharing around need and risk
- Development of shared risk management plans
- Shared decision making and responsibility
- Improved outcomes for the adult

Identifying multiple and complex needs (MCN)

The following definition of MCN should be used, where appropriate, to assess and identify if a person has MCN as part of their needs for care and support:

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MCN is defined for the purposes of this guidance as experiencing a combination of primary disadvantages or needs that exist at the same time and which relate to four out of the following five areas:

- Being a victim of violence and abuse, such as having been raped or sexually assaulted, suffering violence, or subjected to coercive control by any perpetrator.
- Poor mental health is defined as struggling to cope due to the nature and degree to which mental health difficulties are having a detrimental effect on a person's wellbeing and functioning. Mental illness may also appear to be present whether or not it has been diagnosed. Self-neglect, mental capacity issues and hoarding may also be present. This definition also includes poor mental health due to trauma that continues to impact on an individual. This can include trauma that may be the result of changes of child residence arrangements.
- Homelessness - a broad definition is adopted, including not having a settled place to stay, such as sofa-surfing (staying with family or friends because the person affected has no home of their own), staying in temporary or refuge accommodation, rough sleeping or street homelessness.
- Drug and / or alcohol dependency - a broad definition is adopted, including not only regular use of illegal street drugs but also over the counter and prescribed medications, 'harmful' drinking of alcohol and dependence on cannabis.
- Offending behaviour - having contact with the criminal justice system, including being in contact with the police, probation and or community safety services.

The definition is not exhaustive and professional judgement should be used to identify those who are struggling to cope, and who may need support and safeguarding interventions.

The intensity and frequency of needs and the level of risk because of those needs are factors to consider. Some individuals may have fewer areas of need, but the intensity and severity is high with a high level of risk. Others may experience more areas of need with lower levels of risk.

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Assessing and supporting individuals

The evidence-base for best practice when assessing and supporting at risk individuals with MCN, has been built from research and SAR findings. It comprises seven building blocks:

- Person-centred approach
- Professional curiosity
- Exploring the impact of trauma and adverse experiences
- Exploring non-contact or perceived lack of engagement
- Risk assessments
- Mental capacity assessments
- Team around the person

Person-centred approach

A person-centred approach is embedded in the legal framework that accompanies the Care Act 2014. The [Care and Support Statutory Guidance](#) further emphasises the principle of involvement. This means putting the person at the heart of the assessment process to understand their needs, desired outcomes and wellbeing, and to deliver better care and support:

- Individuals should be provided with questions in advance, in an accessible format, to help them prepare.
- To promote involvement, consideration should be given to any preferences an individual may have regarding the location, timing and format of an assessment.
- A strengths-based approach and taking time to get to know and trust each other are important elements. The person should retain ownership of goals and the progress needed to achieve them.
- Care and support assessments must be balanced and consider all needs equally. Assessment should focus on identifying and understanding an individual's needs. It should not start from a position of what services are available and/or normally provided.

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Professional curiosity

Assessments should be characterised by professional curiosity rather than taking situations at face value and without exploration of what a person says. Professional curiosity about people's experiences helps to understand the ongoing impact of trauma and adverse experiences. This gives a better insight into how they come to be the person they are now.

Exploring trauma and adverse experiences

Assessments should include details of a person's life experiences, the impact of significant events and their longer-lasting effects. If the person's story is not considered, this could result in tackling symptoms rather than addressing underlying causes.

The basis for change is a relationship with the person, which expresses professional curiosity about their experiences and what has led them to where they are now. The relationship should identify and build on the person's strengths, goals and aspirations to keep them safe and promote their choices.

- It is not inevitable, but trauma is both a possible cause and can be the outcome of multiple and complex needs.
- Professional curiosity is an important approach in identifying the cause of behaviours that may appear dysfunctional.
- A psychologically informed approach recognises the extent and effect of trauma and responds sensitively to it. This is possible when safe and respectful relationships are established. There needs to be trust and transparency, careful use of language, compassion and empathy, a willingness to connect emotionally and a readiness to learn from those with lived experience.

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Exploring non-involvement

Issues of social justice and oppression may make it more difficult for people with MCN to access support in relation to traumatic experiences, mental distress and substance misuse. Coercion and control from a third party may also impact on a person's ability to access care and support.

- Practitioners must question why a person did not become involved by asking what they can do to encourage involvement.
- Where an individual may have substantial difficulty in maintaining their involvement, an advocate must be appointed to provide representation and support during assessment, care planning and reviews.

Risk assessments

Effective safeguarding depends on robust risk assessment which explores both the likelihood of different risks arising and their potential significance. Different assumptions can obstruct risk assessment:

- The assumption of "lifestyle choice": With individuals who are alcohol-dependent, it is easy to view them as choosing their lifestyle, but the reality is likely to be more complex.
- The assumption that an individual can protect themselves: These narratives can lead practitioners to under-estimate risk.
- The neglect of an individual's strengths and resilience: This can lead to an over-estimation of risk.

The aim of a robust risk assessment is to build a relationship with a person that can support respectful challenge and dialogue about how to mitigate (rather than remove all) risk and agree objectives relating to wellbeing and autonomy.

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Where the duty to undertake a safeguarding enquiry is not met, the local authority must still consider and record how any identified risk will be mitigated. This could be by referral to another agency and/or convening a multi-agency risk management meeting to agree a plan.

There may be occasions where all options have been explored within current threshold criteria and it is still not possible to reduce the level of risk. If after consultation with existing multi-agency functions (for example safeguarding adult, MARAC, MAPPA etc) professionals may want to consider referring the individual to the Vulnerable Adult Risk Management (VARM) group to help identify strategic and operational actions to manage and mitigate risk.

Mental capacity assessments

When working with people with MCN, some of whom will be using alcohol and/or other drugs, an accurate interpretation and application of the principles of the [Mental Capacity Act \(MCA\) 2005](#) is essential.

- The presumption of capacity should not be read as meaning that there is no need to investigate capacity. An apparently unwise decision may be reason to doubt capacity and to complete an assessment.
- Reliance must not be placed solely on what a person says. Adverse experiences, trauma and prolonged substance misuse use can result in frontal lobe brain damage, which can affect an individual's behaviour. This could be a reason to undertake a mental capacity assessment. Assessing the person's ability to put a decision into effect (executive functioning) is therefore essential.
- It may be difficult to assess capacity in people with executive dysfunction. Structured assessments of capacity may need to be supplemented by observation of the person's functioning and decision-making ability to provide the assessor with a complete picture.

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Executive capacity is relevant where the individual has addictive or compulsive behaviours. This highlights the importance of considering the individual's ability to make a decision (decisional capacity) in addition to their ability to put a decision into effect (executive capacity):

- An individual may be driven by compulsions that are too strong for them to ignore. Their actions may contradict their stated intention, for example to control their alcohol use. In other words, they are unable to carry out decisions that they have made.
- The compulsion associated with an addictive behaviour can impair an individual's ability to understand and weigh up the relevant information for the purposes of completing a mental capacity assessment. Assessing the capacity of dependent alcohol drinkers or substance users is complex and it should involve multi-agency discussion and advice from legal services.

Some adults may have fluctuating capacity. It may occur because of their lifestyle or behaviour, and lead to making an unwise decision, for example:

- An adult may decline treatment for an overdose when under the influence of alcohol.
- An adult may prioritise a substance over a serious health need.
- An adult experiencing very high levels of distress and making unwise decisions such as those made by someone with emotionally unstable personality disorder.

This fluctuation can take place over days or weeks, or over the course of a day. Consideration should be given to undertaking the mental capacity assessment at a time when the adult is at their highest level of functioning.

If an adult is subject to coercion and control or undue influence by another person this may impair their judgement and could impact on their ability to make decisions about their safety. Supporting people who are subject to coercion is often complex and challenging.

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If this is the case, professionals need to:

- Work with the person, to explore options that may be available to keep them safe.
- If the situation cannot be resolved in other ways, professionals may need to seek legal advice regarding whether to apply to the High Court for orders under the inherent jurisdiction.
- If an adult refuses intervention to support them with a safeguarding concern, or requests that information about them is not shared with other safeguarding partners, in general, their wishes should be respected. However, there are circumstances where professionals can reasonably override such a decision, including when:
 - The adult lacks the mental capacity to make that decision – this must be properly assessed and recorded in line with the MCA.
 - Emergency or life-threatening situations may warrant the sharing of relevant information with the emergency services without consent.
 - Other people are, or may be, at risk, including children.
 - Sharing the information could prevent a serious crime.
 - A serious crime has been committed.
 - The risk is unreasonably high and duty of care to the individual or others must be considered.
 - Staff in a position of trust are implicated.
 - There is a court order or other legal authority for taking action without consent.
- In such circumstances, it is important to keep a record of the decision-making process. Professionals should seek advice from managers in line with their organisations' policy before overriding the adult's decision, except in emergency situations.
- Managers should make decisions based on whether there is an overriding reason which makes it necessary to take action without consent. They should decide whether doing so is proportionate because there is no less intrusive way of ensuring safety. Legal advice should be sought where appropriate.

- If the decision is to take action without the adult's consent, then unless it is unsafe to do so, the adult should be informed that this is being done and the reasons why. If there are any other adults or children at risk seek advice from the Safeguarding Lead for your organisation.

Team around the person

To improve people's mental and physical wellbeing requires whole system partnership working across mental health and substance misuse providers, outreach homelessness teams, councils, adult social care, police, homelessness support workers, primary care and secondary health care.

Collaboration between practitioners and their services is essential to ensure prompt assessment and provision of care and support. Individuals with MCN will require a range of expertise to holistically assess and support their needs. In this context, it is important to remember that the duty to cooperate is contained in the Care Act 2014.

When several services are involved, it is important to appoint a keyworker, to support people to access and engage with services, and to coordinate provision of support and assistance.

It is important to consider who may be best to work creatively and proactively with an adult who does not wish to or does not feel able to become involved or maintain contact. They may be able to build a relationship of trust that may enable the person to accept support. For example, the adult may have already established a positive working relationship with another professional, such as a worker from a voluntary agency, care agency or health service. It is important that organisations have mechanisms in place for supporting these workers to undertake this role, and to escalate any concerns where necessary.

In situations involving an adult who is self-neglecting, a lead agency should be identified to coordinate a multi-agency response. The local authority will be the lead agency if a safeguarding enquiry under Section 42 of the Care Act is undertaken. However, the local authority may request another agency to lead and coordinate the enquiry if the agency is better placed to do so. This could be because:

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- The agency is already involved with the adult.
- The agency has a duty of care towards the adult because of their needs.
- The agency holds significant information relating to the adult.
- The adult has shown a likelihood to engage best with this agency in the past.
- The adult's care and support needs relate predominantly to the service provided by the agency.

Multiple Exclusion Homelessness: A safeguarding toolkit for practitioners

The [Multiple Exclusion Homelessness toolkit](#) was developed by Bruno Ornelas, Andy Meakin, Fiona Bateman, Dr Michelle Cornes, and Dr Laura Pritchard-Jones with support and feedback from people with lived experience at Expert Citizens CIC. It was launched in December 2023.

The intention of the toolkit is to provide practitioners with a helpful resource to aid fact finding and decision-making in the context of adults experiencing multiple exclusion homelessness. It can be used as an aid to communication and multidisciplinary working across sector boundaries.

The toolkit underscores the principle that safeguarding is a collective responsibility. It equips practitioners with the necessary guidance to actively gather information, unveiling risks that may otherwise be overshadowed by complexity or immediate crises.

Divided into four pivotal sections – assessing needs and risks, chronicling events, identifying immediate risks, and devising protection plans – the toolkit integrates invaluable resources, links, and nuanced guidance for practitioners to consider in reaching conclusions.

Summary

MCN are intricate and potentially, ever changing, within a person's presentation. Reflection and consideration of this within practice is vital. Communication, the use of judgement and practice expertise underpins how professionals should work with people. By starting and enabling conversations about MCN it is hoped that there will continue to be robust and supportive assessments, interventions and meaningful change for all individuals experiencing MCN.

Acknowledgments

The guidance and information within this framework were adapted from the following sources:

- [Supporting People with Multiple Needs Annual Report of the National Evaluation 2016](#), Fulfilling Lives
- [Adult Safeguarding and Homelessness – A briefing on Positive Practice](#), Michael Preston-Shoot, Local Government (LGA) and the Association of Directors of Adult Social Services (ADASS), March 2020
- [Using Strengths-Based Approaches with People Experience Multiple and Complex Needs](#), Theodora Soulantika, Fulfilling Lives South East Partnership, June 2021
- [Adult Safeguarding and Homelessness: Experience Informed Practice](#), Michael Preston-Shoot, LGA, August 2021

Community Safety – an introduction to community safety

Crime, fear of crime and anti-social behaviour is an important consideration in the quality of life of local communities. Compared to other areas of the country, Derbyshire has low levels of crime, but our aim remains to reduce crime, disorder and the fear of crime.

Across Derbyshire, different agencies are committed to working in partnership to reduce crime and risks to safety and to maintain quality of life for people who live, work and visit the area.

Our priorities are identified through a strategic risk and threat assessment.

Anti-social behaviour (ASB)

Anti-social behaviour is defined by the [Anti-Social Behaviour, Crime and Policing Act 2014](#) as 'acting in a manner that caused, or is likely to cause, harassment, alarm or distress to any persons'.

Examples of anti-social behaviour could include:

- Noise nuisance
- Criminal damage, vandalism, graffiti
- Intimidation/harassment
- Litter, dog fouling, fly tipping
- Drug or alcohol misuse
- Nuisance motorcycles
- Hate behaviour that targets people because of their perceived differences

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This is by no means an exhaustive list. The important factors in determining ‘what is’ and ‘what is not’ anti-social behaviour are the level of seriousness and frequency of the behaviour. There is a balance between tolerating behaviour that we personally may not agree with and ensuring that we tackle behaviour that is anti-social.

If the problem is not too serious, try talking to the person; they may not realise they are causing a nuisance. Be calm and friendly, explain what the problem is and how it affects you. Listen to the other person and try to reach an agreement. If the discussion is getting unreasonable, leave and [report the anti-social behaviour](#).

Anti-social behaviour covers a wide range of problems and because of this, the agency that you should speak to varies. Please use the tool on the [Safer Derbyshire website](#) to find out more information on who to report issues to.

When the police, local authority and housing providers receive reports of anti-social behaviour from victims, they will ask questions to establish whether there are any reasons why an individual may be targeted, such as because of their faith, nationality, ethnicity, sexuality, gender identity or disability and also to establish whether there are any personal factors that might increase the victim’s vulnerability or risk of harm as a result of the anti-social behaviour they are experiencing.

[Derbyshire Victim Services \(DVS\)](#) offer free support for all victims of anti-social behaviour, regardless of whether the incidents have been reported.

There is a range of tools and powers available to tackle anti-social behaviour. These are used on an incremental basis, according to nature, seriousness and persistence of the behaviour. Where legal enforcement action is taken an Equality Impact Assessment is undertaken.

The Anti-Social Behaviour Case Review

The Anti-Social Behaviour Case Review gives people affected by ASB the right to request a review of the response to their reports of ASB, if their concerns have not been dealt with, or acted upon, and organisations have been unable to resolve the serious persistent, or targeted, anti-social behaviour successfully. The Anti-Social Behaviour Case Review can be used when three or more related incidents of anti-social behaviour have been reported within the last six months. You can apply for the Anti-Social Behaviour Case Review on behalf of someone else, but you must provide their written consent, alongside the application form.

Concerns about individual officers, or services, should continue to be directed to the relevant organisation's complaints procedure and/or the Local Government and Social Care Ombudsman, the Housing Ombudsman or the Independent Office for Police Conduct.

Further details and an application form can be found at:

- Anti-Social Behaviour Case Review – Derby (a link will be provided when it is available)
- [Anti-Social Behaviour Case Review](#) – Derbyshire

Victims of anti-social behaviour can find more information in the [Derbyshire ASB Hub](#).

Burglary and theft

This is sometimes referred to as 'acquisitive crime'. It includes domestic burglary, theft of a motor vehicle and robbery.

[Burglary and theft](#) can have a large impact on a victim and the local community. Although this crime in Derbyshire is falling, partners in Community Safety continue to work together to reduce these crimes even further.

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Derbyshire Constabulary have information on [protecting your home from crime](#), with door and window security advice, garden and shed security. It also advises that your local community should launch a [Neighbourhood Watch Scheme](#), to share knowledge and information on keeping safe as well as looking out for one another.

To report a crime taking place, telephone: 999. If you want to report a crime, have concerns about your area or want to make an enquiry, telephone: 101.

If you are deaf or hard of hearing, use Derbyshire Constabulary textphone service 18000 or text 999 if you have pre-registered with the emergencySMS service.

Counter terrorism

The current threat from terrorism and other violent extremism requires us all to look out for activity or behaviour which strikes us as out of place in normal day to day life and to report it to the police.

Section 26 of the Counter Terrorism and Security Act 2015 places a duty on certain 'specified authorities' which includes local authorities, social care, schools, universities, health, police, prisons and probation. This duty means that in the exercise of their functions they have 'due regard to the need to prevent people from being drawn into terrorism'.

Extremism is defined as:

“Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas.” (HM Government Prevent Strategy).

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Prevent

Prevent is one strand of the government's counter terrorism strategy, [CONTEST](#), which aims to safeguard and support vulnerable people to stop them becoming terrorists or supporting terrorism of any form. This could include:

- Religious – extreme or militant religious groups
- Political – including extreme far right and far left groups
- Northern Ireland Related Terrorism (NIRT)
- Conflicted ideology – where someone becomes fixated on more than one type of extremism or terrorism, e.g., someone might become interested in extreme far right and extreme Islamist ideologies even though they seem opposing
- School massacre/mass harm – where someone might not have a clear 'ideology' but thinks about doing harm to a lot of people. Although this may stem from a grievance against an establishment or people within that establishment for a variety of reasons, e.g., bullying, religion, particular workforce or group, a location can also be chosen at random to harm a large number of people. This can be carried out in several ways including vehicular targeting, knife attack, shooting and bombing although this list is not definitive.
- Incel subculture – where 'involuntary celibates' think about harming others, usually women and girls, who do not want to have relationships with them. This subculture mainly has an online presence, and they define themselves as unable to find a romantic or sexual partner despite desiring one. Discussions in Incel forums are often characterised by resentment, extreme misogyny, self-pity and self-loathing, racism, a sense of entitlement to sex and the endorsement of violence against sexually active people. Sources report that Incels are mostly male, heterosexual and are predominantly white. Followers of this ideology target attractive or sexually active men as well as women.

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Prevent aims to:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support
- Enable those who have already engaged in terrorism to disengage and rehabilitate

Radicalisation is a process where people are groomed to engage in criminal, terrorist activity. They are often 'radicalised' by other people (sometimes by people they trust, sometimes by strangers), or by things they read on the internet or world events they see on the news.

They might have various grievances, sometimes with no clear ideology or motive or may have suffered a traumatic event, leading to blame for a particular section of society. If someone 'self-radicalises' then starts to threaten or move towards violence they can be known as a 'self-initiated terrorist' or S-IT.

The people who are targeted by radicalisers are often vulnerable or susceptible in some way and need our help to keep them safe. They could be adults or children of any age and can be from any background.

Prevent helps us to safeguard these vulnerable people before they commit any criminal terrorist related offences. This is known as the 'non-criminal space'. It works in a similar way to other safeguarding procedures to support, protect and divert individuals.

Anyone can make a referral to Prevent, and they are received from a wide range of partners including communities, education, health, youth offending teams, police, adults and children's social care. Members of the public can also refer into the police Prevent team. Family and friends who refer individuals to the Prevent program are often best placed to identify concerns as they are the ones who know the individual best and spend a lot of time around them.

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Referrals are first screened for suitability through a preliminary assessment by the police Prevent team. If appropriate, an assessment of the individual's vulnerabilities is made. This is based around 3 criteria:

- Engagement with a cause, group or ideology
- Intent to cause harm
- Capability to cause harm

If suitable, the case is then referred into the 'Channel' process.

Channel

Channel is a confidential and voluntary process whereby safeguarding professionals assess the case and discuss the most appropriate support options. As such, individuals have the final say on whether they accept support or not. The support options on offer encompass an array of different interventions, addressing educational, vocational, mental health and other vulnerabilities tailored to the individual's needs. Ideological support is also common, which may include discussion with credible ideological experts and faith leaders.

What should you do if you have concerns?

If you are worried about someone and think they are at risk of getting involved in terrorism or extremism, you should make a Prevent referral. If it is an emergency, please telephone 999. Anyone can make a [Prevent referral](#).

Safer Derbyshire assists in the [training of all partners](#) so that they fulfil their statutory duty to 'have due regard for the need to prevent people being drawn into terrorism' in all aspects of day to day duties.

We want to encourage local communities to trust instincts and look out for the unusual to help us to continue to keep the public safe. Don't rely on others.

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If you suspect it, report it. Call Derbyshire Police, telephone 101, or the confidential anti-terrorist hotline, telephone 0800 789 321.

Let the police decide if the information is important. What might seem insignificant on its own could actually provide a vital link to a wider investigation.

Referral Pathways (Derbyshire County)

- For referrals for the **County** please use the [referral form](#)
- For referrals for the **City** please use the [referral form](#)
- The Safer Derbyshire website has more information about [Prevent in Derbyshire](#)
- Derbyshire Constabulary have information about [Prevent and role the of their Prevent Team](#).

Cybercrime

What is cybercrime?

In simple terms, cybercrime is any crime that involves a computer, the internet or related technology.

Cybercrime can be split into two broad categories:

Cyber-dependent crimes – These are offences that can only be committed using a computer, computer networks or other forms of information communications technology (ICT). A cyber-dependent crime is an offence under the [Computer Misuse Act 1990](#). An example is gaining unauthorised access into someone's computer network, known as 'hacking'.

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Cyber-enabled crimes – These are offences that can be conducted on or offline, but online, using technology as a tool to commit crimes, the offences may take place at unprecedented scale and speed. Examples of cyber-enabled crimes include fraud, phishing e-mails, the purchasing of illegal drugs and child sexual exploitation.

There are also many other online risks that people can be vulnerable to, such as cyberbullying, cyberstalking, online grooming, online radicalisation and sexting.

More information about different types of cybercrime is available from [Safer Derbyshire](#)

Who is at risk of becoming a victim of cybercrime?

Anyone who is connected to the internet (via a computer, laptop, smart phone, etc.) is a potential victim of cybercrime.

The elderly are no more at risk from general cybercrime than the young, rather risks increase when people do not follow basic online safety advice.

Older people are more at risk from financial abuse and scams. For more information about financial abuse, please visit the [Derbyshire Safeguarding Adults Board website](#).

How can I help prevent people from becoming victims of cybercrime?

There are lots of simple steps people can take to improve their online safety and reduce the risk of becoming a victim of cybercrime. These are best accessed by completing our Digital MOT. This is a free online cyber security assessment tool, developed by the Community safety Unit at Derbyshire County Council, in partnership with the Cybercrime Unit at Derbyshire Constabulary. It takes less than 5 minutes to complete the MOT and find out how to be safer online.

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You can also help by directing people to other reliable sources of information to help protect themselves. There are a number of websites that contain good advice and information about how to stay safe online, these include:

- **Get Safe Online** – provides online safety advice for individuals and businesses
- **Cyber Aware** – government-backed website based on expert advice from the National Cyber Security Centre
- **Childnet** – a national charity providing expert online safety advice for young people, parents and teachers
- **Parent Zone** – provides online safety advice for parents.

For adults with learning disabilities, there are 'easy read' guides available on the Derbyshire County Council website.

Further advice and links to these sites can be found at:

- [Cybercrime – Derby](#)
- [Cybercrime – Derbyshire](#)

How can I help someone who has been a victim of cybercrime?

Victims of cybercrime may feel like they are facing a powerful and invisible attacker. They might feel angry, fearful or sick, under siege in their own home and powerless to defend themselves, even if they are computer literate. People often feel embarrassed, or ashamed, if they are tricked into becoming a victim of cybercrime and blame themselves for not doing more to protect themselves.

You can help victims of cybercrime by ensuring they do everything they can to protect themselves in the future and by helping them to report the incident to Action Fraud, as detailed on the [Safer Derbyshire website](#).

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Who is at risk of committing cybercrime?

Indications are that a number of teenagers (mostly male) are becoming involved in cyber-dependent criminality, whereas they would be unlikely to be engaged in offline, traditional crimes, such as burglary or theft.

A common pathway into cybercrime is via online gaming cheat and 'modding' (game modification) forums.

Motivations for cybercrime include:

- Having a deep interest in technology
- Completing a challenge
- Sense of accomplishment
- Proving oneself to peers
- Financial gain (although this is often secondary)

How can I help prevent people from becoming perpetrators of cybercrime?

Cyber Choices is an early intervention project for young people or vulnerable adults who you are concerned about because:

- They have a high technical ability in computing, and are vulnerable or at risk of cyber exploitation

Or

- They are already on the cusp of cyber criminality

More information about Cyber Choices and the [Cyber Choices Toolkit](#) is available on the Safer Derbyshire website.

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Derbyshire Constabulary

If you have any specific operational questions that are not covered by the above, contact Derbyshire Constabulary's Cybercrime Unit email: cyber@derbyshire.police.uk

Coercive and controlling behaviour

The current Home Office definition of domestic abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality."

Controlling behaviour

This is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

This is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- [Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework](#)

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Legislation

The offence of Coercive Control came into force on 29th December 2015 as part of The Serious Crime Act 2015. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment.

Definition

Coercive control involves the use of abusive behaviours used frequently in daily interactions to gain and maintain power and control over an intimate partner and is not gender specific. Physical and sexual violence are typically used only occasionally to reinforce and add power to the abuse when the emotional tactics are not achieving the desired goals.

To be classed as coercive control the following need to be the case:

- On at least two occasions the victim has feared that violence will be used against them
- They have felt serious alarm or distress and it has had a substantial effect on their usual day to day activities, or serious psychological impact
- It has caused them to change the way in which they live, e.g., the way in which they socialise, do household chores or how they care for their children
- There is related deterioration in their physical or mental health
- The perpetrator should know or "ought to have known" that the behaviour would have a serious effect on the victim
- As a result of the Domestic Abuse Act 2021, control and coercion can now apply after a relationship has ended, acknowledging that abusers will often seek to continue this abusive behaviour to control and coerce a victim even after the end of a relationship.

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Although physical violence is more overt, behaviours involved in coercive control are even more emotionally harmful. These sometimes-subtle behaviours are more difficult to detect and prove. Coercive control is central to the definition of intimate partner violence. Such control creates an ongoing sense of fear and the victim adapts their behaviour to survive.

- Behaviours used by perpetrators
- Intimidation (e.g., threatening looks and gestures)
- Controlling or tracking movements
- Emotional abuse (e.g., excessive criticism and humiliation or controlling appearance and food consumption)

- Isolation (e.g., limiting or creating barriers for contact with family and friends)
- Minimizing or denying the abuse or blaming the victim for the behaviour
- Threatening to take or hurt children or involve them in the abuse (e.g., used to monitor the victim's whereabouts)
- Controlling or preventing sleep
- Controlling social media use
- Using social privilege, such as patriarchy, racism, homophobia, or other forms of oppression
- Coercion and threats
- Economic abuse (e.g., controlling or limiting access to finances/resources).
- Setting rules for the victim to abide by which may be changed arbitrarily.
- 'Gaslighting' distorting a person's sense of their own reality such that they question their own perceptions.

Forms of abuse in which coercion and control may exist

- **Intimate terrorism** is defined as a relationship in which one partner is the primary aggressor and is both violent and controlling.

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- **Mutual violent control** exists where both partners are physically violent and use coercive control
- **Common couple violence** exists where both partners use violence but not coercive control
- **Violent resistance** is where physical violence is perpetrated by the partner who has historically been the victim. This violence is perpetrated in response to the violence and controlling behaviour of the primary aggressor.

Coercion and control in familial and care environments

It is important to remember that behaviours associated with coercion and control are not limited to relationships between intimate partners and may be present in other relationships such as between siblings, parents and their children, or an adult and their carer. When an adult is reliant

on another person for their care and support it can become very difficult for them or for others around them to recognise the behaviour as coercion and control. There are also other factors for practitioners to consider in relation to the adult who is being controlled as they could be afraid of the care relationship being removed or altered by reporting this behaviour or by accepting help from agencies.

A Derbyshire Safeguarding Adult Review, [SAR18A](#), highlighted that there were features of coercion and control between a mother and her adult daughter. The mother was a full-time carer for her daughter and there was evidence that the mother had isolated her daughter, limited her access to fluids and denied her access to services. For many years the daughter's views were not heard by practitioners. It became accepted that mother always answered questions on her daughter's behalf. Mother employed a number of strategies to keep agencies away which indicated the presence of 'disguised compliance'; this is when a person gives the appearance of co-operating with services to avoid raising suspicions. Disguised compliance can be closely linked with coercion and control.

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A summary of learning from [Domestic Homicide Reviews \(DHRs\) 2014 – 18](#) identified that agencies needed to exercise professional curiosity when dealing with domestic abuse, particularly in cases of coercion and control, that staff need training to recognise it and be aware that perpetrators are adept in exercising control and may seek to control and manipulate professionals it is important for professionals to remain neutral and not endorse abusive behaviour by language or actions.

A Derbyshire Domestic Homicide Review, RDCNH 19 identified complexities within families and the roll of carers within those families coping alone to support an individual with mental health and or substance misuse whose condition may be exerting control over a household which is not recognised. Whilst carers play a key role in an individual's care, those providing care will not always identify themselves as Carers. They may not be aware of how they can contribute information nor of what support they can receive. Agencies need to 'Think Family' and be attuned to identifying hidden carers and reach out to support and involve carers in the individual's care.

Gathering evidence

Coercive control can be reported to the police even if the victim does not have any other evidence. The victim's statement itself is evidence in the case. The police will investigate any reports of coercive control and gather evidence. Victims may be able to help the police by providing copies of:

- Emails, screen shots and social media messages
- Text messages
- Voicemail recordings
- Photographs of injuries
- Photographs of damage to property
- Bank statements
- Keeping a diary of day-to-day experiences

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- Medical and financial records
- CCTV
- Witness testimony

Practice and reflection

- Thinking about cases you have worked with previously or currently, what examples can you think of that involve coercive control?
- What do you need to consider for effective risk management in cases involving coercive control?
- How would a multi-agency approach assist in managing cases where coercive control features?
- What support can be offered to victims' experiencing coercive control?

Sexual violence and rape

Violence and abuse in private or public is unacceptable and can affect anyone regardless of gender, sexuality, religion, race or disability. Sexual violence and abuse can be defined as any behaviour perceived to be of a sexual nature which is unwanted and takes place without consent or understanding. The definition of sexual violence used by Derbyshire County Council is:

- Rape
- Assault
- Inducement, threat or deception to procure sexual activity with a person with a mental disorder (involving penetrative activity)
- Incest

There are many rape and sexual violence helplines that you can use, both countywide and nationally – **dial 999 in an emergency.**

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[Supporting Victims of Sexual Violence \(SV2\)](#) provide confidential counselling and support to anyone over the age of fourteen in Derbyshire (UK), at a range of locations throughout the county. Sexual violence counselling is a safe space in which to explore your experiences and feelings, in your own time and way. They offer the opportunity for medicals without Police involvement following recent rape or sexual assault. Telephone SV2: 01773 746115.

[Independent Sexual Violence Advisors \(ISVA\)](#) - the ISVA is dedicated to supporting the service user after an experience of sexual violence. Trained specialists offer practical and emotional support to anyone over the age of 19 who is considering reporting or has reported rape or sexual abuse. ISVAs offer support through the whole process, from disclosure to the trial and beyond, should the victim choose to take this course of action. They provide:

- Advice and support, face to face and telephone support at crucial times throughout the process
- Support with Police statements
- Explain legal jargon and attend court with them
- Keep the service user up to date with their case
- Support them whatever the outcome of their report to the Police
- Help with accessing counselling in crisis with SV2

[Sexual Assault Referral Centre \(SARC\)](#) – is a specialist service for anyone of any age, male or female who have been raped or sexually assaulted. They are open 24 hours per day, seven days per week. They aim to provide medical care and forensic examination following assault or rape, counselling and sexual health services. For those not wanting to report to the Police, self-referrals are accepted. In order to preserve any evidence that may be present it is vital that help from the SARC is accessed as immediately as possible after an assault. In addition, the SARC can advise on and assist with other medical needs.

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Substance misuse (alcohol and drugs)

Parental drug and alcohol abuse

Children are at greater risk of harm when they are living in households with parental substance misuse problems, with an increased risks of domestic abuse, neglect, a poor home environment and exposure to unsafe substances.

Alcohol

Misuse is directly linked to deaths from diseases such as cirrhosis of the liver, lung and stomach issues alongside weight gain, infertility, mental health problems and some cancers. It is also associated with other causes of death including stroke and coronary heart disease.

The NHS recommended limits are 14 units a week, spread evenly throughout the week.

The alcohol you drink travels to your stomach. Unlike food, alcohol doesn't need to be digested and can pass quickly and easily into the bloodstream – in only a few minutes it travels to every part of the body.

As well as the recognised immediate effects of drinking too much like nausea, vomiting and hangovers, binge drinking and prolonged heavy drinking over longer periods of time can affect you in many different ways. These vary from cancer, heart problems, liver, lung and stomach issues, weight gain, infertility and mental health problems.

Drugs

'Harm reduction' refers to interventions directed towards people who continue to use drugs, aimed at reducing the impact of that drug use on their physical health. The most significant harms are associated with injecting behaviour, including the spread of blood-borne viruses, bacterial infections, damage to the circulatory system and overdose.

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While more detail on these risks is given below, the single most important harm reduction measure is to use a new needle and syringe for every injection. Injecting equipment is available from Needle and Syringe Programmes (NSPs) across Derbyshire. Specialist NSPs are provided by Derbyshire Substance Misuse Service at their bases in Chesterfield, Ripley, Ilkeston and Swadlincote and injecting equipment is also available in a number of pharmacies.

Although injecting is the principle cause of harm, it must be remembered that there are risks associated with other aspects of drug use. In particular, there is concern around the proliferation of new drugs, previously known as 'legal highs' and now usually referred to as Novel (or New) Psychoactive Substances. There is concern that people may not be aware of what they are taking, what their effects may be or how strong it is. There have been a significant number of overdoses linked to these substances.

Needle safety – If you find a needle, don't touch, hide it, or put it in the bin. Contact the building owner, local council or the Police to remove safely. A free and confidential needle and syringe programme in Derbyshire is available to anyone injecting drugs and aiming to reduce infection.

In an emergency – Always call an ambulance if you think someone has overdosed. The Police will not attend unless there is a death at the time. If the ambulance crew suspect evidence of harm to children or vulnerable people, or if the crew are in fear of attack, the Police will be called. Those who have detoxed from heroin or other opiates are at very high risk of overdose if they use drugs again as their tolerance steadily subsides over time.

Remember that possession of a controlled substance is against the law and if stopped by the Police you may be searched and prosecuted.

For more information about how to access treatment services for substance misuse go to:

- [Substance misuse treatment services – Derby City](#)
- [Substance misuse treatment services – Derbyshire](#)

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Derbyshire Victims' Services

This is an independent charity working across Derbyshire to support victims of crime. The charity work as part of the Police and Crime Commissioner's CORE (Coping and Recovery) team. If you would like to talk to someone about what has happened to you, or you would like emotional or practical support, please get in touch. All services provided are free and confidential.

- Telephone 0800 612 6505
- Email support@derbyshirecore.org
- Text "COREDVS" to 82228

Organised crime

Community Safety are working in partnership to look into the effects of organised crime, which includes immigration crime, modern slavery and exploitation. We already work with licensed premises, the night time economy and have an [integrated offender management](#) scheme, which all helps to disrupt organised crime.

Trading Standards also work to reduce the number of unsolicited calls by doorstep traders. The Home Office released a serious organised crime strategy 2018, which aims to reduce opportunities, strengthen enforcement and safeguard communities from organised crime.

Modern slavery

The [Derby and Derbyshire practice guidance for responding to adult and child victims of modern slavery](#) intends to provide clear and up-to-date information on the key facts and to help staff recognise the signs and respond effectively, so that more victims get help and perpetrators are brought to justice. The guidance is split between adults and child victims. The reason for this guidance is to address the situations that occur when a child may be accompanied with an adult.

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The guidance will also help staff understand both processes when referring potential victims into services and will assist those who:

- May encounter potential victims of modern slavery
- Are involved in supporting victims
- Are responsible for referring into the National Referral Mechanism (NRM)

Offender management

Derbyshire has an Integrated Offender Management (IOM) scheme which is focussed on offenders, not offences. It improves the way in which criminal justice agencies and other partners share information and work together to control, manage and supervise a small, targeted group of offenders who are assessed as being highly likely to re-offend.

Helping offenders into drug, alcohol, debt, health, children and accommodation services and encouraging them to remain there for as long as necessary is a key factor in reducing re-offending. Offenders will be encouraged to take responsibility and face up to the consequences of their actions by probation and other agencies.

The [Youth Justice Service](#) work with young people and their communities to tackle youth crime in Derbyshire.

Data protection, GDPR and information sharing

The General Data Protection Regulation (GDPR) and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping people safe. They serve to ensure that personal information is shared appropriately.

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Information can be shared without consent to keep an individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional wellbeing. But, where possible, consent should be sought from the individual before information is shared.

Keep a record of your decision and the reasons for it, whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Ensure that the information you share is necessary and proportionate for the purpose for which you are sharing it, is shared only with those individuals who need to have it (i.e., relevant), is adequate for its purpose, is accurate and up to date, is shared in a timely fashion and is shared securely.

Use your judgement when making decisions about what information to share. If in doubt, speak with your manager.

Sharing information without consent

You can share information relating to abuse, without consent from the person:

- If the person lacks capacity to make the decision (Mental Capacity Act 2005)
- For the prevention and investigation of crime (Crime and Disorder Act 1998)
- To prevent serious harm/distress or threat to life (Data Protection Act 1998)
- If there is a risk to others/children
- If the person is under duress, coercion or undue influence
- If staff are implicated
- Domestic Abuse which meets the MARAC threshold
- If there is a court order/other legal authority in place instructing you to do so
- Where the alleged abuser has care and support needs and may be at risk

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Recording information in the case file

If you share information without consent, you must record the following information on the person's case file:

- Why? What is your concern and reason for overriding consent?
- When? Date and time you shared the information.
- Legal basis for overriding consent
- How? In what format you have shared the information such as verbally or in writing?
- What? Exactly what information have you shared?

In cases where a crime is occurring or someone is in need of immediate medical or Police assistance, please contact emergency services on 999.

The Derbyshire Safeguarding Adults Board has in place an [information sharing agreement \(ISA\)](#) in relation to safeguarding adults. This agreement was signed-off by Board members in December 2018.

There is a separate [information sharing agreement \(ISA\)](#) for Derby City.

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Domestic abuse

Introduction

Domestic abuse is still a 'hidden' issue in our society, taking many forms including controlling and coercive behaviour, physical, emotional, financial, psychological, sexual, 'honour'-based abuse or violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. Domestic abuse can affect anyone, regardless of age, disability, gender identity, gender reassignment, race, religion or belief, sex or sexual orientation. Domestic abuse can also manifest itself in specific ways within different communities.

The concept that domestic abuse is everyone's business is now largely accepted and all services are expected to contribute to recognising and reporting abuse and supporting victims. There are also elements of domestic abuse of particular relevance to those providing social care services.

Purpose of guidance

This guidance is intended to provide current information about domestic abuse, to help staff recognise signs of it, raise awareness of safeguarding responsibilities and where domestic abuse and safeguarding intersect, develop professional confidence in responding effectively to support victims. The guidance is aimed at staff:

- Who may encounter victims
- Are involved in supporting victims and/or
- Are responsible for supporting and referring victims to specialist services

More detailed information can be found in the [Domestic Abuse Statutory Guidance](#). A [British Sign Language \(BSL\) version](#) of the guidance is available.

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What is Domestic Abuse

The [Domestic Abuse Act 2021](#) has created a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are personally connected to one another, regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Economic
- Emotional

The Act also introduces a recognition of children as victims in their own right. A child who sees, hears, or experiences the effects of domestic abuse and is related to the person being abused or the perpetrator, is also to be regarded as a victim of domestic abuse.

Definitions

Personally connected. The Act gives the following definition for the personal connection between two people over 16 as:

- They are, or have been, married to each other
- They are, or have been, civil partners of each other
- They have agreed to marry one another (whether or not the agreement has been terminated)

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- They have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- They are, or have been, in an intimate personal relationship with each other
- They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2))
- They are relatives

This clearly encompasses those who are intimate partners or formerly were, irrespective of sexuality and family members

Children as victims. The Act recognises children affected by domestic abuse as victims in their own right where a child under eighteen sees, hears or experiences the effects of the abuse and is related to either victim or perpetrator. They are related to either party if either of them is a parent or has parental responsibility for the child or is a relative of the child.

Physical abuse. Including violent or threatening behaviour towards an individual or other family members (including the unborn child in pregnancy) or pets, over or under-medicating, depriving victim of access to medical aids, poisoning, scalding, strangling, drowning threatening or using weapons (including domestic appliances), damaging property, harming someone whilst performing care for them.

Sexual abuse. Including sexual assault, rape, coercing them into sexual acts or use of pornography against their will, exposing or threatening to expose to sexually transmitted diseases, use of technology including images and revenge porn, sexual exploitation.

Economic abuse. Including, controlling access to money, controlling access to employment, education or training to limit opportunity for financial independence, stealing, controlling household finances, identity theft and taking out debt in the victim's name, controlling accounts on-line, dictating on what money is spent, controlling access to or manipulating benefit claims, involving victim in fraud

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Emotional and psychological abuse. Including ‘gaslighting’, humiliation and belittling, minimising and blaming, jealousy and possessiveness, using children and other family members, isolating, stalking and harassing, threatening to ‘out’ somebody with respect to gender identity, sexuality, immigration status, threats to harm or murder, threats to commit suicide, using technology to track activity, harassment.

Control and Coercion. Including isolating from friends, family and support networks and/or manipulating support networks, setting arbitrary rules, belittling to diminish capacity for self-confidence and autonomy, monitoring activity including use of technology, threatening harm.

The mental and emotional abuse associated with controlling and coercive behaviours can be:

- Isolating a person from social and supportive contact with others
- Wearing a person down mentally by criticising or ridiculing them
- Manipulating a person psychologically, distorting their perception of reality, making them doubt their own sanity sometimes referred to as ‘gaslighting’
- Control and manipulation of their financial situation including:
 - Taking a person’s money
 - Limiting a person’s capacity to work and achieve financial independence
 - Taking out debt or controlling what they are allowed to spend

The Government definition includes ‘honour’ based violence, female genital mutilation (FGM) and forced marriage. It makes clear the types of abuse that are encompassed and the range of victims which may be affected, i.e., that both women and men can be victims and those in a same sex relationship. Abuse from any family member is domestic abuse, taking into account any familial relationship. Domestic abuse can also be from an intimate partner or somebody who was formerly a partner.

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Domestic abuse in Derby and Derbyshire

Applying the national estimated prevalence to Derbyshire County's population, in the year ending March 2022, between 28,000 and over 30,000 residents were estimated to be victims of domestic abuse, of these, around 20,000 were estimated to be females. Whilst in Derby City the figures are between 8,600 and 9,500 residents estimated victims of domestic abuse. Of these, over 6,000 were estimated to be females.

There were 17,346 domestic abuse crimes reported to Derbyshire Constabulary in 2022/2023, with 11,401 individual victims identified and 3,294 individuals a victim of more than one domestic abuse crime in that period.

During 2022-2023 in the Derbyshire Police Force area (Derby and Derbyshire) there were 1,044 offences of engaging in coercive or controlling behaviour in an intimate or family relationship; this showed a decrease of 84 from the previous year. There is an increasing awareness and use of the control and coercive legislation over time when dealing with domestic abuse, despite the slight decrease in numbers in this year.

A [Multi-Agency Risk Assessment Conference \(MARAC\)](#) is a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide. The number of cases discussed at MARAC in the Derbyshire Police Force area in 2022/2023 was 1,520 with 40% of these being repeat cases.

No level of risk in domestic abuse incidents is deemed to be acceptable. Moreover, often patterns of escalation in frequency and risk level are seen in domestic abuse. We also know that reports to the Police do not give an accurate picture of prevalence as many of those experiencing domestic abuse will not report it.

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An under-reporting of familial abuse is always indicated in Derbyshire. This form of domestic abuse is not always recognised as such, and there are additional barriers for victims seeking support if they are being abused, by a relative, particularly if there are caring responsibilities in the situation. The vast majority of clients in 2022- 2023 who engaged with support services were females who had experienced partner abuse. Male victims and those experiencing family abuse are less likely to be supported, with male victims making up 27% of crime victims, 21% of referrals to the Helpline, but only 6% of community support clients. Family abuse accounted for 23% of crime victims, but only 8% of community support clients.

Derby and Derbyshire adopt a multi-agency response to domestic abuse, recognising that domestic abuse is one of the key threats to safety. The Derby and Derbyshire Domestic Abuse and Sexual Violence Partnership Board is a strategic governance group involving key partner agencies, which ratifies the Derby and Derbyshire Domestic Abuse and Sexual Violence Strategy 2023 -2026, which is evidenced and informed by the joint Police and Community Safety threat and risk process and sets out the partnership's commitment to work collaboratively. The overall strategy also includes the Domestic Abuse Support in Accommodation Strategy, which Derby City and Derbyshire County Councils have a duty to produce under the Domestic Abuse Act 2021.

The three main outcomes of the strategy are:

- **Prevention** – Prevent domestic and sexual abuse by challenging the attitudes and behaviours that foster it, promoting understanding and wider awareness of its impact and support available.
- **Protection** – Ensure that victims of domestic abuse are protected from harm and supported to recover.
- **Pursuing Perpetrators and Reducing Re-Offending** – Hold perpetrators of violence and abuse to account, offer programs to change behaviour and target support to reduce future risk.

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Derbyshire is a large county which is geographically diverse, with populations situated in urban centres, small towns and more rurally isolated villages and settlements. Domestic abuse is reported in all areas of the county, though we see higher rates in urban populations. This under-reporting in rural areas is reflective of the findings of [Captive and Controlled – Domestic Abuse in Rural Areas](#), a National Rural Crime Network report published in 2019, which found that rural victims are half as likely to report their abuse to others and that abuse is likely to go on significantly longer. It suggests rural communities can normalise abuse and protect perpetrators and that victims struggle to access support services.

How to spot domestic abuse

The NICE (National Institute for Health and Care Excellence) guidelines for domestic abuse state that, health and social care practitioners should:

- Recognise indicators of possible domestic violence and abuse and respond appropriately
- Make sensitive enquiries of people presenting with indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe

Some of the signs of domestic abuse, such as physical marks, may be easy to identify. Others may be things you can easily explain away or overlook. Domestic abuse affects each person differently, but it impacts everyone both physically and psychologically. It is often a combination of related signs of domestic abuse that tip someone off that a person is at risk.

Domestic abuse can happen to anyone regardless of their social, educational, or financial status. While red flags are not always proof that someone is being mistreated in this way, they are worth knowing. Many who are abused may try to cover up what is happening to them for a variety of reasons, and it goes without saying that these individuals could benefit from help.

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There is no definitive list but generally the signs or symptoms will act as a 'red flag'; they may be seen in isolation or in combination or not at all:

- **Health**

- Symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- Suicidal tendencies or self-harming
- Alcohol or other substance misuse
- Unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction
- Delayed pregnancy care, miscarriage, premature labour and stillbirth or concealed pregnancy
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse)

- **Emotional Signs**

- Agitation, anxiety, or constant apprehension
- Changes in sleep habits (sleeping too much or not enough)
- Developing a drug or alcohol problem
- Extremely apologetic or meek
- Loss of interest in daily activities
- Low self-esteem

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- Seeming fearful
- Symptoms of depression
- Talking about or attempting suicide
- Fear

- **Behavioural changes**
 - Becomes reserved and distant
 - Begins isolating themselves by cutting off contacts with friends and family members
 - Cancels appointments or meetings with you at the last minute
 - Drops out of activities they would usually enjoy
 - Exhibits excessive privacy concerning their personal life or the person with whom they're in a relationship
 - Is often late to work or other appointments

- **Effects of control and coercion**
 - Asking permission to go anywhere or to meet and socialise with other people
 - Constant calls, texts, or tracking by their partner wanting to know where they are, what they are doing, and who they are with
 - Having very little money available to them, not having access to a credit card, or having to account for every penny spent
 - Not having access to a vehicle
 - Referring to their partner as "jealous" or "possessive", or always accusing them of having affairs

Domestic abuse and older adults

Supporting people who are 65-years or older to engage with domestic abuse services has some specific barriers and challenges.

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Two polls conducted by Hourglass in 2020 reported that, from around 5,000 members of the public surveyed, “at least 1 in 3 (35%) don’t believe that ‘inappropriate sexual acts directed at older people’ count as abuse; nearly a third (30%) don’t view ‘pushing, hitting, or beating an older person’ as abuse, while likewise nearly a third (32%) don’t see ‘taking precious items from an older relative’s home without asking’ as abuse.”²

This indicates a widespread issue with public perception – domestic abuse and sexual violence are often seen via the media as mainly affecting younger women and those with children; most services have developed to offer support to this group.

Domestic abuse is considered more hidden in this age group and is complicated by often having a range of care needs and wider relationship issues. Prevention is dependent on recognition and early intervention, especially in situations where carer stress is evident.

Professional curiosity is needed to be alert to the signs of possible domestic abuse, and to follow up on concerns by asking questions and trying to see the person alone.

Professionals may focus on a main presenting issue, e.g., care or health needs, without considering the history/context on a home situation.

Abusive situations for older people may develop over time and coincide with ill-health or mental deterioration and financial dependence.

The victim may not recognise the abuse and be additionally fearful of disclosing because of uncertainty about their future care. It is important to be alert to patterns of coercive and controlling behaviour, as well as incidents of physical abuse, and be aware that an apparently unwise decision when considering mental capacity may be the result of coercive and controlling behaviour. It is also important to take account of gender, sexuality and inter-generational issues.

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² Source: [Hourglass Safer Ageing Press Release](#)

Carer stress is recognised as a significant factor in many incidents, and support for carers is a key part of prevention and intervention, but this should not disguise the fact that abuse may be occurring.

Abuse is not always physical – financial abuse by family members can be common, as is emotional abuse, or neglect.

Older people being hit by a partner who has dementia, or someone with dementia being hit by a stressed family member, is still physical assault in a domestic context. Even if the criminal route feels disproportionate in certain circumstances, we still need to recognise the impact and be very aware of any escalating risk of serious harm.

There are particular issues for older people experiencing domestic abuse

They may have been subjected to many years of prolonged abuse; rely on their abuser for care; be physically unable to leave, even for some respite from the abuser or struggle to use technology to communicate with others, meaning they are isolated within their communities.

Mental capacity may also be a factor. This can mean that for those with care and support needs, domestic abuse remains hidden. Every adult has the right to make decisions about their own lives and relationships and some of these may be seen as unwise by others around them. However, it is important to be sure that the person has all the right information and is supported to understand it; about the options they have, to make that decision. We need to understand the things that are most important to the individual, so that support is offered in a meaningful way to them.

Mental capacity may change over time or be impacted by ill health – remember, capacity is time and decision-specific; revisit decisions where you continue to have concerns and consider how a diagnosis or progression of dementia may change the view of a relationship and impact on decision-making

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A recent [report by Age UK](#) highlights the scale and impact of the domestic abuse faced by older people, as well as the challenges and barriers that prevent victims from accessing the help and support they need. The report identifies that in 2019 over 280,000 people aged 60 to 74 (3.1%) experienced domestic abuse in England and Wales and one in five (22%) victims of domestic homicides were over the age of 60 – 68% of victims were female.

Men can also experience domestic abuse from their partner (male or female), grownup child or carer, and domestic abuse also occurs in same-sex relationships.

The report calls for better reporting of domestic abuse against older people and training for health care practitioners, including GPs and practice nurses, who work with older people, particularly during hospital admission and discharge.

What might be different for older people?

Elements of control within marriage have historically been commonplace, and what we now consider to be domestic abuse, sexual violence, and coercion within relationships, is often not recognised by the individuals, their families, or people working with them.

Normalised by social and cultural views of decades past, people now in their 70s and 80s grew up and married in the 1940s, 1950s and 1960s, when it was traditional for women to look after the home, raise families, be the obedient wife. Men went out to work and routinely held financial control. Marriage vows were to 'love, honour and obey'; marriage was considered lifelong.

A woman could not open a bank account in their own name without a male relative's permission until 1975. Until 1982 it was legal for pubs (seen as traditionally male places) to refuse to serve women. Wives have only been taxed independently from their husbands since 1990; before this, any money they earned was not technically considered their own but rather an addition to their husband's.

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Marital rape was not recognised as criminal until 1991³, and only became a specific crime in the Sexual Offences Act 2003.

Research by SafeLives indicates that people over 60 are much more likely to experience domestic abuse from an adult family member than those under 60. On average, older victims experience abuse for twice as long before seeking help as those aged under 61 – also 48% of older victims have a disability. However, older people are still “hugely under represented among domestic abuse services”

Barriers to older adults reporting domestic abuse

Studies have shown that older people are more likely to remain in an abusive situation even longer than those under 65-years old. Work may be needed with the person longer term to support them to plan for the future and keep themselves safe

There are several possible reasons to consider why they are so under-represented in reporting statistics⁴:

- Deep emotional attachment because of the length of the relationship.
- Love of the abuser, whether a partner or family member; not wanting to ‘break up’ the family
- Acceptance/normalisation – seeing it as part of the duties of marriage, or normal for women of their generation
- Being isolated – the effect of this increases as we age, and social networks decline or become harder to access
- Being unaware of other options – or feeling that services are only for younger women, or not suited to someone with care and support needs

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³ [The Fawcett Society - 150 years of progress on women’s rights and gender equality 1866-2016](#)

⁴ [SafeLives – Spotlight #1: Older people and domestic abuse](#)

- Being financially reliant or depending on the abuser to provide physical or practical support and care
- Worry they will not be believed, shame or embarrassment
- Frightened about what may happen next – loss of their home, routines, care, family relationships
- May feel it's not the other person's fault, especially if they are unwell or living with dementia

Domestic Homicide

One very serious outcome of domestic abuse can be death. When someone dies and it appears to be as a result of neglect, violence or abuse by someone they were related to, living in the same household, or in an intimate relationship with, a Domestic Homicide Review (DHR) is held to consider the circumstances of the death. This is a multi-agency process that must take place by law (section 9, Domestic Violence, Crime and Victims Act 2004 - came into force 2011), and they are intended to identify any lessons for agencies to improve responses in the future.

The duty to carry out DHRs lies with community safety partnerships and in Derbyshire this duty is delegated by the district and borough councils to the Derbyshire Safer Communities Board with oversight of the process and action planning undertaken by the Derby and Derbyshire Domestic and Sexual Abuse Partnership Board.

Panel meetings for a DHR are chaired by an independent chair who also authors the report, which is submitted to the Home Office to be quality assured before publication. The multi-agency panel will determine the level of publication and, sometimes, only the learning brief will be made available. The report is always anonymised with pseudonyms agreed with the deceased's family, where possible. DHRs undertaken by Derbyshire with particular relevance to older or vulnerable adults include the following cases:

Domestic Homicide Review 'Mrs D' – 'Mrs D' was in her 70s in 2019 when she was killed by her grandson 'David' who was in his 20s and had been living with living with his grandparents since he was 16.

David was experiencing a serious psychotic illness at the time, with delusional beliefs about his grandmother, and was a troubled young man who had a poor relationship with his mother and a history of using illicit substances and alcohol.

Mrs D was a key figure in her grandson's life. The family described her as very caring but she would not have described herself as a carer, seeing herself as supportive of her family in her role as mother and grandmother, and she had very little involvement in services in her own right. She had supported her grandson in seeking help with anxiety, depression and problematic substance use, for which appropriate support was provided and referral for mental health support services. Services viewed his grandparents as a protective factor in supporting David's mental health. At no time was David assessed as being a risk of harm to others.

In the year leading up to Mrs D's death his family had noted David exhibiting strange behaviours and voicing paranoid beliefs, periodically, but agencies were not aware of this and, though worried about him, his grandmother was not sure how best to help him.

Key learning points – Given the information that was known to agencies at the time, the death of Mrs D was not predictable or preventable. Reasonable steps to try and engage with David were taken and to manage his mental health needs. Risk assessments that were carried out did not identify him as being a risk to others. These were reasonable findings based on the information known at that time. The review did find that there was effective joint working between agencies with respect to David. Nonetheless, the review identified important learning:

- **Early intervention** – The need to prioritise early intervention in young people's mental health needs to reduce the chance of problematic use of substances and alcohol.
- **Brief intervention** – Where substance or alcohol misuse is known, health professionals need to use every opportunity for brief motivational approaches based around harm minimisation.
- **Recognising carers** – Those providing care to an individual will not always identify themselves as carers. They may not be aware of how they can contribute information nor of what support they can receive. Agencies should 'Think Family' and be attuned to

identifying hidden carers, reaching out to support and involve carers in the individual's care.

- **'Did Not Attend'** policies – Agencies need to avoid blanket policies of ending services where the person does not attend and consider individual circumstances and risks. The needs of carers and family should also be considered within 'Did Not Attend' policies.
- **Role of GPs** – GPs play a critical role in identifying risks associated with domestic violence and abuse. Their use of professional curiosity is essential in this task.
- **Messages to communities:**
 - Families and carers have unique knowledge about the person which can be important to share with agencies to develop a fuller understanding of the individual's needs. Whilst agencies do have duties to protect a person's confidential information, with the individual's consent, information may be shared with others such as carers and agencies can receive information from families and carers without breaching the person's confidentiality.
 - Caring for a family member with problematic substance or alcohol use or mental health needs can be a challenging and stressful role. The services available to support carers, even if the cared for person is not in contact with services, should be promoted and made available to carers.
 - Research has highlighted a causal link between heavy cannabis use and psychotic disorders. Regular use of high-potency cannabis is highly hazardous to mental health.

Domestic Homicide Review 'David' – 'David' was a very private man in his early 70s, largely unknown to agencies; the only living member of his immediate family he resided in the same property for thirty years. He was retired after working in the local area.

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There was a history of a long and rather troubled association with a young man, 'Mark', twenty-nine at the time of David's death. The exact nature of the relationship was not known; they had referred to each other as uncle and nephew at times but at others had denied any family connection and it was confirmed that there was none.

Mark was taken into care by the local authority at the age of seven and had a childhood in which he experienced neglect and exposure to domestic abuse and his father was deceased, his mother dying in 2011, though he did have connection with members of his birth family. Unsettled accommodation, involvement in crime, alcohol and drug use were an on-going feature of his life.

It is thought that David and Mark met in 2005 when Mark left the care of the local authority. The review concentrated on information available on David and Mark between January 2009, when Mark was convicted of defrauding David of money from a building society account, and July 2019, the time of David's death. It was known that Mark had resided with David at various times during this period and was also convicted of assaulting David when refused access to his home in 2014.

In 2018 David reported to the police that Mark was trying to break into his home. The lengthy and troubled connection between the two men was the precursor to events of summer 2019, when David visited the local police station to report that he was having problems with Mark, who was staying at his house and taking money from him.

Contact with David was not made during an arranged visit by an officer to his home the next day and, subsequently, a neighbour contacted the police with concerns both about David's whereabouts and about the 'nephew' who had moved into his property. This report led to further police attendance at the property in which Mark was arrested as a suspect for another unrelated matter, but David was not present and could not be contacted.

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When questioned in relation to the whereabouts of David, Mark gave an account which proved on investigation to be untrue. Subsequent enquiries about Mark's movements led to the discovery of body parts believed to belong to David, leading to him being charged with murder, which he continued to deny. Mark was found guilty of murder and in early 2021, sentenced to a minimum term of 27 years.

Key learning points:

- **Professional curiosity** – There was a lack of professional curiosity and exploratory investigation by agencies to understand the nature of the connection of these two men. Some agencies were aware of their connection but failed to register the exploitative or abusive nature of that connection. In some instances, David did approach agencies and referenced the problems he was experiencing with Mark but there was a failure to see beyond the presenting problem and identify the risks to David. Whilst lack of clarity about the nature of the relationship between the two men may have mitigated against defining the domestic abuse, it is clear that although David was not generally vulnerable, he was certainly vulnerable in his connection with Mark. Agencies should, therefore, ensure that frontline staff interacting with the public are aware of the need for professional curiosity where there is any indication of abuse or exploitation and use exploratory questions in their contacts with individuals to enable thinking beyond the presenting issues.
- **Historical information** – On occasions, historical information did not inform assessments of the situation and, as a result, the cumulative risk to David was not appreciated because the picture of Mark's pattern of offending against David or his propensity to target vulnerable individuals in pursuit of personal gain was not taken into account. Agencies failed to appreciate David's specific vulnerabilities with respect to his involvement with Mark, he had been a victim of economic and physical abuse and had approached agencies identifying this, but information regarding historical abuse was not sufficiently considered when assessing the risk that Mark posed to David subsequently. Agencies should ensure that they access all relevant historical information to inform assessments and interventions and to identify patterns of behaviour and those who may be at specific risk.

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- **Anybody can be vulnerable to domestic abuse** – All professionals need to consider the possibility of any member of the community being vulnerable to domestic abuse or physical or economic exploitation, irrespective of age, gender, sex, sexual orientation and family relationship including non-intimate partners. Agencies need to develop understanding internally of the criteria that constitutes domestic abuse, specifically raising awareness of economic abuse and recognising that men, older people and those who are not intimate partners may be victims. There is a need for public promotion to develop wider understanding of domestic abuse, and who can be affected, to encourage all victims to recognise and disclose abuse and seek support.
- **Effective multi-agency response** – Agencies generally worked in isolation with only limited information sharing and co-ordination. There were occasions when Mark was in contact with a number of agencies, but there was a lack of curiosity, follow-up or co-ordination to support him with more robust assessments and interventions regarding his poor mental health, paranoia and drug and alcohol misuse, gambling, debt and abusive, threatening behaviour. These factors are known to increase the risk in an abusive relationship. Greater information sharing and a multi-agency approach to his situation may have had a more positive impact and enabled a better understanding of the possible impact and risk of the perpetrator to his wider household, family members, friends and community.

Sensitive questions to ask a potential victim

There is no definitive list but having some key questions to help start the conversation when concerns are triggered is helpful. The following may help staff screen for domestic violence. The [NICE guidelines](#) advocate that these conversations need to have time and they need to be carried out in privacy and with an official interpreter if the individual does not speak English.

- Has anyone ever hit, slapped, restrained or hurt you physically? Or emotionally?
- At times, are you afraid of your partner? Previous partner? (it could be any other significant person in their life, i.e., children, parents or other family members?)

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- Have you ever felt unsafe in your home situation?
- Does your partner* like to boss you around?
- If he/she does not get their own way, how do they act?
- Have you been forced to have sex or do sexual things you are uncomfortable doing?
- When arguing with your partner, do they threaten to hurt you or the children, or someone else?
- Has your partner ever stopped you from leaving home, visiting family or friends, or going to work or school?
- Do you have a say in how to spend money?
- Are any of these things going on now?

*partner or spouse or boyfriend/girlfriend or ex-spouse or old boyfriend/girlfriend, or any other significant person in their life. For example, it might be a grown-up child, perpetrators in “forced marriages” are often the mother/grandmother. Other family members might also be the perpetrators.

Risk levels

Referrals into services should be informed by the level of risk posed by the situation the individual is in.

For both Derby City and Derbyshire, there is one [integrated form](#) with the DASH and referral routes included that should be used.

The form has twenty-four scored questions (three additional questions are not scored but give more information about the wider family situation). The form is used to record what the victim tells you to enable you to assess the **current** level of risk. Information about past events can be included but only to give background information. Questions on the DASH include:

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- Is the victim afraid, if so what are they afraid of?
- Are they pregnant or recently had a baby?
- What physical or sexual violence are they subjected to?
- Have they been isolated by the perpetrator?
- What other elements of control and coercion is the perpetrator using?
- Are they being stalked or harassed?
- Are things getting worse or happening more frequently?
- Are there any substance misuse or mental health issues in the situation?

It is a detailed questionnaire and answers should be recorded as Yes/No/Don't Know, in accordance with what the victim tells you. If you have reason to think that the victim is not being candid, or you think the risk is higher than the score indicates, there is space to record this fact along with any other relevant information for each question. The risk level indicates which support services a client and the level of risk.

- Risk levels are assessed from the Derbyshire DASH Risk Assessment form as follows:
 - Score fourteen and above **Yes** answers, indicates high risk.
 - **Professional judgement.** It may be that the score on the form does not reach fourteen "Yes" answers but professional judgement leads you to the conclusion that the case is high risk. This may be because the client has minimised what is happening or is protecting a person. The person may also report fewer incidents but due to the serious nature of them or the frailty of a person they may actually be "high risk". These applications may need evidencing with defensible decision-making recorded within the risk assessment. In the case of adults at risk and those with additional vulnerabilities, being cared for by a family member or partner, professional judgement is particularly important. It may be that some of the questions do not apply (those relating to children or pregnancy, for example) or that the risk associated with vulnerabilities are not adequately reflected (in the case of those with a disability, including learning disability, mental health or impairment, physical disability or sensory impairment for example).

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In these cases, professional judgement should always be used and evidence provided to reflect the risks associated for a victim who may be reliant on their abuser for care and support needs, interpretation, medication and access to aids and particularly vulnerable to abuse because of their condition. Conversely it may be the carer who is being controlled or abused by the person they are caring for, as well as professional judgement, professional curiosity should always be employed when risk assessing to determine who it is who is the abuser and who is being controlled or abused.

- Less than 14 **Yes** answers indicates lower than high risk
- **In all cases** complete the next section of the form with referral details about the victim, the perpetrator, the family situation.
- Follow the flow diagram at the end of the form and email the completed form to the appropriate email address(es) as indicated by the risk level.
- As well as referring into the domestic abuse services, make safeguarding referrals as appropriate in the case of children in the family or any adults who have a care need in the situation

No recourse to public funds (NRPF)

No recourse to public funds (NRPF) refers to people from abroad who are 'subject to immigration control' as defined at section 115 of the Immigration and Asylum Act 1999 and have no entitlement to public funds, welfare benefits, Home Office support for asylum seekers or public housing assistance. It is a general rule for most people who apply to come to the UK.

The Government is aware of the difficulties victims of domestic abuse face, in particular those who cannot access public funds. The Government provides help to these victims who have been admitted to the UK with leave as spouses, unmarried partners or civil partners of a British citizen, or of a non-citizen who is settled in the UK.

This allows domestic abuse victims to apply for indefinite leave to remain in their own right if they have been victims of domestic abuse during the first two years of that relationship.

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The Domestic Violence Rule

If the victim's relationship with a British citizen or a person settled in the UK has broken down as a result of domestic abuse, they may be able to apply for indefinite leave to remain. This is also referred to as permission to settle in the UK permanently.

To be given permission to settle as a victim of domestic abuse, they must prove that:

- They have been given permission to enter or remain in the UK as the husband, wife, civil partner or unmarried/same-sex partner of a British citizen or a person settled here (even if that permission is no longer valid)
- The relationship was existing and genuine (not a 'marriage of convenience', for example) when they were last given permission to enter or remain or they were last given leave in order to access public funds while they applied for indefinite leave on the basis of domestic abuse
- They were the victim of domestic abuse, and this is what caused the relationship to break down before the end of their permission to enter or remain.
- The relationship was existing and genuine (not a 'marriage of convenience', for example) when they were last given permission to enter or remain or they were last given leave in order to access public funds while they applied for indefinite leave on the basis of domestic abuse
- They were the victim of domestic abuse, and this is what caused the relationship to break down before the end of their permission to enter or remain.

Destitution Domestic Violence Concession

A person who successfully qualifies for the Destitution Domestic Violence (DDV) concession will receive temporary leave for three months, which allows them to apply for access to public funds. During this three-month period the person should make a separate application for indefinite leave to remain under the [Domestic Violence Rule](#).

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There are strict eligibility criteria for the concession, which applies to single adults and adults with children. To meet the UKBA's criteria a person must:

- Have entered the UK or been given leave to remain as a spouse, civil partner, unmarried or same sex partner of a British citizen or someone present and settled in the UK
- Have had that relationship break down due to domestic violence
- Be destitute and in need of financial help
- Intend to make a claim to stay permanently in the UK under the [Domestic Violence Rule](#).

Adult Care and Children's Services departments should assess a person or family fleeing domestic violence in these circumstances in the usual way, taking into account a local authority's duty to protect victims of domestic violence.

Where a person appears eligible for the DDV concession, the proportionate response is likely to be the provision of temporary support while their notification is processed.

The DDV concession only applies to people whose leave to enter or remain in the UK was as a partner of a British citizen or person settled in the UK and so social services departments may come across cases where the concession will not apply. In this situation, the presenting person or family should be assessed in the usual way, taking into consideration whether they have no [recourse to public funds](#).

What are the services in Derby and Derbyshire?

Victim/survivor services

Derby City and Derbyshire County Councils commission services to support victims, in partnership with the Office of the Police and Crime Commissioner (OPCC) and Derbyshire Constabulary. We currently have the following support services available within Derby and Derbyshire for those affected by domestic abuse:

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- **Multi-Agency Risk Assessment Conference (MARAC)** – multi-agency intervention for those at high risk of homicide or serious harm.
- **Independent Domestic Violence Advisors (IDVAs)** – dedicated support for high-risk victims of domestic abuse, supporting these individuals through the MARAC process
- **Derbyshire Domestic Abuse Helpline**
 - Telephone 08000 198 668
 - Text 07534 617252
 - Email derbyshiredahelpline@theelmfoundation.org.uk. This provides a single point of access to the domestic abuse services available in the county. The support line can be contacted by victims/survivors or their friends and family seeking support or advice or professionals seeking advice in supporting their clients.
 - [Live Chat](#)
- **Derby Domestic Abuse Helpline**
 - Telephone Refuge 0808 2000247
- **Derbyshire Domestic Abuse Support Services** – including the following elements:
 - Accommodation, including communal refuge spaces and dispersed properties, available to adults and their children fleeing domestic abuse situations
 - Outreach, support in the community for victims/survivors of domestic abuse, including need and risk assessments, safety planning, therapeutic and counselling services and self-esteem and confidence building programmes
 - Children’s support, specialist workers supporting children affected by domestic abuse in the family or young people experiencing it in their own relationships
- **Specialist Domestic Violence Courts (SDVC)**. Regular dates at Derby Court are listed when domestic abuse cases are scheduled to be heard and there is IDVA presence at both Derby and Chesterfield Courts to support victims of domestic abuse.

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- **Core** is the website of [Derbyshire Victim Services](#) commissioned by the Police and Crime Commissioner to support victims of crime to cope and recover and directing to more specialist support organisations, nationally and locally.

- **Specialist support services for particular communities**
 - **Deaf-initely Women** is run and governed by deaf, deafblind and hard of hearing women. Deaf-initely Women serves all deaf and hard of hearing women in Derby, Derbyshire, Nottingham, Nottinghamshire and beyond. They deliver the Deaf Abuse Free service, including drop-in services in Derby and Nottingham. They can provide one-to-one support for those experiencing abuse, IDVAs and ISVAs (Independent Sexual Violence Advocate - Derby/shire only) service. They also deliver workshops, and the Freedom programme adapted and delivered one-to-one.

- **A range of interventions for those who perpetrate domestic abuse including:**
 - **180 Project.** Glow who have the contract for the IDVA service in Derby and Derbyshire deliver this programme for high harm, high risk perpetrators identified as such either by the police or through the MARAC process in both City and County. The service aligns to Respect standards and is designed to keep victims safe, including children, by promoting changes in attitudes and behaviour of those who genuinely want to stop being abusive towards intimate partners. The project offers a varied programme of support, tailored to the individual and they are supported to recognise the difference between a healthy and unhealthy relationship, take accountability for their behaviours and learn to identify safer ways to deal with their emotions and actions. The programme aims to move them to a place where they are able to accept their abusive behaviour and increase their motivation to change. An integrated support service (ISS) (ex) for partners and children is an essential part of the programme to ensure the safety of those affected.

- **Changes Programme** – Delivered by the Derbyshire Domestic Abuse Support Services, the Changes programme is a voluntary intervention for perpetrators of standard and medium risk domestic abuse. The programme aims to reduce a perpetrator’s abusive behaviour and manage risk. It fills the void between a judicial sentence, a high risk and serial offender programme and the abuser who walks away without support and continues to offend. The Changes Programme is for those who want to stop their use of violence or abuse, including heterosexual, transgender, and same sex relationships. The programme is delivered in a group and one to one setting in conjunction with a safety worker who will work with victims and their children offering support and safety planning.
- **Choices** – Delivered by Derbyshire Domestic Abuse Support Services in areas of the County. Choices is a programme that aims to support 11–19-year-olds who are at risk of perpetrating abuse or displaying controlling behaviour in their relationships. It also aims to address issues around Child and Adolescent to Parent Violence and Abuse (CAPVA) where abusive behaviours are happening in the family.

For more detailed information about the services or programmes, including information about locality and referral routes, see the [Domestic Abuse Support Services Directory](#)

Training

- **Derby City**
 - Check the [Derby Safeguarding Adults Board website](#) for current information about courses and availability.

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- **Derbyshire**

- Domestic Abuse Awareness courses, and Risk Assessment are run by the Safeguarding Adults Boards, Safeguarding Children Partnership. The Community Safety Unit regularly runs webinars on Domestic Abuse Awareness, Risk Assessment, and Let's Talk about Sexual Assault and Abuse. E-Learning courses are available on Domestic Abuse, Honour Based Violence and Forced Marriage the courses can be accessed through [Derbyshire Learning Online](#).

Responsibilities of Derby and Derbyshire Safeguarding Adults Boards' agencies

All agencies have a duty to safeguard adults at risk of harm who meet the eligibility for their services. Those eligible for Adult Social Care services may be affected by domestic abuse, and where they are, the impact can be severe and the capacity of the individual to report or seek help greatly affected. However, a victim of domestic abuse is not automatically eligible for Adult Social Care services. Additional care and support needs would need to be established to assess the correct appropriate response (see the [Domestic abuse process flowchart – version 1](#) or the [Domestic abuse process flowchart – version 2](#) – both versions have the same information which is laid out in different styles for you to choose your preference).

The definition of domestic abuse within the Act makes it clear that domestic abuse can take many forms and be perpetrated by a range of people. The links between safeguarding and domestic abuse can take place between a range of family members or an intimate partner, including same sex partners. People with additional care and support needs may have specific barriers to ending the abuse or seeking help. Where abuse is being carried out by a family member or partner who is also a carer, there may be specific categories of abuse, for example:

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- Over medicating or withholding medication
- Controlling access to aids, personal care, interpretation or financial resources
- Control over attending hospital appointments or preventing intervention from professionals

Abusive situations for older people may develop over time and coincide with ill-health or mental deterioration and financial dependence. The victim may not recognise the abuse and be additionally fearful of disclosing because of uncertainty about their future care. It is important to be alert to patterns of coercive and controlling behaviour, as well as incidents of physical abuse, and be aware that an apparently unwise decision when considering mental capacity may be the result of coercive and controlling behaviour. It is also important to take account of gender, sexuality and inter-generational issues.

The Care Act 2014 pulled together legislation built up since the establishment of the welfare state and defines a primary responsibility of local authorities for the promotion of individual wellbeing and for the meeting of needs of an individual, embracing personalisation. The Care Act 2014 specifies that freedom from abuse and neglect is a key aspect of a person's wellbeing and statutory guidance issued in conjunction with the Care Act, states that abuse takes many forms and in a non-exhaustive list, includes the many forms of domestic abuse against which individuals should be protected.

Under the Care Act 2014 safeguarding duties apply to an adult who has a need for care and support (whether or not they are being met by the local authority) who:

- Is experiencing, or at risk of abuse or neglect
- And as a result of their needs is unable to protect themselves from the risk or experience of abuse or neglect
- Abuse or neglect can be inflicted intentionally or unintentionally and domestic abuse is specifically listed in the Act as a category of abuse

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In 2015 Public Health England published [Disability and Domestic Abuse – Risk, impacts and response](#) in which the following was observed:

‘Disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people. They may also experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals. Disabled people also encounter differing dynamics of domestic abuse, which may include more severe coercion, control or abuse from carers.’

Disabled people are often in more vulnerable situations because of care needs, increasing their vulnerability to another person’s controlling behaviour and may not recognise their situation and have greater difficulty in leaving an abusive situation.

Professionals should be aware that there have been cases of forced marriage connected with disability, particularly learning disabilities, which fall into the category of domestic abuse and should be recognised and treated as such.

All staff have a responsibility to ensure that all adults who may be subjected to any form of abuse are able to access services outlined above, that they are risk-assessed in line with [Multi-Agency Risk Assessment Conference \(MARAC\) guidelines](#) and signposted to the relevant service provision.

Professional curiosity and disguised compliance

It is essential to recognise the links between safeguarding and domestic abuse and recognise the complexities involved, i.e., the fact that for victims there are barriers to both recognising the nature and degree of abuse and to seeking help and support or leaving the abusive situation.

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Professional curiosity or ‘respectful uncertainty’ is the capacity and communication skill to explore and understand what is happening within a family, rather than making assumptions or accepting things at face value.

Curious professionals will spend time engaging with families on visits. They will know that talk, body language and interaction can all be important to observe and consider and not make presumptions about what is happening in the family home – they will ask questions and seek clarity if not certain.

If the client is not seen alone there may be indicators that a client never speaks for themselves or checks for the reaction of their partner or carer if they do. It may be apparent that the other person sends clear signals to the victim, verbally or through body language, which affects their communication. They may smooth over any conflict or fail to defend themselves if the other person complains about them. If these signals are apparent it is important not to endorse the outlook of the suspected perpetrator and to **make every attempt to see the suspected victim alone**. Practitioners should be aware of the **potential of increasing risk** for a victim, by questioning inappropriately in the presence of a suspected perpetrator. Disclosures of domestic abuse should never be discussed with a suspected perpetrator, including when that person is caring for the person who has disclosed.

Victims of domestic abuse experience inequality and/or violence in their relationships and levels of control and coercion mean that even when alone, they are often too afraid or uncomfortable to raise the issue of abuse themselves or fail to recognise it.

Practitioners should be prepared to ask questions in a sensitive but direct way in a safe environment in order to establish the nature of the relationship, for example ‘How are things at home?’, ‘Do you feel safe there?’, ‘What happens if you and your partner have a disagreement?’, ‘Have they ever stopped you...leaving the house, seeing friends or family, going to work/college’, ‘Have they ever threatened to hurt you/someone else and you believed them’, etc.

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Professional curiosity is a concept which has been recognised as important in the area of safeguarding children for many years but it is equally important to safeguarding adults with care and support needs.

Curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of a person's situation. It requires looking, listening, asking questions and sometimes having difficult conversations, which may feel uncomfortable for both the service user and practitioner.

Professional curiosity is key in helping to identify abuse and neglect in circumstances where this may be less obvious and harder to establish the facts, and can help to ensure that the right information is gathered to assess needs and risks. It can help determine who is the abuser in a situation where things may not be as they first appear; for example, a person being cared for, may be exerting control on the person who is caring for them.

Tips and things to consider helping develop skills in professional curiosity:

- Is there anything about what you see when you meet with the adult/their family that makes you feel uneasy or prompts questions?
- Do you see behaviours which indicate abuse or neglect, including coercion and control?
- Does what you are seeing contradict or support what you are being told?
- How are family members interacting with each other and with you?
- Are you being told anything that needs further clarification?
- Are you concerned about what you hear family members say to each other?
- Is someone trying to tell you something, but finding it difficult to express themselves or speak openly?
- Are other professionals involved? What information do they have?
- Are professionals being told the same or different things?

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Tips to assist with holding difficult conversations:

- Make time and space to have a private conversation with an adult who may be at risk of abuse or neglect, or subject to coercion and control
- Keep the agenda focused on the topics you need to discuss
- Be clear and unambiguous
- Have courage and focus on the needs of the adult at risk
- Be non-confrontational and non-blaming
- Stick to the facts and have evidence to back up what you say
- Ensure decision-making is justifiable and transparent
- Show empathy, consideration and compassion
- Consider the adult's needs for advocacy support

Disguised compliance can be a feature when working with adults and their carers who are difficult to engage. Resistance may be expressed in aggression, in open refusal to co-operate, or in missed appointments and other forms of avoidance, or it may be masked by superficial co-operation. The common feature in all cases is failure to change, and a refusal or inability to acknowledge or address the risk to the adult's welfare.

The techniques by which carers resist change tend to draw attention toward their needs and away from the adults needs, and to draw the focus of work toward achieving their co-operation rather than ensuring that the adult receives adequate care. The effect of this is to create a situation in which the adult remains at risk of significant harm and there is no sustained improvement in their care.

It can be more difficult for professionals to identify the challenges in working with carers/family members who appear pleasant and amenable, agree with the need for change, but who are unable or unwilling, despite interventions, to bring this about satisfactorily. Sometimes a carer or family member can be very accomplished at misleading professionals. This is referred to as 'disguised compliance'.

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In some family relationships there can be a strong element of 'coercive control' occurring, where a range of behaviour enables a carer to retain or regain control of a partner, ex-partner or family member. The impact of coercive control can have a significant effect on how the person being cared for may respond to professionals, even if they wish to change their situation. Victims of controlling and coercive behaviour may feel it impossible to talk openly and honestly with professionals. Professionals need to be aware how victims may behave where there are high levels of fear and difficulties articulating the abuse and what makes them afraid. Professionals may unwittingly collude with the abuser, further isolating the victims within the family and care should be exercised not to, and perpetrators may seek to manipulate and control professionals or make allegations about the victim.

The use of professional curiosity when disguised compliance is suspected, is particularly important, not taking things at face value but investigating, observing, listening, asking direct questions and reflecting on information received. Professional curiosity involves testing out professional assumptions about different family or caring situations, seeking information from different sources to gain a better understanding of family dynamics and seeing beyond the obvious.

When a professional feels that a carer/family member may be resisting change that is necessary to safeguard the adult's welfare, they should:

- Assess the evidence
- Consult other professionals
- Revisit the causes for concern
- Weigh the level of resistance and the seriousness of the concerns
- Ensure that agencies co-ordinate their efforts and arrange a review of the risk assessment, including the impact of any delays
- Confirm carer understanding of what is expected from them

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Vulnerable Adults Risk Management (VARM) – Derbyshire County Council area only

In some domestic abuse situations, it may be that even where an individual does not qualify under safeguarding as having care needs and does have capacity, the situation they are in does represent a risk to them which they are choosing not to protect themselves from. It may be thought that in this situation the case would benefit from a multi-agency response and so calling a Vulnerable Adult Risk Management (VARM) meeting may be considered.

A VARM is called when working with adults deemed to have capacity to make decisions for themselves, but who are at risk of serious harm or death through:

- Self-neglect (Care Act 2014)
- Risk-taking behaviour/chaotic lifestyles, or
- Refusal of services

The VARM is a multi-agency adult assessment risk management process to:

- Identify the relevant risks for the individual
- Discuss and agree agency responsibilities/actions
- Record, monitor and review progress with the agreed action plan
- Agree when the risks have been managed and evaluate the outcome

The aim of the [VARM policy and practice guidance](#) is to provide professionals with useful information and a framework to facilitate effective multi-agency working with adults who are at significant risk of harm or death.

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Any agency may call a VARM, and if domestic abuse has been identified in the situation, domestic abuse agencies should always be invited. The VARM is not intended to replace the [Multi-Agency Risk Assessment Conference \(MARAC\)](#) and if domestic abuse has been identified, a DASH risk assessment should always be completed, and if the client is identified as at high risk of serious harm or homicide, then they should, in the first instance, be referred into MARAC.

More information about the [VARM process and all relevant documentation](#) is available from the Derbyshire Safeguarding Adults Board website.

Any agency may call a VARM, and if domestic abuse has been identified in the situation, domestic abuse agencies should always be invited. The VARM is not intended to replace the [Multi-Agency Risk Assessment Conference \(MARAC\)](#) and if domestic abuse has been identified, a DASH risk assessment should always be completed and if the client is identified as at high risk of serious harm or homicide then they should in the first instance be referred into MARAC.

More information about the [VARM process and all relevant documentation](#) is available from the Derbyshire Safeguarding Adults Board website.

Out of hours

Derbyshire County

The [Derbyshire Domestic Abuse Helpline](#) in the Derbyshire County area operates from 8:00am until 10:00pm, Monday to Friday, and it is staffed by a domestic abuse specialist worker. Overnight, at weekends and bank holidays the call automatically diverts to Call Derbyshire. Procedures have been established and call guides created to ensure that:

- Situations of immediate danger are responded to, the caller is either advised to ring 999 immediately, or Call Derbyshire does so on their behalf if they are unable to do so.
- The safeguarding of any children in the situation generates an appropriate referral to Children's Services.

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- If adults in the situation are in need of social care a referral is made to the Out of Hours Adult Care Team.
- If a Derbyshire resident is fleeing domestic abuse and seeking emergency refuge an accommodation a referral can be made to the [SALUS Project](#) by Call Derbyshire; the call handler should check if there are any children involved – in which case a referral should be made to the Out of Hours (OOH) Children’s Services Team, or if the person fleeing has care and support needs, in which case a referral would be made to the Out of Hours (OOH) Adult Care Team. If neither of these social care situations apply, they can contact the SALUS project giving them a safe contact number for the victim (they do not give out the SALUS contact number). The SALUS project is designed to give short-term specialist domestic abuse support in dispersed accommodation to victims fleeing domestic abuse, either out-of-hours or where there are additional complexities. This project means that the victim can be supported into accommodation at any time and subsequently risk assessed, any additional agency support identified and sought and then moved on to more permanent safe accommodation, either within Derbyshire or out of area as appropriate.
- If a caller is not in immediate danger but seeking support and advice they are asked if they would like a specialist worker from the Helpline to contact them. With permission, their details, including preferred method of contact, safer contact times and background information are sent to the Derbyshire Domestic Abuse Helpline for attention the next working day.
- Contact details for the Derbyshire Domestic Abuse Helpline and the National Helpline are given to them.

Derby City

In Derby City the [Glow helpline service](#) runs from 9am – 8pm, Monday to Friday and 10am – 4pm on Saturdays, phone: 01332 985 111.

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The current advice is to call the national 24-hour Domestic Abuse Helpline out of these hours, phone: 0808 2000 247.

- If a caller is not in immediate danger but seeking support and advice they are asked if they would like a specialist worker from the Helpline to contact them. With permission their details, including preferred method of contact, safer contact times and background information are sent to the Derbyshire Domestic Abuse Helpline for attention the next working day.
- Contact details for the Derbyshire Domestic Abuse Helpline and the National Helpline are given to them.

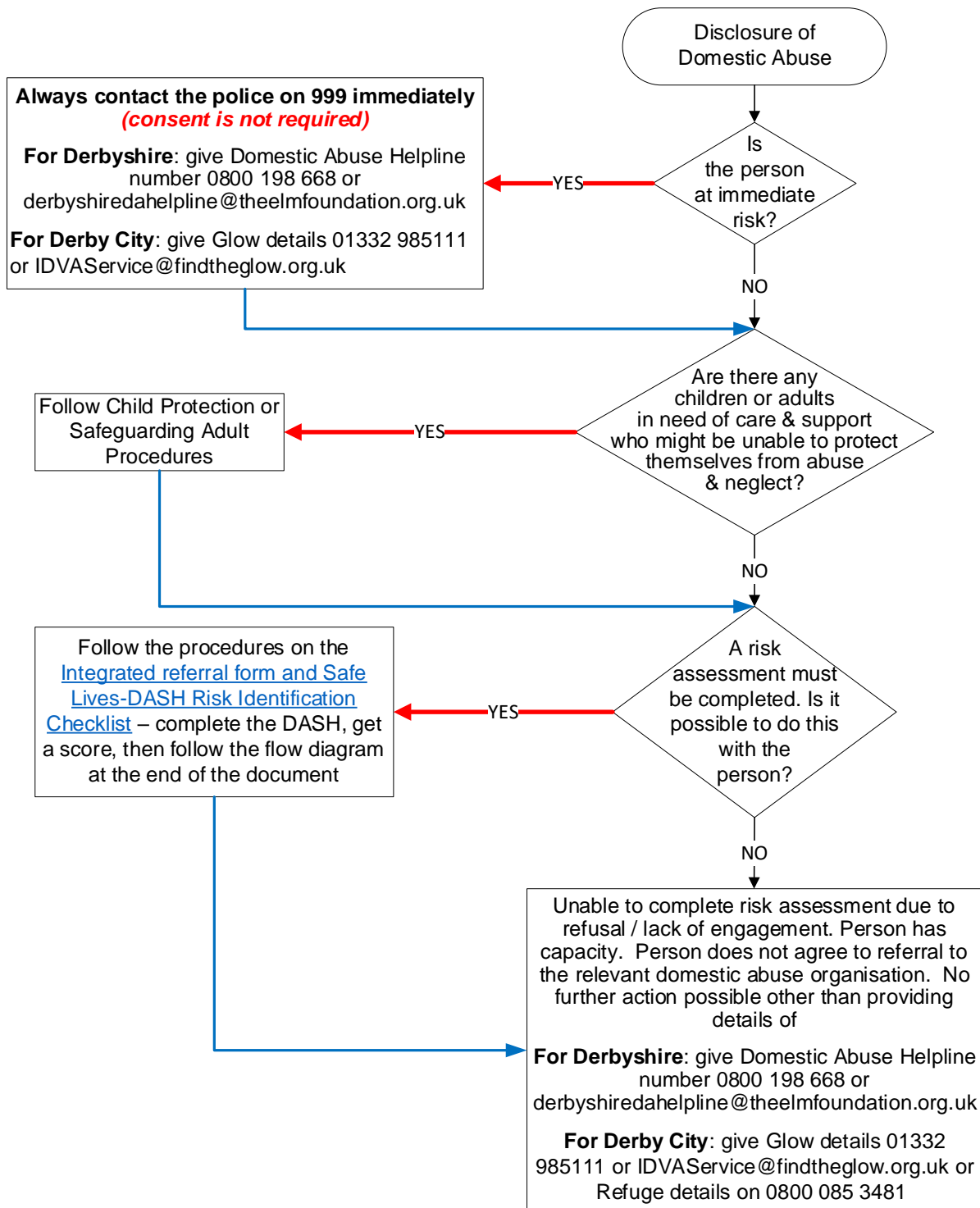
Derby City

In Derby City the [Glow helpline service](#) runs from 9am-8pm, Monday to Friday and 10am-4pm on Saturdays, phone: 01332 985 111.

The current advice is to call the national 24-hour Domestic Abuse Helpline out of these hours, phone: 0808 2000 247.

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Domestic abuse process flowchart – version 1



If person gives permission,

For Derbyshire: refer to [Derbyshire Domestic Abuse Helpline](https://www.derbyshire.gov.uk/domestic-abuse-helpline) on 0800 198 668 or via email at derbyshiredahelpline@theelmfoundation.org.uk. This is the single point of contact for those suffering domestic abuse, which will enable referral to further local support services.

For Derby City: refer to Glow on 01332 985111 or IDVAService@findtheglow.org.uk (for high Risk) or refer to Refuge on 0800 085 3481 for (medium and standard risk) or DCDVS@Refuge.org.uk

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Domestic abuse process flowchart – version 2

<p>1. Is the person’s safety at immediate risk? (the person does not feel safe and they do not have somewhere safe to go)</p>	
<p>Yes Always contact Police via 999 immediately consent is not required Go to Q2</p>	<p>No Go to Q2</p>
<p>2. Are there any children present or non-resident children who have contact?</p>	
<p>Yes Follow Safeguarding Children Procedures (where there is immediate risk) and refer to the Threshold document (if there is no immediate risk) Go to Q3</p>	<p>No Go to Q3</p>
<p>3. Are there any adults in need of care and support who might be unable to protect themselves from abuse and neglect?</p>	
<p>Yes Follow Safeguarding Adult Procedures Go to Q4</p>	<p>No Go to Q4</p>

4. Is it possible to complete a DASH risk assessment* with the person? *Integrated referral form and Safe Lives-DASH Risk Identification Checklist	
Yes	No
Complete the DASH risk assessment Get a score and follow the flow diagram at the end of the document (MARAC referral can be made without consent)	Complete the DASH risk assessment using all available information. Where the risk is identified as high from the information and/or professional judgement, refer to MARAC (referral can be made without consent)
If person has capacity and does not agree to referral to the relevant domestic abuse organisation give their details and helpline numbers, see below: Derbyshire: Domestic Abuse Helpline number 0800 198 668 or derbyshiredahelpline@theelmfoundation.org.uk Derby City: Glow number 01332 985111 or IDVAService@findtheglow.org.uk / Refuge: 0800 085 3481	

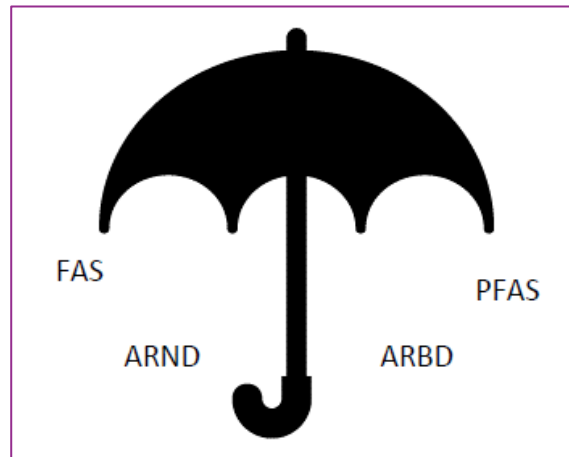
Fetal Alcohol Spectrum Disorder (FASD)

Introduction

Fetal Alcohol Spectrum Disorder (FASD) is a lifelong neurodevelopmental condition. Neurodevelopment is a term referring to the brain's development of neurological pathways that influence performance or functioning (e.g., intellectual functioning, reading ability, social skills, understanding consequences, attention or focus skills). It is caused when an embryo/fetus is exposed to alcohol prenatally (before birth). According to the UK Chief Medical Officers, there is no safe type or amount of alcohol use in pregnancy.

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Alcohol use in pregnancy can also lead to miscarriage, premature birth, still birth and sudden infant death syndrome (SIDS). Currently, FASD is an umbrella term encompassing the following diagnostic terms:



FAS Fetal Alcohol Syndrome

ARND Alcohol Related Neurodevelopmental Disorder

ARBD Alcohol Related Birth Defects

PFAS Partial Fetal Alcohol Syndrome

Whilst more people have heard about FAS, it is not the most common subtype of FASD. Less than 10% of people with FASD will have the sentinel facial features required to get a diagnosis of FAS. Sentinel facial features are short palpebral fissures (small eye openings), indistinct philtrum (flattened groove between nose and Mouth) and thin vermilion border (thin top lip).

How a person is affected will depend on a number of factors including the amount of alcohol consumed, the pattern in which it was drunk as well as the timing within the pregnancy. There can be other genetic and environmental impacts too.

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Prenatal alcohol exposure (PAE) can result in a large variety of impairments. Research shows there are 428 conditions associated with PAE. Although few people have the sentinel facial features, all people with FASD have an impairment to their brain and the rest of their central nervous system. FASD is a complex condition. These conditions can affect each person in different ways and can range from mild to severe.

Whilst some people with FASD will have a learning or intellectual disability with an IQ (intelligence quotient) <70, the majority have IQ within the normal range. However, people with FASD may have a large variance in their functional abilities and should undergo comprehensive assessments from Speech and Language and Psychology. In particular looking at receptive language, executive functioning and adaptive behaviour.

- In September 2021, the Department of Health and Social Care published the fetal alcohol spectrum disorder: health and needs assessment [SIGN 156 guidelines](#). This document is a health needs assessment for people living with FASD, their carers and families, and those at risk of alcohol-exposed pregnancies in England.
- In March 2022, NICE (National Institute for Health and Care Excellence, published the fetal alcohol spectrum disorder [quality standard QS2024](#). This quality standard covers assessing and diagnosing fetal alcohol spectrum disorder (FASD) in children and young people. It also covers support during pregnancy to prevent FASD. It describes high-quality care in priority areas for improvement.

How common is FASD?

The UK's first small-scale active-case [ascertainment study](#) showed that 2% to 4% of people have FASD. That matches international studies and shows that FASD affects more people than autism. However, FASD is sadly most often undiagnosed or misdiagnosed. FASD is often called a 'hidden disability.'"

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People with FASD may have co-morbidities (the presence of two or more diseases in the same person) including ADHD, autism, dyslexia, dyspraxia, dyscalculia, borderline personality disorder and more.

However, if someone with FASD, for example, had an ADHD diagnosis, this diagnosis would only explain part of their presentation, whereas FASD would explain much more about their symptomology and needs. High risk child populations include looked after children, those who are adopted and young offenders. In adulthood, high risk populations would include people who are homeless, require support for mental health, drug or alcohol misuse and those within the criminal justice system.

Diagnostic process

In Derbyshire there is currently no adult diagnostic pathway for adults with FASD. This means that accessing a diagnosis is complex due to a lack of current provision, training and expertise.

Psychiatry or psychological services should be able to make the diagnosis if there is sufficient expertise in FASD. Alternatively, there is a National FASD clinic based in Surrey which will take referrals from throughout the country. This offers gold standard assessment of FASD with a comprehensive report given about the individual's functional skills as well as their diagnosis.

FASD presentation

Naturally, all people with FASD will present differently. However, typically a person with FASD presents as superficially chatty. This often belies their level of understanding. Speech and language assessments can often show that the person may have poor higher-level expressive language and very poor receptive language. This means that they may appear to understand more than they actually do.

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People with FASD tend to be prosocial and desperate for social relationships but may seem immature and struggle to maintain them. This is an area of particular vulnerability.

Other areas of difficulty can include:

- Memory (especially working memory)
- Attention
- Executive function, including impulse control and hyperactivity
- Emotional regulation
- Adaptive behaviour, social skills or social communication

When a person with FASD does not do what is expected of them it can seem like it is intentional. People with FASD are often described as being able to talk the talk but not walk the walk. For example, if a person with FASD does not turn up for an appointment it could be that they had not understood what they had to do (poor receptive language skills), did not remember they had an appointment (working memory deficit), did not leave enough time to get there in time (poor planning and organisation skills) or they were distracted on the way (attention skills). However, what may be recorded in the person's notes is simply that they did not attend. This may be viewed as intentional and can have negative consequences. However, the negative consequences are unlikely to change this behaviour as people with FASD struggle to link cause and effect.

FASD and safeguarding

Adults with FASD experience a range of substantial and complex difficulties, signalling a high level of service need. Many people with FASD will require ongoing functional and needs-based service provision. If the assessments have not accounted for FASD there may be significant risks.

Whilst FASD need not be a life-limiting condition and there are many people who are living safe and happy lives with a normal life expectancy, a study showed that the average life expectancy for a person with FASD is 34 years old. Without the appropriate level of support, people with FASD are at risk from suicide, accidents and poisoning by illegal drugs or alcohol.

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Other risks from an inappropriate level of support include grooming, mate crime, cuckooing, modern slavery, homelessness, drug and alcohol misuse, unplanned pregnancy and contact with the criminal justice system.

The [Derbyshire Safeguarding Adults Board multi-agency learning review \(MALR19A\)](#) was undertaken in relation to Aaron who was diagnosed with FASD as a young adult.

Support

What level of support an adult with FASD will need is entirely specific to that person, as all people with FASD will present differently. What is important is that all assessments consider the results of speech and language and psychological assessments, rather than IQ alone. IQ is not a good predictor of functional ability in someone with FASD. Recommended assessments can include but are not limited to:

- Speech and Language assessment such as the CELF (Clinical Evaluation of Language Fundamentals)
- Adaptive functioning assessment such as the Vineland
- Executive functioning assessment such as the DKEFS (Delis-Kaplan Executive Function System) or BRIEF (Behaviour Rating Inventory of Executive Function)

These assessments can show the wide gaps in functioning a person with FASD may have. They may have IQ in the normal range, they may have superficially good language skills yet have the social and communication and daily living skills, of a young child.

When conducting assessments such as a mental capacity assessment. It is imperative that the process be FASD-informed. A person has to understand, retain and use or weigh the relevant information.

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It can be crucial to consider input from families, carers or professionals as part of the capacity assessment, who can give observational real-world evidence and other relevant assessment results. The following capacity areas should be considered:

- Managing finances
- Care and support arrangements including self-neglect
- Managing medication
- Managing safety online
- Decisions about sexual relations
- Capacity to conduct court proceedings

If the assessor or IMCA (Independent Mental Capacity Advocate) does not understand FASD and presumes capacity, the person with FASD could be at risk of harm.

When given support appropriate to their needs, people with FASD can live safe, happy and productive lives.

“FASD is a lifelong disability that requires accommodations and supports to maximise success”.⁵

“People with FASD live lives of courage. With diagnosis and the support they deserve, they can shine. Things are changing in the UK but the risks of alcohol in pregnancy are still too little known. We encourage everyone to work together to reduce the rates of FASD and to increase awareness.” – [National Organisation for FASD](#).

Use the National Organisations for FASD’s [Myth Buster](#) to identify and ‘bust’ your own myths about FASD, or prompt a discussion with colleagues.

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⁵ Section 3.6.2 *Making the assessment meaningful*, SIGN 156 Children and young people exposed prenatally to alcohol, a national clinical guidance, January 2019

[Drymester](#) is a website aimed at inspiring and supporting parents to go alcohol free when pregnant or planning a pregnancy.

[Walk Along With Me](#) is a song sung during the COVID-19 pandemic by people with FASD about how they want to be understood and supported and how they are all individuals and are affected differently.

Useful resources:

- Joanna Buckard, [Red Balloon Training and Consultancy](#)
- [National FASD](#)
- [UK FASD Alliance](#)
- [National FASD Clinic](#)
- [FASD – Alcohol in Pregnancy](#) (video)
- [Information and resources for Midwives](#)
- [Alcohol and pregnancy](#) – Royal College of Obstetricians and Gynaecologists
- [Living with Fetal Alcohol Spectrum Disorder \(FASD\) – a Mum’s journey](#) (video)
- [Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities](#)

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Financial abuse and scamming

Financial abuse includes:

- Having money or other property stolen
- Being defrauded
- Being put under pressure in relation to money or other property
- Having money or other property misused

The Derbyshire Safeguarding Adults Board's Financial Abuse Working Group is a multi-agency group of professionals who meet quarterly to share information, raise awareness of initiatives, plan events and develop resources for both the public and professionals in relation to all aspects of financial abuse. This includes different types of scams, familial abuse, cybercrime and fraud.

Further information and resources about [financial abuse and scamming](#) are available from the Derbyshire Safeguarding Adults Board website.

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Guidelines for reporting accidents and assaults to adults with care and support needs

Introduction

Under [The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations \(RIDDOR 2013\)](#), certain types of accident that occur 'arising out of or in connection with work' are 'notifiable' and reportable to the Health and Safety Executive (HSE).

From a safeguarding adult perspective, the types of accident which come under this category are:

- **Any person** who dies as a result of an accident arising out of or in connection with work (employees, clients, members of the public, visitors to an establishment, etc.)
- Any person **not at work** (client's, members of the public, visitors to an establishment, etc.) who suffers an injury as a result of an accident arising out of or in connection with work and that person is taken from the site of the accident to a hospital for treatment in respect of that injury

'Arising out of or in connection with work', means that the accident has occurred because of something done or not done by the staff of an organisation carrying a work activity or because of a defect in the environment, which is controlled by the organisation. Please see below examples of reportable and non-reportable accidents under RIDDOR (2013):

- A person being hoisted using a sling with 6 loops, falls out of the sling due to one of the loops not being properly attached. – **Reportable**
- A resident in a care home is found on the floor with an injury which requires them to be taken directly to hospital after falling. The fall was caused by the resident tripping over the edge of a worn carpet. – **Reportable**

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- A resident in a care home is found on the floor with an injury which requires them to be taken directly to hospital after falling. The fall was caused by the person's health or condition which meant they were unable to mobilise. – **Not reportable**

In Adult Care establishments in Derbyshire, the process for reporting these types of incident is to contact the Adult Care Health and Safety (H&S) Section as soon as possible by telephone or e-mail, with details of the accident, as far as is known at the time. The Adult Care H&S section will notify the Health and Safety Executive (HSE). A completed [e-report](#) form will then need to be completed within 10 days. This form will automatically be sent to the Adult Care H&S Section on clicking the 'submit' button.

On approval by the H&S section, a PDF copy of the form will automatically be returned to the sender.

Where the work is being carried out by a private care provider or a voluntary organisation, it is that organisation's responsibility to report incident to HSE.

Definition of assault

What is an assault?

Any interaction between people which results in one or more of them **feeling** threatened.

For the purposes of reporting, the assault has to be an act of 'non-consensual violence' This is to differentiate between situations where the injured person agreed to the violent act taking place, such as professional sporting activities, e.g., boxing.

- An assault can be physical, i.e., where a person is attacked by someone using a weapon or by the perpetrator using physical force (grabbing, punching, kicking, head-butting biting, scratching etc.), or
- Non-physical or verbal, i.e., where the perpetrator shouts, swears or postures resulting in the victim feeling threatened although no physical contact actually takes place

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For the purposes of safeguarding, the following types of incident must be reported to H&S section using the [e-reporting form](#) and following the pathway set out above.

- Any assault that results in an injury to a client that results in them being taken directly to hospital for treatment
- Assaults by clients on other clients, brought about by their mental health or other diagnosed medical condition that do not result in them being taken directly to hospital for treatment are not reportable to AC H&S Section but must be recorded on Mosaic.
- Any assault to a client that reaches the action threshold set out in the Derbyshire Safeguarding Adult Board's [Decision-Making Guidance](#).

It is important to note that any assaults will also need to be considered under the Derby and Derbyshire Multi-agency Adult Safeguarding Policy and Procedures, with reference to the Derbyshire Safeguarding Adult Board's [Decision-Making Guidance](#).

All incidents described above will need to be reported to CQC. This is the responsibility of the Unit Manager or Manager of the service.

It is worth noting that the Care Quality Commission (CQC) and the Health and Safety Executive (HSE) have produced a [Memorandum of Understanding \(MoU\)](#), which includes co-operation on the notification and reporting of incidents.

Hate crime

Hate Crime is Any 'criminal offence' which is perceived by the victim or any other person, to be motivated by a hostility or prejudice based on a person's:

1. **Race** or perceived race
2. **Religion** or perceived religion
3. **Sexual orientation** or perceived sexual orientation
4. **Disability** or perceived disability
5. **Gender identity**, i.e., who is **transgender** or perceived to be transgender

For information – Derbyshire Police monitor crime that is motivated by prejudice relating people's gender and alternative subcultures.

In Derbyshire there are a number of ways that you can report hate crime and access services:

[Stop Hate UK](#) is a free confidential, 24-hour per day, third party reporting line which is independent from the Police and provided by the charity Stop Hate UK:

- Telephone: 0800 138 1625
- Text: 07717 989 025
- Email: talk@stophateuk.org
- [Web chat/instant messaging](#)
- [Online form](#)
- Post: P.O. Box 851, Leeds, LS1 9QS

Derbyshire Police

- Telephone: 101 (non-emergency) / 999 (emergency)
- Use the [online portal](#) for non-emergencies
- SMS Text
 - Non-emergency: Text to 07800 002414
 - Emergency: Text to 999. You'll need to pre-register. Visit www.emergencysms.org.uk for more information.
- [Online](#) (non-emergency)
- Email (non-emergency): deafsms@derbyshire.pnn.police.uk
- Textphone – Deaftext users should still continue to use that system as it is available to all mobile phones.

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[Derbyshire Victims Services](#) is an independent charity working across Derbyshire to support victims of crime. The charity work as part of the Police and Crime Commissioner's CORE (Coping and Recovery) team. If you would like to talk to someone about what has happened to you, or you would like emotional or practical support, please get in touch. All services provided are free and confidential.

- Telephone: 0800 612 6505,
- Email: support@derbyshirecore.org
- Text "COREDVS" to 82228

For further information and support organisations see:

- [Hate Crime – Derby](#)
- [Hate Crime – Derbyshire](#)

Involvement of Derbyshire Constabulary

Safeguarding Coordination Hub (SCH)

The Safeguarding Coordination Hub (SCH) is part of the Derbyshire Constabulary Public Protection Department. The SCH should be contacted where a crime has been committed or there is suspicion of a crime being committed and for adult safeguarding enquires. A referral should be made on either an initial enquiries form or S42 enquires form. These should be completed in full, with full names, date of birth and address etc.

The SCH should be contacted via email at the following email address:

Derbyshire Adult and Derby City Social Care:

SCHadultenquiries@derbyshire.police.uk

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It is important to use secure email when exchanging confidential information with the Police. The email will be reviewed by a member of staff who will obtain further information from the referrer as appropriate and highlight to the Adult at Risk Detective Sergeant for review and decision making.

The Detective Sergeant or staff member will call-back as soon as possible, in order to further discuss the referral. More serious referrals/incidents will be given priority. However, if there is a crime in action or a more immediate concern regarding an adult at risk then the Derbyshire Constabulary Force Control Room must be contacted via **101 or 999** as appropriate in addition to submitting the referral to the SCH, the incident number provided by the Force Control Room **must** be included in the referral.

The SCH can be contacted, Monday–Friday, 9am–5pm via email. **If an adult safeguarding concern arises outside of these office hours, call the Police on the most appropriate number – either 101 or 999. Please advise the operator that the referral is a safeguarding matter regarding an adult at risk.**

Referral to the Safeguarding Coordination Hub (SCH)

A referral to the SCH will see a NICHE Occurrence created (NICHE – the Police computer system for crime and intelligence recording). This will create a chronological record of any actions required/taken, discussions and decisions which take place and when. Staff should make a note of the reference number to avoid delays in future communication.

The SCH may decide that there is no criminal offence and therefore no investigative role for the Police. However, they may still be able to provide advice and guidance for consideration as to what would bring the matter into the Police arena or consider whether it is appropriate to refer to the Community Safety Team for involvement.

If you are in any doubt that further information received may alter the stance of Police decisions, please call the SCH for further discussion.

If appropriate and proportionate the SCH will carry out research on those involved in a case and consider whether information should or can be shared with other agencies.

Possible actions by the Safeguarding Coordination Hub (SCH)

If the referral concerns a serious assault, sexual assault, high value financial abuse or where a professional is involved then it will be referred to the Adult at Risk Detective Sergeant for consideration. The Detective Sergeant will determine if it is appropriate for police to investigate, if so, will allocate to the relevant policing unit for investigation.

Once the referral has been allocated to the relevant unit then the role of SCH ends. SCH will remain a point of contact if difficulties are encountered in contacting allocated officers.

Where a referral requires immediate Police attendance then consideration will be given to creating a Police incident which will be attended by uniformed Police Officers in the first instance to deal with any immediate presenting threat to the adult at risk. A decision will then be made whether it remains with them or is allocated to other officers.

Adults at risk

Adults at risk may well require services from the Local Authority and various agencies but may not meet the safeguarding threshold. These persons may still be susceptible to harm, require assistance from services or care reviews of services already received.

It may be that they are living in the community in very poor circumstances, not taking medication or have a mental health issues and as a result they may be viewed by the Police as an adult at risk.

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Vulnerable witnesses

Definition of a vulnerable witness

Witnesses who are under the age of 18 at the time of the hearing. All witnesses in this category of vulnerable witness are eligible for special measures to assist them to give their evidence in court.

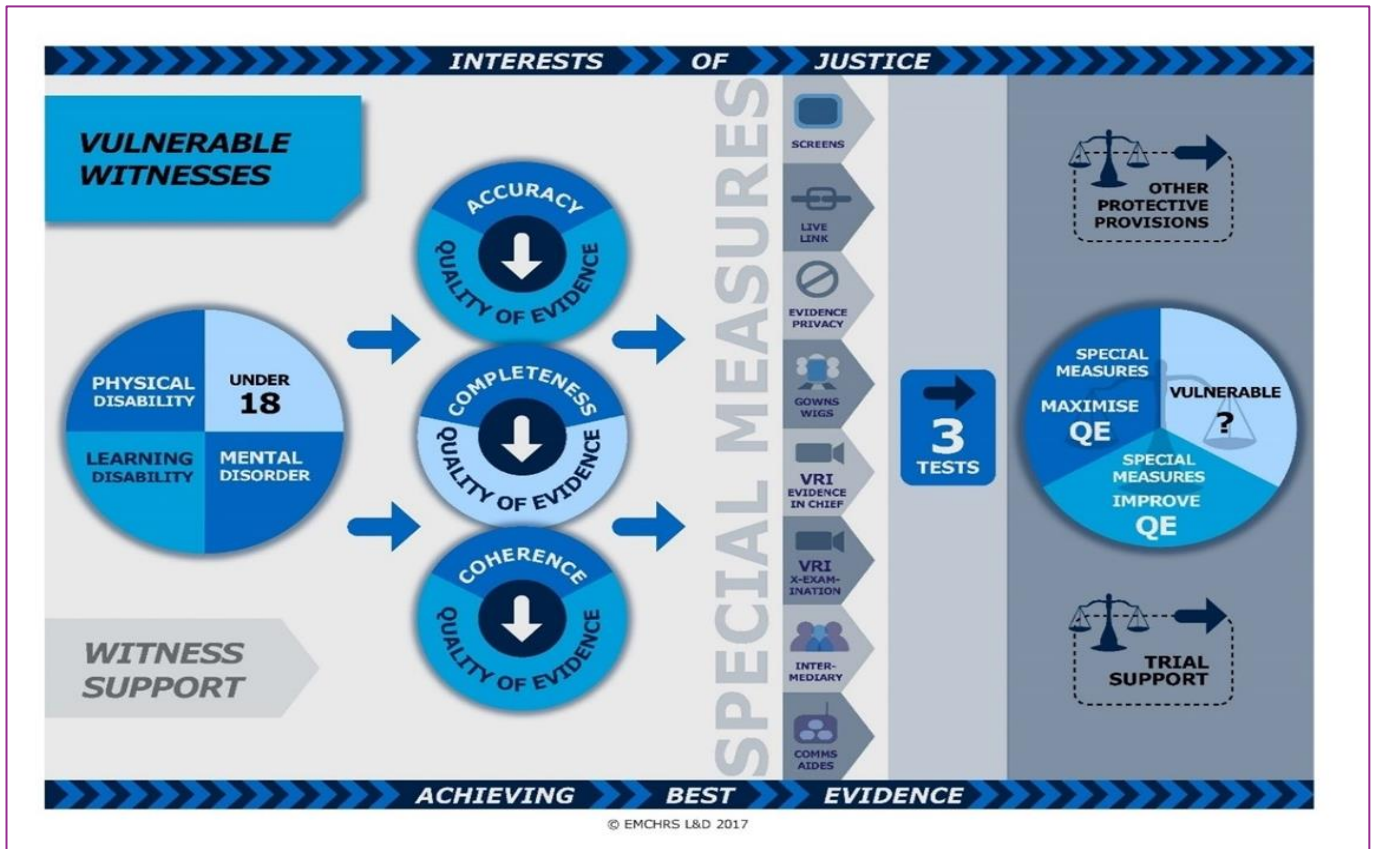
- Witnesses who have a mental disorder
- Witnesses significantly impaired in relation to intelligence or social functioning (learning disability)
- Witnesses who have a physical disability

The quality of a witness's evidence is based on three components as follows:

1. Completeness
2. Coherence – a witness's ability in giving evidence to give answers which address the questions put to the witness and can be understood both individually and collectively
3. Accuracy

Whilst the Act distinguishes between 'vulnerable' and 'intimidated' (Section 17) witnesses, it is important to recognise that some witnesses may be both.

The Act introduced a range of special measures that can be used to facilitate the gathering and giving of evidence by a vulnerable witness.



Special measures

The special measures that are available for a vulnerable witness include:

- The use of screens
- The use of live TV link
- Giving evidence in private (Section 25 – limited to sexual offences and those involving intimidation)
- The removal of wigs and gowns
- The use of video recorded interviews as evidence in chief
- The use of video recorded cross examination
- Communication through intermediaries
- The use of special communication aids

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Access to special measures

The Court will apply three tests to a vulnerable witness in order to determine whether or not one or more of the Special measures are accessible to them. The Court will decide if Special Measures are to be utilised. The three tests are:

- Is the witness vulnerable?
- Whether any of the special measures or any combination of them are likely to improve the quality of the witness's evidence
- Which of the available special measures are most likely to maximise the quality of the witness's evidence?

Other provisions contained within the Act

- Mandatory protection of witness from cross-examination by the accused in person. This applies to the cross examination by an unrepresented defendant of a vulnerable child or adult victims in certain cases involving sexual offences.
- Discretionary protection of witness from cross-examination by the accused in person. In other types of offence, the court has a discretion to prohibit an unrepresented defendant from cross-examining the victim in person.
- Restrictions on evidence and questions about complainant's sexual behaviour. The Act restricts the circumstances in which the defence can bring evidence about the sexual behaviour of a complainant in cases of rape and other sexual offences
- Reporting restrictions. The Act provides for restrictions on the reporting by the media of information likely to lead to the identification of certain adult witnesses in criminal proceedings (Section 46). (The C&YP Act 1933 applies in relation to child witnesses)

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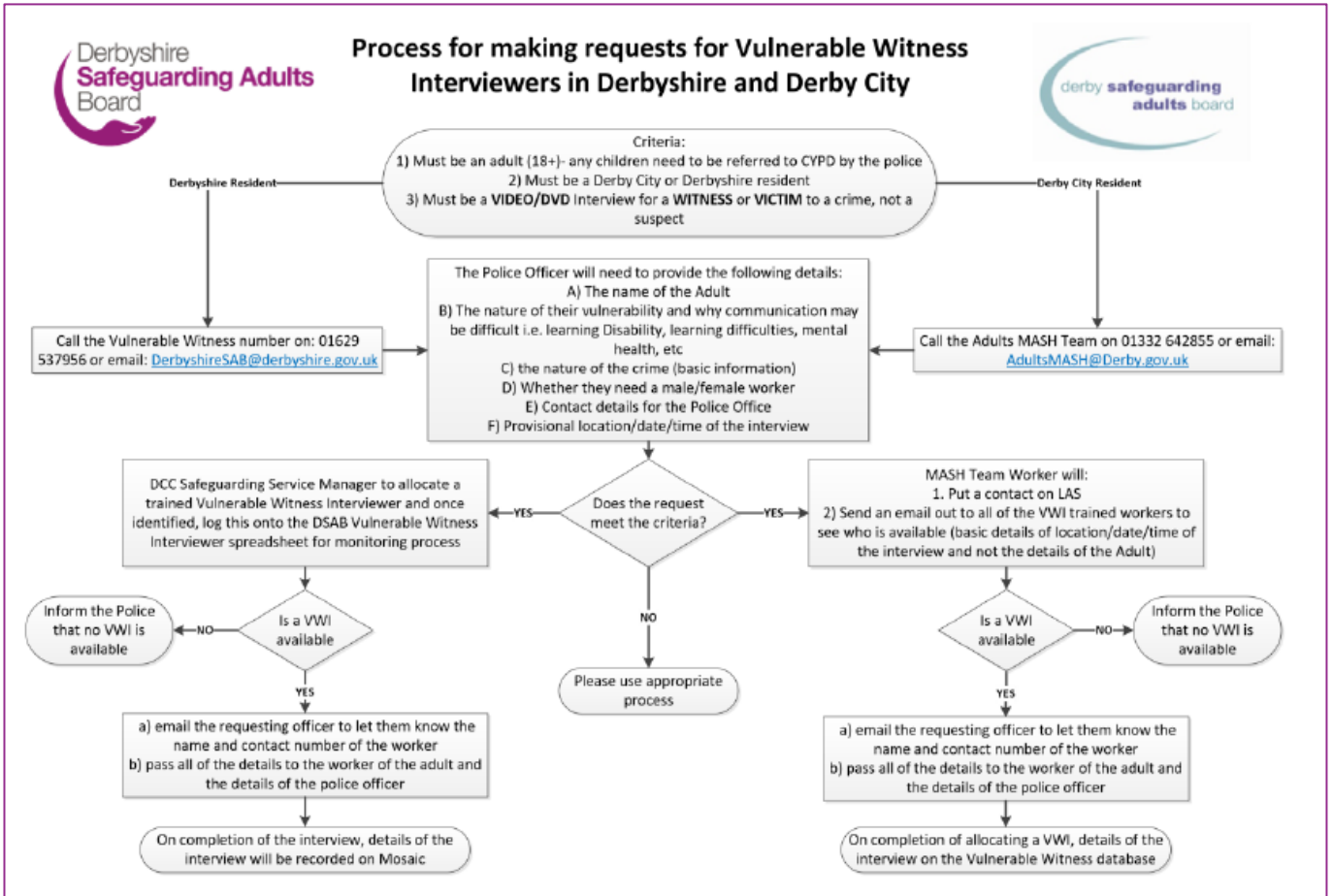
Social support

A vulnerable witness can receive social support at all stages of an investigation. Three distinct roles for witness support have been established as follows:

- Interview support – provided by someone independent of the police, who is not a party to the case being investigated and who sits in on the original interview.
- Pre-trial support – provided to the witness in the period between the interview and the start of a trial.
- Court witness support – provided by someone who may be known to the witness, but who is not a party to the proceedings, has no detailed knowledge of the case and may have assisted in preparing the witness for their court appearance.

Pre-trial support and court support can be undertaken by the same person. However, an interview supporter cannot be used for either pre-trial or court support because they are already aware of the witness's account.

The flow chart below shows the process for police officers requesting vulnerable witness interviewers in Derbyshire and Derby City.



Where there is no Police role

If having considered all the presenting information it is decided by Derbyshire Constabulary that there is no role for the Police, relevant advice will still be offered and the SCH may be able to carry out research and share information to assist in a safeguarding investigation.

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Involvement of Health professionals

Introduction

There are a number of health providers throughout Derbyshire and Derby City, which include:

- Barlborough NHS Treatment Centre
- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Health Care NHS Foundation Trust
- DHU Health Care CIC
- East Midlands Ambulance Service
- General Practitioners
- University Hospitals of Derby and Burton NHS Foundation Trust

Also included are the independent provider's dentists, optometrists, and pharmacists.

All these services are quality assured by NHS Derby and Derbyshire Integrated Care Board.

The NHS Derby and Derbyshire Integrated Care Board will have an Adult Safeguarding lead and a lead for the Mental Capacity Act. It will ensure that this guidance is included in policies and training for all health professionals.

Health-focussed assessments

Health professionals will work in partnership with other agencies to safeguard adults at risk and investigate concerns of abuse or neglect. This will be regardless of a patient's age, colour, ethnicity, religious affiliation and belief, sexuality or gender orientation. An adult safeguarding health focussed assessment can:

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- Identify the immediate, and medium-term needs of the adult at risk
- Establish that their treatment and care needs are being met
- Identify safeguarding protection/safety plans for the adult at risk
- Identify whether an urgent change of care setting is required

Health-focussed investigations

A health-focussed investigation into the treatment and care of an adult at risk should demonstrate:

- What treatment and care was delivered to meet the needs of the adult at risk
- Whether there was an omission or provision of treatment and care to meet the needs of the adult at risk
- If professionals involved in the delivery of treatment and care knew what to do and whether they acted reasonably
- Whether within the specific context the involved professionals took all reasonable actions to prevent the harm from occurring
- Whether the consequences of the action or inaction could have been avoided, or the risk of harm occurring could have been significantly reduced if alternative action had been taken

Where a health care professional is the investigator, they could be asked to assess the health care needs of the adult(s) at risk, both current and historic, and in relation to their present or previous care placement including hospital, care homes, residential nursing homes and community-based care settings, if appropriate.

The investigating health practitioner can only give an opinion and write reports about areas where they have relevant professional knowledge and experience. The findings should be balanced, objective and accurate. Assistance can be obtained from other health practitioners when needed, and specialist advice should be sought from the relevant service area when needed. The investigating health practitioner will complete a written report for the Local Authority Safeguarding lead/Safeguarding Manager detailing their opinion based on the available information as to whether, on a balance of probabilities, the abuse or neglect occurred.

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Making Safeguarding Personal

Provider Manager – responding to concerns

Please note, this list is not exhaustive nor a definitive guide, it is intended to support practice and decision-making and should be considered alongside adult safeguarding policy and procedure and practice guidance, which can be found at:

- [Safeguarding policy, procedures and practice guidance – Derby](#)
- [Safeguarding policy, procedures and practice guidance – Derbyshire](#)

Provider Manager – immediate action

- Ensure the safety of the adult who is alleged to have been harmed and, if necessary, the safety of the adult alleged to have caused them harm
- Contact the relevant emergency services as required – DO NOT wait to speak to a senior colleague to seek permission to do this. Make sure you have all relevant information to hand – e.g., date of birth, communication issues, health/care needs, next of kin/GP details (this list is not exhaustive). Think about maintaining potential forensic evidence, particularly in the light of a sexual allegation, or where a crime has been committed
- Consider risks to others and take appropriate protective measures
- Provide support and reassurance to the adult and, if possible and appropriate, check out their wishes and explain what will happen next
- Where relevant, ensure the person reporting the concerns documents what they have witnessed or what has been disclosed to them, any action taken, if anyone else was present, content of discussions with the adult. Also ensure the date, time and location is recorded
- Think about maintaining potential forensic evidence particularly in light of a sexual allegation or where a crime may have been committed

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- DO NOT 'question' the person alleged to have caused harm; if this person also has care and support needs, make sure immediate risk and safety measures are taken; but should the person want to talk listen, take notes. If possible, the conversation may be recorded but local organisational policy must be followed
- Photographs should not be taken unless following policy and procedure
- The manager should ensure all discussions and decisions are recorded demonstrating proper process has been followed, consistency and providing a clear audit trail
- Report the incident to Police if a criminal offence appears to have been committed, if you are witnessing an incident dial 999 if urgent or 101 if not
- Consider if any immediate disciplinary action is required

Provider Manager – action required the same day

- If possible, discuss a safeguarding referral with the adult and their family/advocate (where appropriate) and seek consent. Reassure the adult as necessary at this point regarding the safeguarding process and why you need to refer to Police/make a safeguarding referral, etc. Consent may be overridden if there is a potential risk to the adult and/or others
- Where an adult needs support, think about contacting a relevant person or advocate to assist them
- Complete a safeguarding referral form (Derby City or Derbyshire) as comprehensively as possible: describe the reasons for concerns, how they came to be reported, the wishes/outcomes of the adult and immediate action taken to respond to the allegations/risk, identify the adult's consent and capacity to the referral
- Inform Care Quality Commission /Health and Safety
- Complete the appropriate risk assessments, review care plans, rotas
- Clearly record all actions taken and decisions made

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Provider Manager – possible actions/outcomes after safeguarding referral

- Further measures required to support and protect the adult and any others felt to be at risk
- Support for the person alleged to have caused harm if they also have care and support needs
- Immediate measures to address practice and quality concerns
- Support for a whistle-blower and other staff, as required
- Consider if advocacy/Independent Mental Capacity Advocate (IMCA)/Independent Mental Health Advocacy (IMHA) is required
- Further discussions with the adult and family (where appropriate)/advocate to engage them fully with MSP and ascertain their wishes and desired outcomes
- After initial enquiries are completed, a decision will be taken about any further information required under a s42 enquiry for the provider and any other relevant agency
- Consider if a [Local Authority Designated Officer \(LADO\)](#) / [Persons in a Position of Trust \(PIPOT\) referral](#) is required
- Contact with commissioners/quality team
- Continue as appropriate (and alongside safeguarding procedures) HR involvement and any further contact with Care Quality Commission (CQC)
- Formal meetings: you will be required to contribute and attend safeguarding meetings and undertake all actions as agreed as part of a S42 enquiry, safeguarding/safety plan
- Refer to Disclosure and Barring Service (DBS) and professional bodies as /when appropriate
- Ensure information is shared with staff as appropriate and relevant to role and on a 'need to know basis'
- Agree any further actions, timescales and Service Manager/Group Manager/Lead

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Myths and realities about MSP

This guidance has been developed to address misconceptions about Making Safeguarding Personal. It is a summary of work undertaken by the [Local Government Association \(LGA\)](#) and the [Association of Directors of Adult Social Services \(ADASS\)](#) as a result of regional and national work since autumn 2018 and references the [Care Act \(2014\) safeguarding statutory guidance](#).

The guidance has been developed to support safeguarding practice within Derby and Derbyshire. It supports and promotes relationship and strengths-based approaches in practice. It acknowledges the complexity of people's lives, and challenges for practitioners to enable people (with their representatives or advocates, if they lack capacity) to make decisions to keep themselves safe.

The purpose of this guidance is to expose some 'myths' about Making Safeguarding Personal for practitioners in Derby and Derbyshire across social care and multi-agency partners.

Relevant [policies, procedures and practice guidance](#) are available from the Derbyshire Safeguarding Adults Board's (DSAB) website, including:

- [Adult Safeguarding Decision-Making Guidance](#)
- [Vulnerable Adult Risk Management \(VARM\)](#)
- [Persons in a Position of Trust \(PIPOT\)](#)
- [Derby and Derbyshire Safeguarding Adults Boards practice guidance](#)

Making Safeguarding Personal requires us to engage with the adult and colleagues across agencies, to promote the values and principles set out in [The Care Act \(2014\)](#), [Mental Capacity Act \(2005\)](#), [Human Rights Act \(1998\)](#) and ensure adult safeguarding:

- Is person-led
- Is outcome-focussed

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- Engages the person and enhances involvement, choice and control
- Improves quality of life, well-being and safety

“Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting” (other than prisons and approved premises s14.6, Care Act 2014 statutory guidance).

Making Safeguarding Personal (MSP) is not a procedure or tick-box exercise. In practice MSP means embracing core statutory principles that should underpin all aspects of adult safeguarding work in order to provide flexible responses around the needs, wishes and desired outcomes of the person. Recording should reflect how the principles have been considered in defensible decision-making.

- **Empowerment** – people being supported and encouraged to make their own decisions and have informed consent
- **Prevention** – it is better to take action before harm occurs
- **Proportionality** – the least intrusive response appropriate to the risk presented
- **Protection** – support and representation for those in greatest need
- **Partnership** – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- **Accountability** – accountability and transparency in delivering safeguarding

Safeguarding adults is complex because people’s lives are complicated, and everyone’s situation is different. Also, there are many ways people can be abused or neglected. That is why our response needs to be personalised: different people and agencies may be involved in a safeguarding enquiry, and partnership work is essential in MSP.

Examples of MSP myths and realities

Myth 1: MSP means that if someone says they do not want anything to happen you can close the case.

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Reality: MSP DOES NOT mean walking away.

- It is expected that practitioners in Derby and Derbyshire will use and demonstrate professional curiosity and relationship/strengths-based practice
- You need to ensure that someone is not pushing you away because they are being coerced, controlled, or influenced by someone else, or they may have no trust in agencies
- Do not make assumptions about what someone may consider to be a proportionate decision; adults have complex relationships and maybe unrealistic or ambivalent to their circumstances
- You should work with the adult to understand what matters to them, what being safe means to them and how this can be achieved and promote their well-being
- It is important that you explain what options the adult has, what the implications are/could be relevant to their situation/concern and provide examples of things what can be done to help
- You should do this before being assured that the adult is making an informed decision (supported by an advocate, as appropriate)
- It is important to persevere and work to establish trust with the adult to aim to minimise the impact of unwise decision-making on their health and well-being
- Remember, people are likely to feel anxious and distressed already and being involved in safeguarding may escalate these feelings
- **Concerns about risks to others and public protection override a person's preference/decision, and all appropriate action should be taken in these circumstances**

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Myth 2: “Doing” MSP takes too much time.

Reality: Making Safeguarding Personal is effective.

- It does take more time to explain to the adult what safeguarding is and have conversations that establish what is happening to them, what is important to them, what they want to happen and what the options are moving forward. Again, it is expected that practitioners will use professional curiosity to take time to establish the above and will do this at a pace of the person’s choosing
- Evidence has consistently found that since MSP was implemented it is more time efficient in the long-term because better choices can be made by individuals, safety plans will be more effective and people are supported to achieve outcomes they have been identified as important to them. Re-referrals are also reduced using the MSP approach

Myth 3: It is not possible to use a Making Safeguarding Personal approach when an adult cannot make decisions for themselves.

Reality: Making Safeguarding Personal is for everyone, including adults unable to make decisions for themselves.

- Assume the adult can make their own decisions
- It is expected that staff will use their professional judgement and balance many competing views to manage risk and ensure the adult is in control of decision-making as much as is possible
- MSP is an approach to adult safeguarding for everyone, regardless of their ability to make decisions for themselves
- Use advocates, consider asking people who know the adult what they might have wanted to give you an idea of what outcomes they may have wanted. Find ways to gather information from family, friends, care, health workers, etc

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Myth 4: Once a safeguarding referral is sent to the Local Authority, it is over to them to investigate.

Reality: Safeguarding is everyone's responsibility.

- Safeguarding is not just about sharing information and then handing over the concern to someone else; it is about actively taking responsibility for things to be done right and to supporting the safeguarding process in order for best outcomes to be achieved
- Safeguarding means protecting an adult's right to live in safety and free from abuse and neglect, making sure their wellbeing is promoted. It is the responsibility of all practitioners in Derby and Derbyshire to ensure that safeguarding concerns are addressed, and that people feel they are being heard and feel safe to report concerns and during enquiries
- Working in partnership with the person making the referral, the adult and any other appropriate person, professional or agency is central to MSP. It is about people and organisations working together to prevent and stop the risk and experience of abuse or neglect.

This guidance is intended to offer support to practitioners across Derby and Derbyshire to improve practice and support confident, consistent and defensible decision-making.

Acknowledgements

- ['Myths and Realities' about Making Safeguarding Personal](#)
(Dr Adi Cooper OBE, Local Government Association)
- [Making decisions on the duty to carry out Safeguarding Adults enquiries](#)
(Local Government Association and Association of Directors of Adult Social Services Making Safeguarding Personal Advisory Group)
- [Making Safeguarding Personal](#)
(Local Government Association and Association of Directors of Adult Social Services)
- Local Government Association, Making Safeguarding Person Workshops 2018 and 2019

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MAPPA (Multi-Agency Public Protection Arrangements)

MAPPA stands for Multi-Agency Public Protection Arrangements. Established in England and Wales since 2001, the arrangements serve to identify, assess and manage the risks of re-offending and harm posed by certain sexual, violent and other dangerous offenders. The value of the arrangements lies in partnership, through which the agencies involved can together achieve results which help to make communities safer.

In Derbyshire and Derby City the arrangements bring together Derbyshire Constabulary, the National Probation Service and HM Prison Service into what is known as the MAPPA 'Responsible Authority'. A number of other services and agencies have a 'duty to co-operate' with the Responsible Authority through the arrangements. These co-operating partners include:

- Derbyshire County and Derby City Children and Adult Social Care Services and Education services
- Derbyshire County and Derby City Youth Offending Services
- Derbyshire District and Derby City Authorities' Housing Services, and certain registered social housing providers
- Derbyshire Healthcare NHS Foundation Trust and other health providers
- Electronic monitoring ('tagging') providers
- Jobcentre Plus (Department for Work and Pensions)
- UK Visas and Immigration (formerly the UK Border Agency)

MAPPA categories

There are three categories of MAPPA offender:

Category 1: registered sexual offenders

These are sexual offenders, who as a result of a conviction or caution for a relevant offence, are required to notify the police of their name, address, and other personal details, and also notify

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any subsequent changes. Registration periods are fixed by law and can last from 12 months to life depending upon the offender's age at the time of the offence, the age of their victims, and the nature of the offence or type of sentence imposed. These offenders remain within MAPPA until the registration ends.

Category 2: violent and other sexual offenders

These offenders have been sentenced to imprisonment or detention for 12 months or more, or have been detained under a Hospital Order, for murder or one of a wide range of other serious violent offences contained under Schedule 15 of the Criminal Justice Act 2003. The category also includes a small number of other sexual offenders who do not qualify for registration but are contained under Schedule 15 of the Criminal Justice Act 2003, and offenders disqualified by a court from working with children can be included in the category. Offenders in this category are included under MAPPA until the end of their sentence or licence or order

Category 3: other dangerous offenders

This category contains offenders who do not meet the criteria for either Category 1 or Category 2 but who are considered by agencies to pose a risk of serious harm to the public which requires active multi-agency management.

To register a Category 3 offender, the person will have committed an offence which indicates that he or she is capable of causing serious harm to the public and must reasonably consider that the offender presents a current risk of serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks. The person must have been convicted of an offence or have received a formal caution or reprimand/warning (young offenders). Offenders convicted abroad could qualify for Category 3.

Offenders considered in the first two categories are always included under the Arrangements until the end of their sentence, disqualification, or registration period.

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The third category is included only when it is agreed that an offender should be managed at MAPPA Levels 2 or 3 and ends when they are discharged from joint management.

MAPPA levels

MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at level 1 (ordinary agency management). This involves the sharing of information but does not require active conferencing.

Level 1: ordinary agency management

Offenders managed at level 1 are subject to the standard arrangements applied by whichever agency is supervising or managing them. Management at this level can still involve information sharing and liaison between partner agencies. For example, regular information exchange meetings take place between the Police, National Probation Service and other agencies on high risk registered sex offenders and violent offenders who are not managed at levels 2 or 3.

Level 2: active multi-agency management

The risk management plans for offenders at this level require the continuing active involvement of several agencies, co-ordinated through regular MAPPA meetings. Comprising core representatives and other agency workers, regular monthly meetings take place across Derby and Derbyshire, usually at Probation or YOS offices.

Level 3: active enhanced multi-agency management

Needing co-ordinated management, as at Level 2, these cases additionally require the active involvement of senior officers/managers who can identify or authorise extra resources, such as police surveillance or specialised accommodation, or provide ongoing senior management oversight. This may apply to certain cases that raise major public interest or concern. An Area Level 3 meeting is held every month at Derbyshire Police HQ, and at other times, if needed.

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At each level the aim is to make sure that all reasonable steps are being taken to keep to a minimum the offender's risk of re-offending and causing further serious harm. Management normally takes place at the lowest level at which this can be achieved. Though more likely to call for an active multi-agency approach higher risk cases can be managed at any level, and there can also be grounds sometimes for a lower risk case to be managed at levels 2 and 3 if the case has sufficiently complex needs or where there is a high level of public interest.

Disclosure

If an offender poses a significant risk of harm and members of the public need to be protected, information can be given to community organisations, faith groups, families or individuals, as relevant.

The protection of members of the public counts for more in these situations than an offender's right to privacy.

Further information

The latest version of the [MAPPA statutory guidance](#) is available from the GOV.UK website.

MARAC (Multi-Agency Risk Assessment)

What is MARAC?

MARAC is the abbreviation for Multi-Agency Risk Assessment Conference. It is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic abuse. Agencies involved include:

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- Police
- Health
- Child Protection
- Housing
- Fire Service
- Independent Domestic Violence Advisers
- Adult Social Care
- Mental Health
- Probation
- Drug and Alcohol Advisors
- Specialists from statutory and voluntary sectors

The process ensures that there is a sharing of information and an action plan is discussed so that each agency can ensure they have an appropriate risk and safety plan in place. Usually there is no follow up by MARAC after this meeting, so it is important each agency completes its own agreed actions.

Referrals into MARAC

If a person is referred into Adult Care and is experiencing domestic abuse, stalking or 'honour-based' violence, consideration should be given to the MARAC process. Ideally, there will be a discussion with the person to gain their consent to do the risk assessment and make the referral.

The risk assessment and referral forms should be completed with the person. However, where the situation is high risk, lack of consent can be overruled, and a referral made to MARAC if appropriate. Consent and/or reasons for overriding consent should be documented on the person's care records. Referrals to IDVA, however require consent from the adult.

Workers should complete a Risk Assessment on the MARAC CAADA DASH checklist form.

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Send domestic abuse referrals directly from your 'derbyshire.gov', or 'derby.gov.' email to the standard email of the two organisations who received these referrals – checks have been made that they are able to accept these emails securely.

When referring high-risk domestic abuse clients to the MARAC and IDVA teams, please send the IDVA referral form and the DASH Risk Assessment from your 'derbyshire.gov.' or 'derby.gov' email to:

- MARAC@derbyshire.pnn.police.uk (All)
- IDVAService@archnorthstaffs.org.uk (County)
- sharon.ryan@bolsover.gov.uk (Bolsover)
- idva.service@glow.cjsm.net (City)

For Derbyshire, when referring all other levels of risk to the Derbyshire Domestic Abuse Support Line, please send the Domestic Abuse Support Services referral form and DASH Risk Assessment to: DerbyshireDAHelpline@actionorg.uk.

For Derby City, all other level of risk should be referred via the Refuge Referral Form and sent to Refuge: refuge.dcdvs@refuge.cjsm.net.

The 'cjsm' accounts of both of these organisations still exist and are on the forms as external partner agencies may need to use them – for anyone to be able to send securely to a 'cjsm' account, they would need to have set up a 'cjsm' account.

[Forms](#) can be downloaded from the Safer Derbyshire website – please do not use locally-stored forms as these may contain incorrect email addresses and information.

A [guide on how to refer to MARAC](#) can be found on Safer Derbyshire's website. Alternatively, advice can be sought from the Safeguarding Team within Adult Care or the Community Safety team in Derbyshire County Council.

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It may be that the person is also referred into safeguarding. If so, a referral to MARAC will automatically be considered under the Strategy Meeting Agenda.

When a referral is received by the MARAC co-ordinator, if the referral is appropriate and complete, the person will be put on to the list for the next MARAC meeting.

General principles of information sharing relating to MARAC

- All attendees at MARAC meetings must understand their responsibilities – a statement should be referred to at the start of each MARAC reminding participants of their ethical and legal responsibilities
- Normally victims are told that they are to be referred to MARAC, what that means and that a referral will be made to the IDVA (Independent Domestic Violence Adviser) service who will offer them one to one support
- Consent should be asked for; however, it is not necessary, as the decision will already have been taken that a MARAC is needed, based on the risk to the victim. If the victim does not engage and does not agree to the referral, the MARAC will still go ahead although its effectiveness may be reduced
- There should normally be transparency around the process of the victim's information and potentially that of their children (if any) being shared – unless this would itself increase the risk of harm
- Furthermore, the alleged perpetrator should not be asked for their consent or informed about the MARAC referral as to do so might jeopardise the victim's safety
- Information sharing about both the victims and perpetrators is shared in the context of sharing without consent for the prevention and detection of crime or serious harm
- MARAC representatives should be reminded that although the process is victim focussed, the rights and humanity of the perpetrator also need to be recognised and addressed. The perpetrator may need the support and engagement of multiple agencies in addressing their own needs in relation to mental health, drug or alcohol abuse, housing or other issues

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- In addition to the risks posed to the victim, information shared at MARACs can raise significant issues to public safety, where for example a perpetrator is threatening to kill either their family or others. Some information on alleged perpetrators may justify alert 'flagging' on information systems to protect staff

Specific guidance for Health staff

It will be helpful for health representatives to have triaged, in advance, the information they have available to share, but they should not share information until they are convinced that it is justified to do so.

Health information is often particularly sensitive, and it is therefore suggested that it should be held back until other agencies have shared sufficient information for the health representative to conclude that sharing is indeed justified and proportionate. For example, the fact that a woman has had repeat attendances at Accident and Emergency Department might not be disclosed at MARAC unless another agency brought information to the MARAC that indicated that these were directly or indirectly as a result of violence from the alleged perpetrator.

The decision on whether and what to share therefore requires appropriate consideration, as the decision to share will often be context dependent. **Even when there is a clear justification to disclose some information staff should apply the Caldicott Principle of 'sharing the minimum amount of information'.**

Decisions to disclose must be properly documented immediately, identifying the reasons why the disclosures are being made (i.e., what risk is believed to exist), what information will be disclosed and what restrictions on use of the disclosed information will be placed on its recipients.

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Specific information for Adult Care staff

It is expected that a Service Manager, Principal Social Worker or Senior Practitioner will attend the MARAC meeting and that details of the perpetrator, victim and any children will be provided. Information will only be shared on people who receive a service from Adult Care. Any details regarding the victim or perpetrator can be shared in line with the information sharing agreements which are signed up to in the MARAC process.

It is likely that most people will not receive a service from Adult Care. When a person is known it may be necessary to consider the use of Adult Safeguarding Procedures if we are not already aware of this, and this may be an action or outcome of the MARAC process.

Sometimes within the MARAC process, information is shared regarding a person who may be an employee within a care setting. If this person poses a risk to others this will need to be shared with a manager to discuss if any information is required to be shared with an employer.

The Mental Capacity Act (2005)

[The Mental Capacity Act 2005](#) is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. This could be due to a mental health condition, a severe learning difficulty, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident.

The Act's purpose is:

- To allow adults to make as many decisions as they can for themselves
- To enable adults to make advance decisions about whether they would like future medical treatment

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- To allow adults to appoint, in advance of losing mental capacity, another person to make decisions about personal welfare or property on their behalf at a future date
- To allow decisions concerning personal welfare or property and affairs to be made in the best interests of adults when they have not made any future and cannot make a decision at the time
- To ensure an NHS body or local authority will appoint an independent mental capacity advocate to support someone who cannot make a decision about serious medical treatment, or about hospital, care home or residential accommodation, when there are no family or friends to be consulted
- To provide protection against legal liability for carers who have honestly and reasonably sought to act in the person's best interests
- To provide clarity and safeguards around research in relation to those who lack capacity

Principles of the Mental Capacity Act (2005)

There are five guiding principles which should be borne in mind when working with the Mental Capacity Act, these are:

- A person must be assumed to have capacity unless it is established that they lack capacity
- a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because they make an unwise decision
- 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
- Before the act is done, or the decision 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 freedoms of action

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Mental Capacity Act

The Mental Capacity Act states that a person is presumed to make their own decisions "unless all practical steps to help him (or her) to make a decision have been taken without success".

Every person should be presumed to be able to make their own decisions. You can only take a decision for someone else if all practical steps to help them to make a decision have been taken without success. For example, someone might have the capacity to walk into a shop and buy a CD but not go into an estate agent and purchase a property. Incapacity is not based on the ability to make a wise or sensible decision.

Making a decision on capacity

To determine incapacity, you will need to consider whether the person being looked after is able to understand the issues that the decision is being made about. You need to consider if they have:

- An impairment or disturbance in the functioning of the mind or brain and
- An inability to make decisions

A person is unable to make a decision if they cannot:

- Understand the information relevant to the decision
- retain that information
- Use or weigh that information as part of the process of making the decision; or
- Communicate the decision

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Making a decision for someone

If, having taken all practical steps to assist someone, it is concluded that a decision should be made for them, that decision must be made in that person's best interests. You must also consider whether there's another way of making the decision which might not affect the person's rights and freedoms of action as much (known as the 'least restrictive alternative' principle).

Best interest decisions

Section 4 of the Mental Capacity Act (2005) sets out a checklist of things to consider when deciding what's in a person's best interests. You should:

- Not make assumptions on the basis of age, appearance, condition or behaviour
- Consider all the relevant circumstances
- Consider whether or when the person will have capacity to make the decision
- Support the person's participation in any acts or decisions made for them
- Not make a decision about life-sustaining treatment "motivated by a desire to bring about his (or her) death"
- Consider the person's expressed wishes and feelings, beliefs and values
- Take into account the views of others with an interest in the person's welfare, their carers and those appointed to act on their behalf

For further advice and guidance on issues related to the Mental Capacity Act, please refer to the [Mental Capacity Act Code of Practice](#).

Role of a Care Act Advocate

[The Care Act 2014](#) aims to strengthen the voice of people who use services, and their carers, over the process of assessing, planning and safeguarding.

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Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

When to instruct an advocate?

Under the Care Act 2014, local authorities must arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of their care plan, if two conditions are met:

- The person has **substantial difficulty** in being fully involved in these processes
- There is **no-one appropriate available** to support and represent the person's wishes

Substantial difficulty

Substantial difficulty in being fully involved in decisions about their care and support, means the person finds one or more of the following very difficult:

- Understanding relevant information
- Using or weighing up the information
- Retaining information
- Communicating their views, wishes and feelings

Appropriate individuals

If somebody has substantial difficulty being involved, an appropriate individual must be able to facilitate the person's involvement. In the majority of cases, if there is nobody appropriate to facilitate, for whatever reason, access to an independent advocate **MUST** be offered.

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There are two exceptions to this where an appropriate individual AND an advocate can be appointed.

- When a placement is being considered in NHS-funded provision in either a hospital (for four weeks or more) or in a care home (for eight weeks or more) and the local authority believes that it would be in the best interests of the person to arrange an advocate
- Where there is a disagreement between the local authority and the approach

Advocates are available for:

- Adults with care and support needs
- Carers of adults and carers of children in transition
- Children who are approaching the transition to adult care and support

What are the care and support processes that an Independent Advocate can provide help with?

- An adult needs assessment
- A carer's assessment
- The preparation of a care and support plan or support plan for adults
- The review of an adult's care and support plan
- The review of a carer's support plan
- A young person's needs assessment (if the young person is under transition to adult care/support)
- A child's carer's assessment (if the young person is under transition to adult care/support)
- A young carer's assessment
- A safeguarding enquiry
- A Safeguarding Adult Review

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The role of an advocate

Advocates support people to make their own decisions and be involved as fully as possible, supporting them to communicate their views and speaking on their behalf if necessary. Advocates work with people to:

- Understand the local authority process
- Access and understand information
- Communicate their wishes, views and feelings
- Secure their rights
- Have their interests represented
- Explore choices and support them to develop plans that incorporate the least restrictive options available to them
- Challenge decisions if the person wishes them to

If the advocate does have concerns about decisions that have been made, they will write a report stating these and the local authority must address issues face to face and in writing.

The advocate may need to access records and information on behalf of the person they are representing and will need to be kept informed of any developments and of the outcome.

Referrals

Referrals should take place immediately when it is clear that someone needs advocacy support. Considering the need for advocacy should be made from the point of first contact, request or referral (including self-referral) and at any subsequent stage of the care and support process.

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If a referral is not made straight away, because advocacy was not required, a referral can be made at any stage in the care and support process. Additionally, somebody who has previously worked with an advocate during an earlier process should be re-referred at any time if they need support.

The right to an advocate applies in all settings whether the person lives in the community, a care home and includes prisons (except for safeguarding enquiries or SARs).

For people whose ordinary residence is in Derbyshire a referral form can be downloaded from [Derbyshire Mind](#), or call 01332 623732.

For people whose ordinary residence is Derby City, a referral form can be completed at [One Advocacy Derby](#), or call 01332 228748 and speak to a member of the team at One Advocacy Derby.

Other types of statutory advocacy

Advocacy under the Care Act interacts with other statutory advocacy, including:

- Independent Mental Health Advocacy (IMHA)
- Independent Mental Capacity Advocacy (IMCA)
- Children's Advocacy

If you are not sure what type of advocacy is needed, just consult Derbyshire Mind for those whose ordinary residence is Derbyshire, or One Advocacy for those whose ordinary residence is Derby City.

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Minimum standards for recording information for safeguarding cases

Good record keeping practice in safeguarding adults cases provides:

- Evidence of safe and effective care/support by communicating history, findings and communication in relation to the service
- Evidence of consent to the safeguarding process
- The opportunity for scrutiny of decisions made by professionals involved in the case
- Information documented in a timely manner in line with professional standards and information governance (GDPR) compliance
- An audit trail of actions taken

The following points should be considered:

- Handwritten records should be legible and written with black ink so the report can be photocopied
- Each entry should have date, time and be signed
- Record factually how the disclosure came about
- Record factually the incident and any injuries/consequences for the victim
- Where appropriate, use a body map to indicate where there are injuries/marks
- Keep the information as concise and factual as possible
- If it is appropriate to include an opinion or third-party information, ensure this is made clear

It is important to remember that information you record is evidence of your interaction with the individual and can be used in legal proceedings, or for case reviews. Also, the General Data Protection Regulation (GDPR) 2016 gives individuals the right to access their health and social care records held manually or on computer.

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When receiving the initial safeguarding referral, it may be necessary to contact the adult at risk to collate further information. Where there are issues of capacity, contact may be made with an appropriate relative or friend. Contact should **not** be made with the alleged perpetrator.

Making Safeguarding Personal places the individual at the heart of the safeguarding adults process. This should be reflected in the way in which the work is recorded by:

- Clearly reflecting the adult's views and wishes
- Recording the adult's actual words in relation to the description of the event, and their feelings about the outcome. Include the date and the time that the record was made.
- Ensuring that the language use when recording is in plain English, avoiding jargon that the adult may find difficult to understand
- Considering the ways in which the recorded information is communicated with the adult, do you need to have information translated, put into pictures of braille?

Chronologies

Learning from SARs has highlighted the importance of considering the use of chronologies in all cases. They are particularly helpful in cases where neglect is known or suspected. Chronologies are a useful tool for all partner agencies to enable them to easily understand the history of a case.

It was identified in [SAR18A](#) that Lisa became very isolated, and that her contact with agencies was intermittent. If a chronology had been completed earlier and reviewed across agencies it may have been possible to notice patterns sooner, particularly regarding initial engagement with services prior to disengagement by Lisa's parents. The review highlighted that there may be benefit in preparing chronologies for cases where agencies had been involved with the family over a long period with little or no progress being made.

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Missing persons (including the Herbert Protocol)

The following information has been taken from the College of Policing Authorised Professional Practice (APP) Missing persons Missing persons (college.police.uk)

Definition

The College of Policing APP definition of a missing person is:

Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed

Incidents and Investigations

A person reported missing can be at risk of significant harm. When dealing with a missing adult (18 years and older) there may be mental health or other underlying vulnerabilities to consider.

A child (under 18 years) reported missing carries a significant risk of harm. Regular missing episodes are a known sign/trigger of child exploitation. For further guidance see the Children at Risk of Exploitation category.

A missing incident can be an indicator of child abuse, neglect or criminal or sexual exploitation. It may be a sign of a safeguarding concern for a vulnerable adult. The investigation is about finding the person and also understanding why they went missing and providing support to prevent a repeat occurrence. Missing person investigations will be conducted in line with national APP to achieve the following objectives:

- Protecting those at risk of harm
- Minimising distress and ensuring high quality of service to the family and carers of missing people

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- Prosecuting those who perpetrate harm or pose a risk of harm when this is appropriate and supported by evidence

Reporting a missing person to the Police

The police call handler will ask for details of the person:

- Name
- Age
- Description of person
- Description of clothing
- Home address
- Location missing from
- Circumstances of going missing
- Details of any vehicle or other transport used
- The relevant information concerning the person reporting the disappearance
- Location of where the missing person might be
- Any medication the missing person requires, frequency of taking and effects of not taking it
- Information about known risks, e.g., a child known to be at risk of being sexually exploited
- Information about any person who might have contact with the missing person, such as people with whom the missing person was found in previous incidents, e.g., estranged parents, boyfriends and girlfriends
- Name, address and telephone number of person reporting. (if the missing person is in local authority care, consideration should be given to obtaining alternative and out-of-hours contact details in case the investigation is ongoing when the person reporting goes off duty.)

When a missing report is made to the Force Control Room an incident is created. An operator assesses whether circumstances meet the APP definition, considering the efforts the informant has made to establish the person's whereabouts.

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To assist in assessing the level of risk, the following questions will also be asked:

- Why are you worried about the missing person?
- What has been done so far to trace this individual?
- Is this out of character?
- Have they been missing before? If yes, what happened whilst they were missing?
- Are there any specific medical needs?
- Are they likely to become the victim of crime?
- Are they likely to be hurt or harmed?
- Are they currently at risk of sexual exploitation?
- Are they likely to self-harm or attempt suicide?
- Do they pose a danger to other people?
- Are they likely to have travelled abroad?
- Is there any other information relevant to their absence?

The operator then assesses whether the person or public is at risk as a consequence, or whether there is no apparent risk at that stage and the incident remains pending further information and review.

If risk is identified the incident will be allocated to an investigating officer. When the officer confirms the person is missing a Compact missing report is generated. The officer must review the incident and transfer all information relevant to the investigation to the Compact report.

For missing adults, the officer completes the found report on Compact and ensures when dealing with the report of a missing adult with vulnerabilities identified a Safeguarding Adult occurrence is created on NICHE and a PPN (Public Protection Notification) is attached to it. The PPN then needs to be shared with the necessary partners to provide support for the adult.

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Police risk assessment and response see table below:

No apparent risk (NAR) - absent

There is no apparent risk of harm to either the subject or the public.

Actions to locate the subject and/or gather further information should be agreed with the informant and a latest review time set to reassess the risk.

Low risk

The risk of harm to the subject or the public is assessed as possible but minimal.

Proportionate enquiries should be carried out to ensure that the individual has not come to harm.

Medium risk

The risk of harm to the subject or the public is assessed as likely but not serious.

This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting.

High risk

The risk of serious harm to the subject or the public is assessed as very likely.

This category almost always requires the immediate deployment of police resources – action may be delayed in exceptional circumstances, such as searching water or forested areas during hours of darkness. A member of the senior management team must be involved in the examination of initial lines of enquiry and approval of appropriate staffing levels. Such cases should lead to the appointment of an investigating officer (IO) and possibly an SIO, and a police search adviser (PoISA).

There should be a press/media strategy and/or close contact with outside agencies. Family support should be put in place where appropriate. The MPB should be notified of the case without undue delay. Children's services must also be notified immediately if the person is under 18.

The level of risk can be re-assessed at any stage during the investigation when new information impacts upon it. Any change to the level of risk should be supported with a clear rationale.

Prevention interviews

The police have a responsibility to ensure that the returning person is safe and well. The purpose of the prevention interview is to identify any ongoing risk or factors which may contribute to the person going missing again. Prevention interviews should therefore be carried out in all high-risk cases but should also be considered for no apparent risk (absent), low and medium cases. The interview provides a valuable opportunity to find out useful information that may indicate harm suffered by the returning person. It can also identify details that may help trace the person in the event of a future missing episode.

The interviewer should check for any indications that the person has suffered harm, where and with whom they have been, and give them an opportunity to disclose any offending against or by them.

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Safeguarding and missing adults

There is no local authority protocol for adults who go missing but if you have questions or need assistance, please refer to the Neighbourhood Safeguarding Teams for North and South Basic Command Unit (BCU) within Derbyshire police.

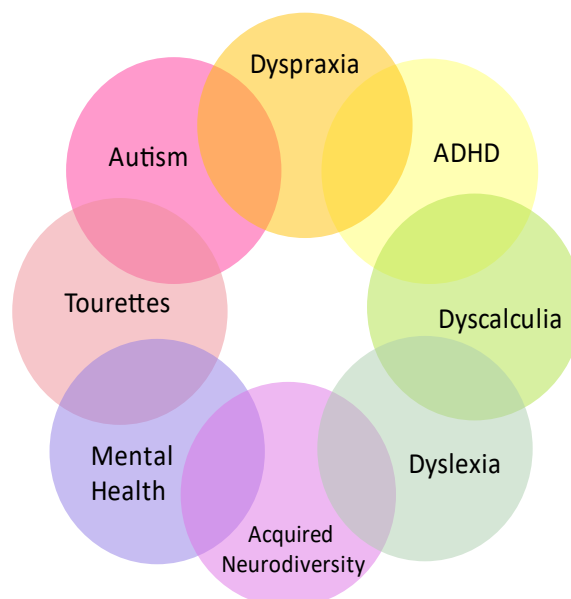
Consider the [Herbert Protocol](#) in relation to adults who may be experiencing memory loss.

Neurodiversity and safeguarding adults

Understanding the issues around the “non-engagement” label from a neurodivergent perspective

Neurodiversity is the concept that all humans vary in terms of our neurocognitive ability.

Everyone has both talents and challenges. However, for some people the variation between those strengths and challenges is more pronounced, which can bring advantage but can also be disabling. ([GeniusWithin.org](#)).



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It is estimated that 1 in 7 people in the UK are neurodivergent; conditions as seen in the graphic above usually cluster together as traits overlap with each other.

Many neurodivergent people are not recognised in society due to the stigmatised view that only those with extremely high needs are affected. This is not true. It is also important to note that neurodivergence is unrelated to intelligence.

A person with one diagnosis will have traits of another; therefore, looking at just one, for example autism spectrum disorder, will not meet that person's needs.

Understanding “non-engagement”

A person may be finding it difficult to accept support from a service due to the way things are being communicated, because their sensory needs are not being taken into account, because they are not being understood due to their own individual way of communicating. Examples of this could be:

- Not answering the door to a cold call from a service due to it not being expected and the anxiety this would cause.
- Not understanding what is required due to no clear guidelines being given, or verbal information not being followed up in writing.
- Executive functioning impacting on a person's ability to be able to attend an appointment/make a phone call/ manage to deal with a visit.

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Without exploring a person's needs it is easy to see "non-engagement", rather than understanding why a person is finding it difficult to accept support. It is also not just the person's responsibility to engage, it is our responsibility to facilitate engagement.

Disguised compliance can also be misunderstood when it comes to neurodiversity – is it disguised compliance, or is it a person trying to please people, not quite understanding what is needed, agreeing to things but then being unable to carry it out (all common neurodivergent traits)?

What are the aspects of our executive function?

It is important to know that not all neurodivergent people have issues with all the aspects of executive function. For instance, an individual might have the ability to plan, but lack the initiation to follow through. They might be able to problem solve once they realize there is actually a problem but are unable to verbalise it. Below is a list of our executive functions and their basic descriptions:

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- **Planning.** This is the ability to forward-think and choose the necessary actions to reach a goal, decide the right order, assign each task to the proper cognitive resources, and establish a plan of action. Those on the spectrum can have difficulty formulating plans to get through their days and organise tasks into completable sections.
- **Problem solving.** To problem solve, an individual must identify a problem and then formulate a strategy to solve the problem. Problem solving uses almost all the other executive functions including reasoning, attention, planning, initiation, working memory, and monitoring. Depending on which of the executive functions the individual struggles with, that is where the problem-solving chain will be broken.
- **Working Memory.** Neurodivergent individuals notoriously have specific memory deficits and strengths. They can seemingly remember every Jedi name, rank and serial number in all ten Star Wars movies, but have trouble remembering to eat, or what day it is, or what the order of the steps are when brushing teeth. Working memory is the ability to remember specific short-term memories needed to execute a function or daily task.
- **Attention.** This is closely tied to working memory and, again, people can show great strengths in some areas and severe challenges in others. Neurodivergent people often have a keen ability to focus but directing that focus can be challenging. If the person has sensory issues, then it is possible all they will be able to focus their attention on is the sound of the lights buzzing or the smells of the other people in the room. An individual's ability to focus directly affects what they can keep in and recall from their short-term memory.
- **Reasoning.** Reasoning, or verbal reasoning, is the ability to understand, analyse and think critically about concepts presented in words, and then relay them back or integrate them successfully. Many of those on the spectrum struggle with verbal acuity. Verbal reasoning can also be hindered by social meanings that are not obvious to those with autism.
- **Initiation:** This is the ability to start an activity, plan, or task. For those with executive function difficulties with initiation, they may want to play a certain game, do their homework, or play an instrument, but unless the activity is initiated by someone else it does not happen. It has nothing to do with desire or want – it is about lacking the function of “just doing it”.

A person failing to attend appointments, forgetting information, not making phone calls and so on, is closed to services. As explained above, it is common for neurodivergent individuals to have challenges with their executive functioning, meaning extra support could be needed to complete these tasks, and an understanding that it is not a failure to engage.

How to be inclusive in our practice

- Present information summarised in point form and send out reminders, if possible
- Back-up verbal information with written.
- Consider environment – avoid background noise if possible, such as ticking clocks, or strong smells.
- Provide clear invitation to meetings detailing who will be present, what is to be expected with time and location.
- Be tolerant of stimming (fidgeting with something or repetitive actions or movements to allow focus).
- Understand that everyone is different and needs fluctuate. Just because something is working one week, does not mean it will do the next.
- Consider the persons individual communication needs and adapt. For example, no cold calling, time of day.
- Think about language – ask the person what language they prefer, e.g., autistic, person with autism
- Recognise that a reluctance to engage socially does not imply dislike or rudeness
- Understand the impact of executive dysfunction and explore alternative ways to provide support.
- Normalise – talk about it and reduce the stigma – the person is best placed to tell you about their strengths and needs and how you can adapt to support them.

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Office of the Public Guardian

The Office of the Public Guardian (OPG) helps people in England and Wales to stay in control of decisions about their health and finance and make important decisions for others who cannot decide for themselves. They help people plan for someone to make decisions for them, should they become unable to do so because they do not have mental capacity and support people to make decisions for those that do not have the ability to decide for themselves.

A lasting power of attorney (LPA) is a legal document that enables a 'donor' to appoint one or more people to help them make decisions or to make decisions on their behalf in the event that they become unable to do so themselves. There are two types of attorney, property and financial affairs, and health and welfare. The donor can choose to make one type or both.

The OPG is responsible for:

- Taking action where there are concerns about an attorney, deputy or guardian
- Registering so that people can choose who they want to make decisions for them
- Maintaining the registers of attorneys, deputies and guardians
- Supervising deputies and guardians appointed by the courts, and making sure they carry out their legal duties
- Looking into reports of abuse against registered attorneys, deputies or guardians

More [information about the services provided](#) including how to find out if someone has an attorney, deputy or guardian acting for them and how to report concerns can be found on the OPG website.

To request a search of the registers, an [OPG100 form](#) should be submitted via email. The OPG aims to respond within five days.

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The OPG has introduced a [‘rapid’ service](#) to support staff from local authorities, social care, police and NHS, who are dealing with adults at risk. Staff can request information held on the registers to help them make urgent decisions about someone who may lack mental capacity.

Where a donor of a health and welfare attorney has also made a written [advance decision to refuse treatment \(ADRT\)](#), this can be held by the OPG in the LPA register

How to contact the Office of the Public Guardian (OPG)

- Email: customerservices@publicguardian.gov.uk
- Telephone: 0300 456 0300
- Textphone: 0115 934 2778

PIPOT (Person in a Position of Trust)

The statutory guidance to the Care Act 2014 requires Safeguarding Adults Boards to establish and agree a framework and process to respond to allegations against anyone who works (either paid or unpaid) with adults with care and support needs.

A joint PIPOT framework and process has been agreed by Derbyshire and Derby City SABs as of 9 October 2023 and replaces the previous process followed by Derbyshire SAB partners.

The purpose of the [Person in a Position of Trust \(PIPOT\) framework and guidance](#) is to provide a framework for managing cases where allegations have been made against a person in a position of trust (PIPOT) and is focussed on the management of risk based on an assessment of abuse or harm against an adult with care and support needs. It provides a framework to ensure appropriate actions are taken to manage allegations, regardless of whether they are made in connection with the PIPOT’s employment, in their private life, or any other capacity.

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This guidance applies to the local authority, all partner agencies and commissioned local authorities' relevant partners, and those providing care and support services.

Pressure Ulcer and Safeguarding Assessment Checklist (PUSAC)

Below is the Pressure Ulcer and Safeguarding Assessment Checklist (PUSAC)

Review of care: use the questions below to review the adult's care provision	Findings: document and tick the relevant boxes to indicate the findings
<p>1 Background</p> <p>Identify current care setting/recent transfers.</p> <p>Is there a history of PUs?</p> <p>Is the adult currently receiving PU management, if so, from whom?</p>	
<p>2 Skin damage</p> <p>Category, number, site of PU(s): category 3/4/unstageable/suspected deep tissue injury (DTI)/multiple sites of category 2.</p> <p>Is the damage new from previously intact skin?</p> <p>Is this deterioration in a current PU?</p>	
<p>3 Decision-making</p> <p>Is the adult able to make decisions about care?</p> <p>Is the adult concordant with the care?</p> <p>Where the adult cannot make a decision about care has a capacity assessment and best interest process been followed?</p>	<p><input type="checkbox"/> Able to make decisions: concordant with care</p> <p><input type="checkbox"/> Able to make decisions: non-concordant with some/all care</p> <p><input type="checkbox"/> Unable to make decisions: capacity assessment and best interest process documented. Non-concordance with care identified where relevant.</p> <p><input type="checkbox"/> Unable to make decisions: capacity assessment and best interest process not documented. Non-concordance with care not identified where relevant*</p>
<p>4 PU management and care plan</p>	<p><input type="checkbox"/> Yes</p>

	Is a PU risk assessment and care plan documented as per organisation's policy?	<input type="checkbox"/> <i>Assessment/care plan not documented or incomplete*</i>
5	<p>Pressure relieving equipment</p> <p>Is the necessary equipment in place (as per assessment), e.g., bed, mattress, heel off loading, cushion, hoist, slide sheets?</p>	<input type="checkbox"/> Necessary equipment is in place <input type="checkbox"/> Necessary equipment assessed as required and ordered <input type="checkbox"/> Non-concordance with equipment <input type="checkbox"/> <i>Some/all equipment unavailable *</i> <input type="checkbox"/> <i>Delay in equipment provision contributing to development/deterioration of PU*</i>
6	<p>Physical health</p> <p>Has the physical condition changed over days/hours, e.g., infection, pyrexia, anaemia, end of life, critical illness?</p> <p>Is/are there underlying health condition/s contributing to skin damage, e.g., significant weight loss, malnourishment, nil by mouth, recent fall?</p>	<input type="checkbox"/> Change in condition days/hours <input type="checkbox"/> Health condition(s) contributing to skin damage <input type="checkbox"/> History of recent fall / time spent on floor <input type="checkbox"/> <i>No – none of the above*</i>
7	<p>Expert advice</p> <p>Was advice required/sought, e.g., from community nursing team / tissue viability team?</p> <p>Was the advice followed?</p>	<input type="checkbox"/> Advice not required (as per organisation's policy) <input type="checkbox"/> Advice sought and acted upon <input type="checkbox"/> <i>Advice sought and not followed or not sought contributing to development and/or deterioration of PU*</i>
8	<p>Care provision</p> <p>Is care delivered as per the care plan?</p> <p>Is the carer not providing care and/or preventing access to care/services?</p>	<input type="checkbox"/> Care delivered as per care plan <input type="checkbox"/> <i>Care not provided/equipment not used*</i> <input type="checkbox"/> <i>Access to care prevented by carer*</i>

Safeguarding assessment: seek advice from other professionals where necessary and consider the adult's wishes (*Making Safeguarding Personal*)

Safeguarding referral is indicated: there is evidence of a new PU and/or deterioration in a PU that has developed as a result of omissions in care, i.e. one or more asterisked findings 3-8 **ticked** and the safeguarding duties are met: *“an adult has needs for care and support (whether or not the local authority is meeting any of those needs); is experiencing, or at risk of, abuse or neglect; as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.”*

Safeguarding referral is not indicated: there is evidence of care delivered according to the assessed need, plan and changes in the adult's condition, i.e., asterisked findings 3-8 **not ticked**

Plan: tick the relevant box below to identify the outcome, note discussion with other professionals/adult and any further information about the rationale for the decision

Safeguarding referral **is required** - comments:

Safeguarding referral **is not required** – comments:

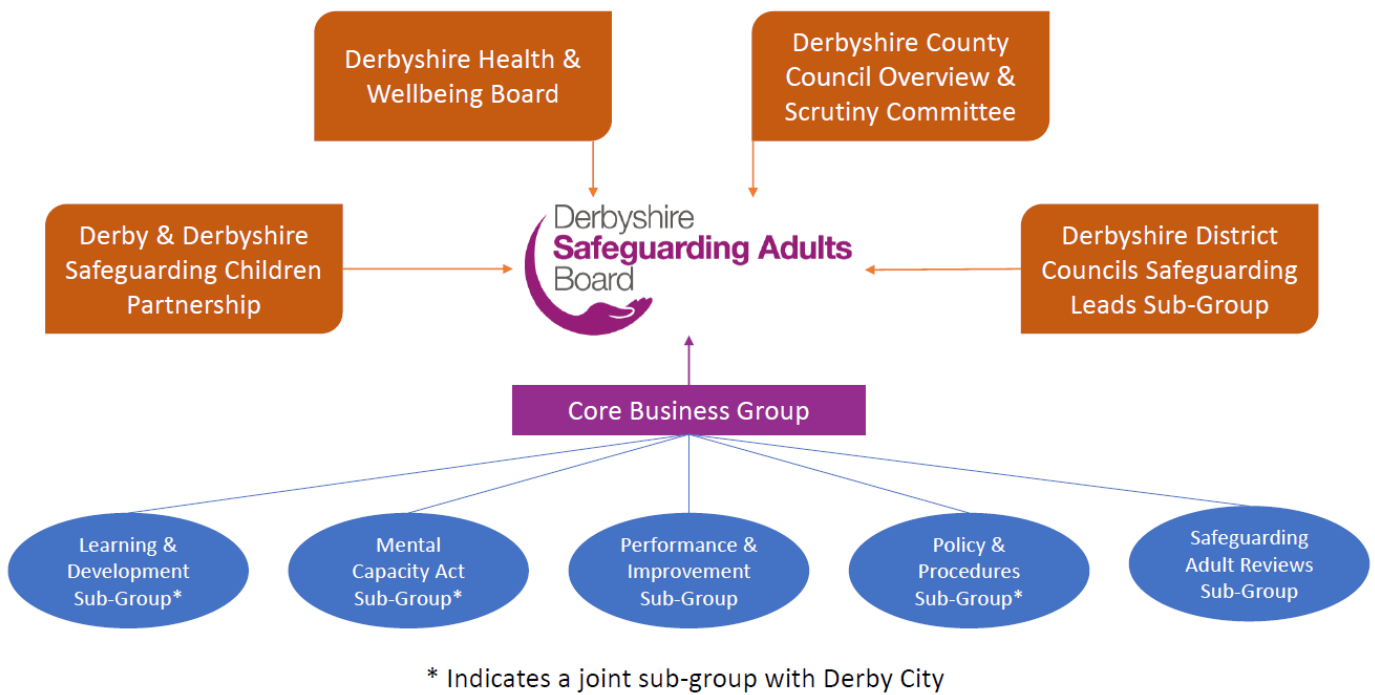
Signature:	Signature:
Print name:	Print name:
Role:	Role:
Date:	Date:

Role of the Safeguarding Adults Boards and sub-groups in safeguarding

Derbyshire Safeguarding Adults Board

Derbyshire Safeguarding Adults Board is a multi-agency strategic partnership, which ensures and oversees the effectiveness of arrangements made by individual agencies to safeguard adults who have care and support needs or are experiencing, or at risk of experiencing, abuse or neglect.

Information in relation to the [Derbyshire Safeguarding Adults Board and its sub-groups](#) can be found on the Derbyshire Safeguarding Adults Board website.



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Derby Safeguarding Adults Board

Derby Safeguarding Adults Board is committed to working together to ensure that Adults who have care and support needs in Derby are supported to safeguard themselves from abuse and can report any concerns they may have.

Information in relation to the Derby Safeguarding Adults Board and its sub-groups can be found on the [Derby SAB website](#).



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Role of the CQC (Care Quality Commission)

The Care Quality Commission is the independent regulator of health and social care in England.

CQC's purpose

The CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.

CQC's role

The CQC registers, monitors, inspects and rates services to make sure they meet fundamental standards of quality and safety and they publish what they find, including performance ratings to help people choose care.

CQC's work and safeguarding

Safeguarding is a key priority for the CQC and people who use services are at the heart of what they do. The CQC's work to help safeguard children and adults reflects both their focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services. Regulated providers of health and social care services all have a key role in safeguarding children and adults.

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CQC's role and responsibilities in safeguarding

The CQC's role in safeguarding is:

- Checking that care providers have effective systems and processes in place
- Using Intelligent monitoring to assess risks to people using services
- Acting promptly on safeguarding issues they discover or are told about
- Speaking with people using services, their carer's and families as a key part of their inspections
- Holding providers to account by taking regulatory action to ensure that they rectify any shortfalls in their arrangements to safeguard people
- Publishing their findings about safeguarding in their inspection reports
- Supporting the local authority's lead role in conducting enquiries or investigations by co-operating with them and sharing information. They assist the police in a similar way
- Explaining their role in safeguarding to the public, providers and other partners so that there is clarity about what they are responsible for and how their role fits with those of partner organisations
- Working with other inspectorates (Ofsted, HMI Probation, HMI Constabulary, HMI Prisons) to review how health, education, police, and probation services work in partnership to help and protect children and young people and adults from harm

Fundamental standards

In April 2015 fundamental standards of safety and quality were introduced, which all providers of regulated health and social care activities must meet. The standards set the benchmark below which care must not fall.

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Enforcement

Where the CQC finds that systems and processes to safeguard is weak or ineffective, they consider what regulatory action may be appropriate. Where risks are unacceptable, the CQC can prosecute the provider to ensure improvement takes place and people are protected.

Providers are required by law to notify the CQC of the following events:

- The death of a person using their service
- Abuse or allegations of abuse
- Serious injury
- Unauthorised absence of a detained mental health patient
- Any incident that is reported to, or investigated by, the police

The CQC has a range of enforcement powers they can use to hold providers and individuals to account for failures in protecting people from abuse and neglect. There is, therefore, a clear and direct link between safeguarding and some of the CQC's enforcement powers.

The action the CQC may take responds to the severity of the risk posed to the individual(s) and evidence of multiple or persistent breaches. The CQC will only take action that they judge to be proportionate. Sometimes, the CQC may take informal enforcement action instead of formal action. For example, if the provider is able to improve the service on their own and the risks to people are not immediate, they CQC will generally work with them to improve standards rather than taking enforcement action.

Please see further information on the [CQC's role in safeguarding](#) and how they monitor regulated services.

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You can contact the CQC at their National Customer Service Centre in Newcastle:

- Telephone: 03000 616161
 - Fax: 03000 616171
 - Or write to: CQC National Customer Service Centre, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA
-
- [Report a concern if you are a member of the public](#)
 - [Report a concern if you are a member of staff in a regulated service](#)
 - [Report an unregistered service](#)

SARs (Safeguarding Adult Reviews) and Learning Reviews

A safeguarding adult review (SAR) is carried out when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk.

A SAR may also be conducted when a person has not died but it is known or suspected that they have experienced serious abuse or neglect, sustained a potentially life-threatening injury, serious sexual abuse or serious or permanent impairment of health or development.

All relevant board agencies should contribute to the review, sharing information and implementing and disseminating the lessons learnt.

The SAR brings together and analyses the findings from individual agencies involved, in order to make recommendations for future practice where this is necessary and also highlights good practice.

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Information about Safeguarding Adults Reviews in Derby can be found on the [Derby Safeguarding Adults Board](#) website and in Derbyshire on the [Derbyshire Safeguarding Adults Board](#) website.

Section 42 guidance and form

In Derbyshire, [practice guidance and a form](#) are available from the Derbyshire Safeguarding Adults Board's website. Information about [agencies roles and responsibilities](#) is also available.

The Care Act 2014 requires that a local authority must “make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.” An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect.

The Section 42 enquiry request form should be completed on every occasion when adult care (prevention and personalisation) requests external agencies or colleagues undertake further enquiries.

The practice guidance aims to provide information to support best practice for staff; from the point of receipt of a safeguarding referral, through to initial enquiries, Section 42 enquiries, safety planning and closure of safeguarding.

Self-neglect and hoarding

The [Multi-Agency Hoarding Framework \(MAHF\)](#) provides a collaborative multi-agency ‘person centred approach’ for addressing matters arising as a result of hoarding in Derby City and Derbyshire County. The MAHF offers clear guidance for all professionals and agencies, working with people who hoard, with an expectation that everyone engages fully to achieve the best possible outcome for the individual involved, whilst meeting the requirements and duties of their agency or Board.

The MAHF includes a section about the recognition of self-neglect within the Care Act 2014.

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Support for carers in relation to safeguarding adults

How carers meet the criteria for safeguarding

There are three main ways in which informal carers may be involved in a situation which requires a safeguarding response:

- A carer may witness or speak up about abuse or neglect within the community or a care setting
- A carer may experience intentional or unintentional harm from the adult they support or from professionals and organisations they are in contact with
- A carer may unintentionally or intentionally harm or neglect the adult they support, either on their own or with others

Factors which increase the likelihood of abuse or neglect:

- A change in circumstances
 - Carers who feel emotionally and socially isolated or undervalued
 - Carers who do not have access to practical and/or emotional support
 - Where the needs of the person depending on care exceeding the carer's ability to meet them
 - Where the carer or person depending on care rejects formal or informal help and support, including breaks
 - Where the carer or person depending on care is angry about their situation and seeks to punish others for it
 - Where the carer or person depending on care has sought formal help and/or support but did not meet thresholds for formal support
-
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- Where the carer or person depending on care has unmet or unrecognised needs of their own
- Where the carer or person depending on care is targeted, because of their class, gender identity, age, disability, sexual orientation, race, religion or culture.
- Barriers which may prevent carers from reporting abuse or neglect, negative and discriminatory attitudes and practice based on assumptions about class, gender identity, age, disability, sexual orientation, race, religion, culture or eligibility for service. Lack of someone to talk to or a source of trusted advice and support
- Denial, guilt or a sense of shame in asking for help
- Perceived impact and/or future consequences for themselves and the person they care for

Good practice when supporting a carer through safeguarding

- Do not make assumptions about a carer's ability or willingness
- Recognise the stress arising from the caring role and consider ways to reduce the impact of caring by exploring how they can obtain support to improve their health and wellbeing
- Involve carers in safeguarding enquiries that relate to the person they care for and avoid excessive emphasis on the requirements of confidentiality
- Encourage carers to share their concerns regarding the risk of abuse and neglect without fear of an automatic safeguarding referral or process
- Include carers in assessments and support planning by taking a whole family approach
- Provide access to information, advice and advocacy that is clear and empowers carers to share concerns and change harmful circumstances
- Signposting to information, advice and support guidance available for carers in Derbyshire
- A Carer assessment is an important opportunity to explore the carer's circumstances and provide information, signposting and support that prevents abuse or neglect from occurring
- Carer training can assist carers to understand more about the condition of the person they care for, to enable them to care safely and effectively, minimising the stress experienced by the carer
- Peer support can help carers to talk through the unique challenges that face carers in similar positions

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Derbyshire County

For information, advice and support in Derbyshire, contact [Derbyshire Carers Association](#) on 01773 833833.

Carers may require Independent Advocacy or representation to ensure their voices are heard in the safeguarding process. Contact [Derbyshire Independent Community Advocacy Service](#), tel: 01332 623732 (Derbyshire only)

Jude Boyle, Commissioning Manager (Carers)

Commissioning and Performance, Derbyshire County Council, The Old Gym, Matlock, DE4 3AG

Tel: 01629 532483

Fax: 01629 538368 Ext: 32483

Email: jude.boyle@derbyshire.gov.uk

Derby City

For information, advice and support in Derby City, contact Citizens Advice Mid Mercia, tel: 0300330 9002 (Derby only)

Carers may require Independent Advocacy or representation to ensure their voices are heard in the safeguarding process. Citizens Advice South Derbyshire and City, One Advocacy Derby on 01332 228748.

Kevin Day, Senior Commissioning Officer

Adult Social Care Commissioning and Market Management Team, Integrated and Direct Services, Council House, Corporation Street, Derby, DE1 2FS

Tel: 01332 64 2573

Email: Kevin.Day@derby.gov.uk

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Supporting decision making as a child enters adulthood (transition and the Mental Capacity Act 2005)

Introduction

Across Derby and Derbyshire, Health and Social Care providers want to make available a Mental Capacity resource pack for young people with a profound and multiple learning disability (PMLD) and those that support them. We know that young people and their family/carers want to know more about the Mental Capacity Act 2005 and its implications for decision-making during the transition from children's to adult services.

What do we mean by profound and multiple learning disabilities?

People with profound and multiple learning disabilities:

- Have more than one disability
- Have a profound learning disability
- Have great difficulty communicating
- Need high levels of support
- May have additional sensory and physical disabilities, complex health needs or mental health needs
- May exhibit behaviour that challenges us

[Choice Forum](#) has a fuller explanation of this and the challenges that people with profound and multiple learning disabilities.

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What does the Mental Capacity Act 2005 say about making decisions?

The law applies to anyone who is 16 years and over in England and Wales, and says we must help people make their own decisions wherever possible, based on the five principles below:

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 in their **best interest**
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.

When a person cannot make their own decision, other people must decide what is in their *best interests*. Often the person's family will make these decisions, but sometimes other people must make the decision. They may be carers or close friends because not everyone will have family to consult with. If it is a medical decision this will be made by the doctor. Sometimes the Local Authority will make some decisions. Anyone making a best interest decision on behalf of someone with profound and multiple learning disabilities must consult with the person's family or person closest to them as above.

Can't I just go on making decisions for my relative as I have done since they were a child?

No. The Mental Capacity Act is a law that says that every person 16 years and over, whatever

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their disability, has the right to make their own decisions wherever possible. There are many important decisions that people with profound and multiple learning disabilities will not be able to make for themselves. The Mental Capacity Act provides a legal way for people to make decisions for adults when they lack the capacity to do so themselves. It provides guidance to make sure that decisions taken this way are in the person's best interests.

When should I start thinking about all this?

As soon as possible. The Mental Capacity Act is designed to respect the rights of both you and your relative. Most of the Mental Capacity Act applies to people from the age of 16 upwards. Transition into adult life can be stressful and emotional time and there is a lot to think about. There are many important changes to face as your relative becomes an adult. It is worth thinking about the Mental Capacity Act and what it means for your relative as early as you can. This is so you can plan for adult life and things are not left to the last minute.

What does this mean for family carers?

As a family carer you need to think about how the Mental Capacity Act will impact on the life of your relative when they are an adult. The Mental Capacity Act gives you an opportunity to plan for decision making throughout their lives. You will have a major role to play in decisions made for your relative. This is because you will be making best interest decisions for them or because you will need to be consulted when other people do so.

There are many important decisions, especially involving large amounts of money, where somebody must be given the legal powers to make the decision. It's a good idea to plan whom you wish to do this.

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We're our child's parents can't we just decide for them?

The Mental Capacity Act says that adults have the right to make their own decisions wherever possible. If they are unable to make their own decisions, then others must still remain at the centre of any decisions made in their best interests. The phrase 'mental capacity' used in the Mental Capacity Act refers to our ability to make decisions. These can be everyday decisions about what to eat and what clothes to wear. They can also be bigger decisions about where to live, how to spend money or what medical treatment to have.

For some decisions, you can apply to be given the legal power to make decisions by becoming a deputy. You will need to think whether this will be necessary for your relative. A deputy is someone (often a family member), appointed by the Court of Protection, who has legal authority to make particular decisions for someone who lacks capacity. This can be for a one-off decision or to take ongoing responsibility for making decisions on a person's behalf. To become a deputy to allow you to make specific decisions on behalf of your relative, you will need to apply to the [Court of Protection](#).

So, who decides if my relative can make a decision?

As a family carer you know your relative very well and are used to the various, often subtle ways in which they communicate their likes and dislikes, needs and wishes. It can feel strange or even hurtful that other people become more involved in decisions about your relative once they become an adult. This is not because your views are no longer important, but because the law says your relative must be treated as an adult. Part of this involves following the principles of the Mental Capacity Act.

The [GOV.UK](#) is an important source of information about the Mental Capacity Act

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I am not happy!

"Failure to follow the law is very serious and all organisations should be checking their staff are meeting requirements under the Mental Capacity Act and its Code of Practice" Six Lives progress report, 14 October 2010.

The Mental Capacity Act has been in force since 2007 and some professionals are still not getting everything right. In October 2010 the Department of Health published a progress report on the recommendations made in the Six Lives Report⁶ The report says that there are still some concerns that need to be addressed.

People who may lack capacity tend to be more vulnerable to having decisions made which are not in their best interests and outside the Mental Capacity Act. This can lead to neglect, abuse, fraud or crime.

If you are concerned that someone making a decision on behalf of your relative has not followed the principles of the Mental Capacity Act, then you should raise your concerns. In the first instance it is always best to do this informally with the person or organisation concerned. If this fails, then you should consider a formal complaint.

Since 2009 the NHS and Local Authorities have operated a simple two-stage process for complaints. You can find out more about how to complain about NHS and Social Care services on the [Care Quality Commission \(CQC\) website](#).

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⁶ Six Lives (2009) was a report on the deaths of six people with a learning disability first highlighted by Mencap in their 20017 report Death by indifference.

Find out more

- [Making Money Easier](#) – work by United Response and ARC
- [Wills and trusts](#) – advice from Mencap
- [Banking decisions for people who lack capacity to make decisions](#) – the British Bankers Association

Any further questions?

The Learning Disability Helpline is an advice and information service for people with a learning disability, their families and carers. It also provides information and advice to anyone wanting to know about learning disability issues and services.

Call the Learning Disability Helpline on 0808 808 1111

Think Family staff guidance

Think Family is an approach to ensure better outcomes for children, adults and families are achieved.

Think Family is fundamental to effective and efficient planning, coordinating and delivering support. It requires all staff to work together in order to improve multi-agency professional practice and achieve best outcomes for families.

In relation to safeguarding concerns, while the referral may identify a particular individual it is important to locate that individual in their wider family and social network. It is also important to consider whether as a result, safeguarding or other referrals need to be considered in relation to others in the wider family and social network.

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Think Family throughout the safeguarding process

Whilst following the principles of Making Safeguarding Personal, Think Family is an approach that needs to inform all aspects of your practice. This would include:

- When receiving a safeguarding referral, it is best practice to seek details of the person's wider family and social network
- When making enquiries it is important to Consider issues of equality, diversity and inclusion and talk to the wider family (including key family members who may not live in the household) and social network, liaising and seeking advice from other professionals who are working with them
- In organising safeguarding meetings, it is important to consider what may be gained from inviting the wider family and social network, ensuring everyone can participate and the meeting is accessible
- When developing and implementing safeguarding plans it is important to consider a person in the context of their family and wider social network, including any equality, diversity and inclusion issues to maximise a person's strengths, in order to maximise a person's strengths and existing resources whilst also recognising how any plan may impact on the wider family and social network.

Throughout this, if there are any concerns about a child's welfare, it is important to make a referral to the relevant Children's Service. If a referral is made, but the threshold for children's services to intervene is not met, the adult care worker will need to continue to consider the caring responsibilities the adult they are working with has for a child (Care Act 2015) and re-refer if risks to the child increase.

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‘Was not brought’ – guidance for a withdrawal or refusal of services by the adult

An adult may refuse or withdraw from services/treatment/contact, which may place them at increased risk of neglect or self-neglect. The questions below will help professionals/agencies to explore whether there are any barriers, risks, and vulnerabilities which will inform information sharing and action that may be necessary to support the adult:

- Are there any risks and vulnerabilities known or that need to be considered?
- Was the person informed of the appointment and/or visit; was adequate notice given?
- Did the person choose to DNA/NAV and was this their own decision?
- Who cancelled the appointment?
- Is there any evidence of coercion and/or control which may have influenced the person to cancel the appointment or decline visit/access?
- Did the person/carer forget about the appointment/visit; could reminders be agreed to reduce the potential of this occurring again?
- Has the person/carer provided a rationale for not attending?
- Can staff contact the person/carer by telephone or letter and arrange a further appointment/visit?
- Was the appointment/contact sent to the correct address?
- Is the person currently homeless and if so, what contact arrangements would support future appointment attendance and service engagement?
- Could the appointment or visit be offered at an alternative venue or time?
- Are there any other instances/patterns where visits or appointments have been missed?
- Are there any reasonable adjustments (Equality Act 2010) that could be made to support the person/ carer to enable attendance or access e.g. transport, times of day, venue, communication resources or practical changes such as fitting a key safe?

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- Is the person accessing care and support through other services and would any joint working support engagement with this service?
- Have the needs of either the person and/or their carer changed, consider if health appointment is still relevant and if a referral is required to the local authority to support further assessment?
- What are the potential health implications for the person if an appointment or visit has been missed? Does the person/carer understand these potential health implications?
- Could any other person who resides at the same address be affected or at risk as a result of services not being accessed or care being missed?
- Does any action need to be taken to safeguarding the person or others potentially at risk? i.e. escalation, information sharing with other agencies and professionals.

The circumstances will be unique for each adult and the action required may range from a simple reminder for the adult/family/carers of services/treatment/contact, to a safeguarding referral. Where there is any concern about the information received and/or action to take, staff should discuss further with their agency's safeguarding lead.

Working with the Coroner

Who is the Coroner?

Prior to 2013, a Coroner could be either a qualified Doctor or Lawyer with at least 5 years practice experience. Since 2013, all newly appointed Coroners must be Lawyers. A Coroner is an independent judge who used to be appointed by public vote but is now appointed locally by Council/Cabinet following approval centrally. The Coroner has no contract of employment – The Queen is the Coroner's boss - the Coroner is not answerable to government, parliament or any other state body. A Coroner's decision can only be reviewed in certain limited circumstances.

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The function and purpose of the Coroner's court

The main function of the Coroner's court is to enquire into the death of a person within the Coroner's jurisdiction where there is reasonable cause to suspect that person has:

- Suffered a violent or unnatural death, or
- Suffered a death from an unknown cause, or
- Died in prison "whilst in custody or otherwise in state detention"

The purpose of the inquest is to determine who the deceased was and **how, when and where** the person has died. The Coroner has an inquisitorial role conducting the proceedings and asking most of the questions. The Coroner will ask questions of all the witnesses under oath or affirmation. Any Lawyers attending on behalf of the estate, family or interested persons will be given the opportunity to ask questions regarding the cause of death.

The focus of the inquest is the cause of death and on matters relating to the cause of death. The Coroner's inquest **is not about apportioning blame**.

Partner agencies may be approached to attend a pre-inquest meeting along with other agencies who could potentially be involved in an inquest. This enables the Coroner to ensure all agencies have the correct documentation required for a full inquest, and to ensure that all the necessary agencies will be involved. Consideration may also be given to whether a jury is required.

Where a person dies within a care setting

If a person has died or is suspected to have died in any of the circumstances listed above, the Care Provider must immediately call the Police. Staff must:

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- Avoid touching the body (after ensuring there is no sign of life)
- Shut the door and leave the scene undisturbed
- Stay at the address until the Police arrive
- Notify the person's GP
- Inform his/her line Manager
- Follow the safeguarding policy and procedures if the death appears to have been a result of abuse or neglect
- Inform the Safeguarding Service Manager/Contracts Manager at the Council and CQC if in a regulated setting
- In cases where there are high concerns regarding the circumstances of a death and in extreme circumstances, the Coroner can be contacted directly via Police Control Room

Staff should check whether the GP or the Police will alert the Coroner's Office about the death. The Manager of the care setting can also alert the Coroner on the next working day. It is important to agree who is going to inform the Coroner and not assume another colleague will do this.

Actions Coroners take

On being notified of a death, provided the Coroner has reason to suspect s/he has jurisdiction, an investigation will be opened, and the Coroner has the power to request for a post-mortem to go ahead.

In the first instance the Coroner will usually contact the deceased person's GP to gather information.

If the GP is unconcerned about the circumstances surrounding a person's death, then the Coroner completes Form A, sends this to the registrar and the death can be registered.

If the cause of death is unclear a post-mortem will be completed. If no suspicions or unnatural causes are identified then the Coroner completes a Form B.

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There is always a jury inquest if a death occurs in state detention. An inquest can be opened and adjourned whilst a criminal investigation takes place.

Where a person has died within a care setting and the death falls within the categories listed above, the Coroner is likely to review risk assessments, care plans, training records, mechanical inspection of equipment, e.g., in the event of a fall, did the person have their glasses on, up-to-date relevant care plan, appropriate footwear, no slip hazards, safety signs displayed, etc.

If a Coroner identifies poor practice which gives rise to a concern that other deaths may occur in the future as a result of that practice, a report will be sent to the appropriate organisation setting out the action that the Coroner requires to be taken. The organisation responsible must respond, setting out the action that has been taken. These responses go to the Chief Coroner (based in London) to assist in identifying themes or patterns.

Initial investigation by the Coroner

If the Coroner is notified about a death, they will start an investigation.

The circumstances of the death may have also invoked safeguarding procedures, or the adult at risk may have been subject to safeguarding enquiries prior to death.

The Coroner's office should be notified of the Local Authority's involvement: as previously stated it should be agreed who will do this.

If a person dies when they are the subject of safeguarding procedures, consideration should be given to whether it is appropriate to notify the Coroner of the death.

Examples of when a death may fall within the categories set out above include where there has been a fall or skin integrity issues, which may have resulted in an untimely death. Each case requires individual consideration. Please discuss with Managers or Coroner's Office if you are not sure.

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The Coroner's Office Assistants are employed by DCC Corporate Resources, so the email addresses are secure within Derbyshire County Council. However, areas often use Nottingham, Stockport and Derby, so attention to confidentiality must be considered.

Where the Coroner asks for information from the Council in relation to the death, **legal advice from the in-house legal team must be sought before any documentation is provided to the Coroner's office.** This is to enable full consideration of the evidence requested to be undertaken.

It is important to note that anything shared with the Coroner may be shared within a bundle in the proceedings with the family and all other agencies who are present at the hearing.

Factual and detailed recording is vital on all our records as these will be under scrutiny in the Court.

It is also possible that these hearings may have media attention and most inquests are open to the public with very few exceptions.

In circumstances which involve the Council or its personnel, the Council Solicitor should always be informed. Where a crime is suspected the Coroner will contact and inform the Council's Director for Legal services directly of his views together with all the appropriate parties within the partner agencies.

If the Coroner is concerned that a person was unlawfully killed, a referral will be made to the Police. If the Police think that there is a case to answer they may refer the matter to the Crown Prosecution Service. In this circumstance the inquest may be adjourned.

The inquest hearing

The Coroner usually sits alone at the inquest, although a jury is required in certain cases.

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Inquests are open to the Press and public to attend and usually take place in open court. Inquests are tape recorded. The usual court rules regarding hearsay do not apply and the Coroner has the final say over what questions may or may not be asked. The Coroner also determines which witnesses will be called and the order in which they will be called. However, any party has the right to ask the Coroner to hear evidence from additional witnesses.

Providing evidence to the Coroner

If you are called to Coroner's court as a witness you will be asked to produce a witness statement/report. The Coroner can compel a person to give evidence or make a report. If the task ordered by the Coroner is not done, then a warrant may be issued for the person's arrest, or the witness may be issued with a penalty fine of £1000.

Points to remember when giving evidence in Coroners Court

- Tell your legal representative if you anticipate any problems with your evidence before the day
- Arrive early and tell the court you have arrived
- Keep a copy of your own statement/report with you – use markers or post its to mark important areas
- Reports for Coroner need to contain facts and accurate dates and times
- Wear suitable clothes
- As a witness you will stand in the witness box and take an oath
- Address the Coroner as Sir/Madam
- The Coroner will ask you questions as a witness – stick to your own area of expertise – avoid commenting on what you think other people should do/have done and stick to the facts of your own involvement. Avoid expressing an opinion outside of your area of expertise

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- Once the Coroner has asked the witness questions, questions can be asked of the witness by the legal representatives present, followed by any other interested parties, e.g., insurance companies, family members, CQC. If a jury is present, the jury can also ask the witness questions. All questions put to the witness must be 'proper questions', i.e., that they relate to the four main points of who, when, where, how
- Address your answers to the Coroner or the jury
- If you do not know, then say so
- Use short sentences, avoid jargon and explain terminology
- Do not be rushed – the answers you give are often complex and not a simple yes or no
- Do not get rattled or angry – stay professional
- Do not get into an argument with the Coroner, counsel or family
- Be sensitive, professional and respectful in your demeanour and presentation – emotions will be heightened
- Refer to the person the inquest is being held for as Mr/Mrs/Miss plus surname for adults. Be cautious using the first name of an adult and do not refer to the person as 'the deceased'. If the person is a baby or a young child it is acceptable to refer to them using their first name

Inquests can be attended by members of the public and the Press (open court), unless excluded because of national security. Inquests are advertised and the Coroner's Office is currently setting up a website where the cases will be listed.

The witnesses

Confirmation of the identity of the deceased person is required at the start of the proceedings. This is usually provided by a member of the family, or it could be provided by a Doctor or Nurse, or someone else who knew the deceased person.

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The Coroner will then usually call witnesses in an order that establishes a clear account, in sequence, of the events leading up to the person's death. Witnesses can usually sit in an inquest from the start and must stay until released by the Coroner. They are required to swear an oath or affirm, and to identify themselves before any evidence is given.

Once each witness has given his/her evidence, the Coroner will ask any 'interested person' present whether they would like to ask questions. An interested person being an individual with personal interest in the case who the Coroner considers should have 'interested person' status. The witness may then be asked questions by that interested party. This is most likely to be a family member or advocate appointed on their behalf about the cause of death, together with any legal representatives of interested parties.

In cases where Adult Care staff are called to be a witness, DCC Legal Department may appoint a Barrister to support and advise within the hearing.

The Solicitor may help with the witness statement and attend the hearing. The hearing may be a few days or over a longer period of time in some cases. Witnesses may be called to partially attend or be present over a number of days and the legal team will advise in these matters (each agency should seek support from their own legal representation).

Reports

Witnesses will almost always be asked to prepare a report prior to the inquest hearing. If Council staff receive such a request the Council's Adult Care Solicitors must be contacted as soon as possible.

The statement/report must be concisely written and concentrate on the facts of the case, including accurate dates and times. It may be helpful to provide a chronology of involvement in a case stating the actions taken, the date, by whom, explaining the reason and outcome of the actions.

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It is vital that original documentation is retained, as far as possible, as the Coroner's office will require the submission of any original documentation to supplement reports. It is highly likely that copies of minutes of the safeguarding meetings that have taken place will be provided to the Coroner.

Writing good quality reports is dependent on keeping good records. Care must be taken with dates and times, and signatures on notes and letters must be legible. Copies of reports are likely to be shared with the deceased person's family and the legal representatives of all interested parties.

It is important that, if called to give evidence, staff take time to prepare prior to the inquest. Staff should attend court in good time and take with them a copy of their statement/report and any relevant documentation or case notes.

Giving evidence

The Coroner can call any staff member to attend the hearing who they consider may be able to provide relevant information. Where the officer is employed by Derbyshire County Council they should inform their line manager, who will organise support via the legal team in Adult Care.

If you are asked to attend an inquest you must do so. The Coroner has the power to compel someone to attend and give evidence, produce documents, and make items available for inspection, examination and testing. Someone who does not comply or co-operate with such a notice or request can be fined or given a custodial sentence.

Summing-up and the verdict

After considering all the evidence the Coroner will sum-up and they will usually state in public the verdict they have reached. The following standard verdicts are available:

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- Natural causes
- Industrial disease
- Alcohol/drug-related
- Want of attention at birth
- Suicide
- Accident/misadventure
- Lawful/unlawful killing
- Open verdict
- Narrative verdict

An open verdict may be returned where there is insufficient evidence to return any other verdict. The Coroner often makes a narrative verdict falling into none of the categories above but providing a short factual account of how the death came about.

The Coroner also has the power to require a report to be produced if a Coroner identifies poor practice which gives rise to a concern that other deaths may occur in the future as a result of that practice. They can write to a party reporting the circumstances of the case requiring that party to serve a report addressing certain issues which relate to remedial action being taken to prevent or reduce the risk of future deaths.

Other court proceedings

It may be that an inquest is suspended if, for example, there is going to be a criminal investigation or public enquiry. The Inquest will be resumed following the conclusion of those proceedings. It may be that a civil claim for damages is brought by an interested person, but this will follow the conclusion of the Inquest.

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Reporting concerns

For staff who work in registered care settings where a resident has died of an unknown cause, it will be necessary to report to the following agencies where there are implications for the safety of others:

- Police
- Care Quality Commission (CQC)
- Adult Care Safeguarding Team
- DCC Contracts and Compliance
- Health and Safety Executive

The Coroner will refer any cases that meet the safeguarding adult criteria to the appropriate Local Authority Safeguarding Manager.

When there are circumstances which may pose a risk factor to other adults who are in a regulated care setting, it may be necessary to have a safeguarding meeting to look at the risks and to minimise them.

If a referral is made by the Coroner and they feel that there may be a risk to others in a regulated care setting, a safeguarding Strategy Meeting/Concerns Meetings will be held to co-ordinate an investigation and to consider the safety implications of other adults who may be at risk.

This process may also be occurring at the same time as a Police investigation.

There may also be times where there are major concerns around a systems failure in a care environment. If a Service Manager who is chairing a concerns or safeguarding meeting feels that people are at major risk of harm or death due to institutional neglect, this can be discussed with the Safeguarding Team as to whether the Coroner needs to be alerted.

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Safeguarding procedures and the Police, Next Steps meetings, Safety Planning and Concerns meetings

At any of the above meetings, if there are serious concerns about the death of an individual, the Safeguarding Coordination Hub should be notified. It may be that the Police are already involved.

Once the meetings are held the Police may attend or wish to have details of the meetings.

It is worth noting that with consultation with the Police that other investigations/procedures may still follow or go side by side, e.g., disciplinary procedures and Contractual Action Plans.

The Police Investigation will always take precedence, so we need to be mindful of that. However, in the complex world of Health and Social Care, the Police often welcome the expertise and opinion of the investigative specialist world of professionals.

These meetings should also conclude with a protection plan to minimise the risks to others.

The social network of the deceased person should be involved if there is a safeguarding meeting and given the option of being invited to that part of the meeting. It is expected in the safeguarding process and the Inquest that family member's involvement is paramount and included in the process. An exception to this would be if the family member was implicit in the death. In these cases, Police will advise in any impending investigation.

We also need to be mindful of confidentiality around third-party information being shared

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The Chair will need to decide at the end of the safeguarding meeting whether it will be appropriate to conclude the safeguarding process or proceed to a further meeting of professionals following further investigation or awaiting outcome of the coroner's inquest hearing. This is not always easy to determine and discussion with the Safeguarding Team may be beneficial. Sometimes the only way forward is for the Coroner to call expert witnesses within the Inquest arena for opinions and the Inquest will be supported by the Police. The Coroner will be interested in the

Details of the safeguarding meetings, the involvement of family and a summary of the meeting by the Chair is helpful. It is vital there are safety measures and plans in place for protecting other individuals if there are any outstanding risks presented.

Action plan for risk to others

Where the safeguarding refers to the safety of others in a group or domiciliary setting, a further meeting may be required. In doing this, reference should be made to the Care Provision Escalation Plan for Derbyshire. Any action plan arising from such a meeting may be of interest to a Coroner who will often want to know what actions have been taken by the Local Authority and others to address the safety of other adults who may be at risk.

Working with bereaved families in situations of a suspicious or unexpected death

The Coroner's Office liaise with the bereaved families and discuss details of the inquest.

It is extremely difficult to gauge the right response with families, especially if there has not been a relationship prior to the death. Good practice always suggests we make some form of contact whether this is written, telephone or face to face.

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At the time of the death the family may not welcome the added burden that organisations are looking into suspected neglect of their loved one, particularly if they are in the process of funeral arrangements. Going at their pace is helpful, and allowing the family to overcome the initial shock, will assist. It is important to give the family the opportunity to be involved in the concerns and process of the Safeguarding meetings.

The Chair of the potential safeguarding meeting may want to meet with the grieving family members prior to the meeting to understand what the outcomes and wishes are of the family, and generally to enable them to understand that it is the role of the Chair to ensure independent co-ordination of the safeguarding meeting.

Families may feel mistrustful. It is helpful for families to understand the independence of the Local Authority and their role in the investigation in the safeguarding meetings. The Chair will need to ensure that the family's voice is heard throughout the process. This may often mean spending time before and after the meeting with the family, where appropriate. The Chair's role will also involve assessing any risks to others if the person was in an institutional setting at the time of their death.

All documents considered by and generated by the safeguarding process may be shared with the Coroner.

Once the Chair has concluded the safeguarding meeting and is satisfied that they have investigated appropriately, then the safeguarding episode can be closed.

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Guidelines on notification of deaths to the Coroner where there are safeguarding concerns

Introduction

This guidance has been produced by Robert W. Hunter, HM Senior Coroner at the Office of Her Majesty's Coroner Derby and Derbyshire Coroner's Area.

A number of deaths occur where there are in life safeguarding concerns relating to the deceased, whether the deceased is a child or adult.

The aim of this guidance is to assist professionals involved in safeguarding to appreciate the role of the Coroner, coronial process, and notification to the Coroner.

The law

A Coroner has a duty to investigate a death (sections 1(1) and 1(2) Coroners and Justice Act 2009) where the body of the deceased lies within the Coroner's area and the Coroner has **reason to suspect that**:

- The cause of death is unknown, or
- The deceased died a violent or unnatural death, or
- The deceased died in custody or otherwise in state detention.

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Violent or unnatural death

A violent death occurs when there is trauma or injury to the body which has either caused or more than minimally contributed to the death. For example, a fall resulting in a head injury causing death.

The injury or trauma does not have to be physical but can be a chemical injury. For example, the administration of medication which caused liver or kidney failure, resulting in death.

An unnatural death occurs where there is a culpable human failing that has made an otherwise natural death from natural causes unnatural. For example, an elderly woman in a care home develops a fever, shortness of breath and a chesty productive cough and dies of pneumonia. The cause of death is natural causes (the pneumonia); however, her death would be unnatural if the care home staff failed to summon a doctor or obtain medical attention, and that failure caused or contributed to her death.

Reason to suspect

A Coroner only needs to have a reason to suspect that the death is violent or unnatural. This is a very low threshold. A Coroner at this stage does not require any evidence or proof that the death was unnatural. If a Coroner has reason to suspect that it was so, then they must begin an investigation into the death as a statutory duty.

A Coroner may make whatever enquiries seem necessary in order to decide whether their duty to commence an investigation arises, (section 1(7)(a) Coroners and Justice Act 2009).

The decision to commence an investigation is a judicial decision made by the Coroner. It is for the Coroner to decide whether the safeguarding issue has caused or more than minimally contributed to the death. No other person can make that decision.

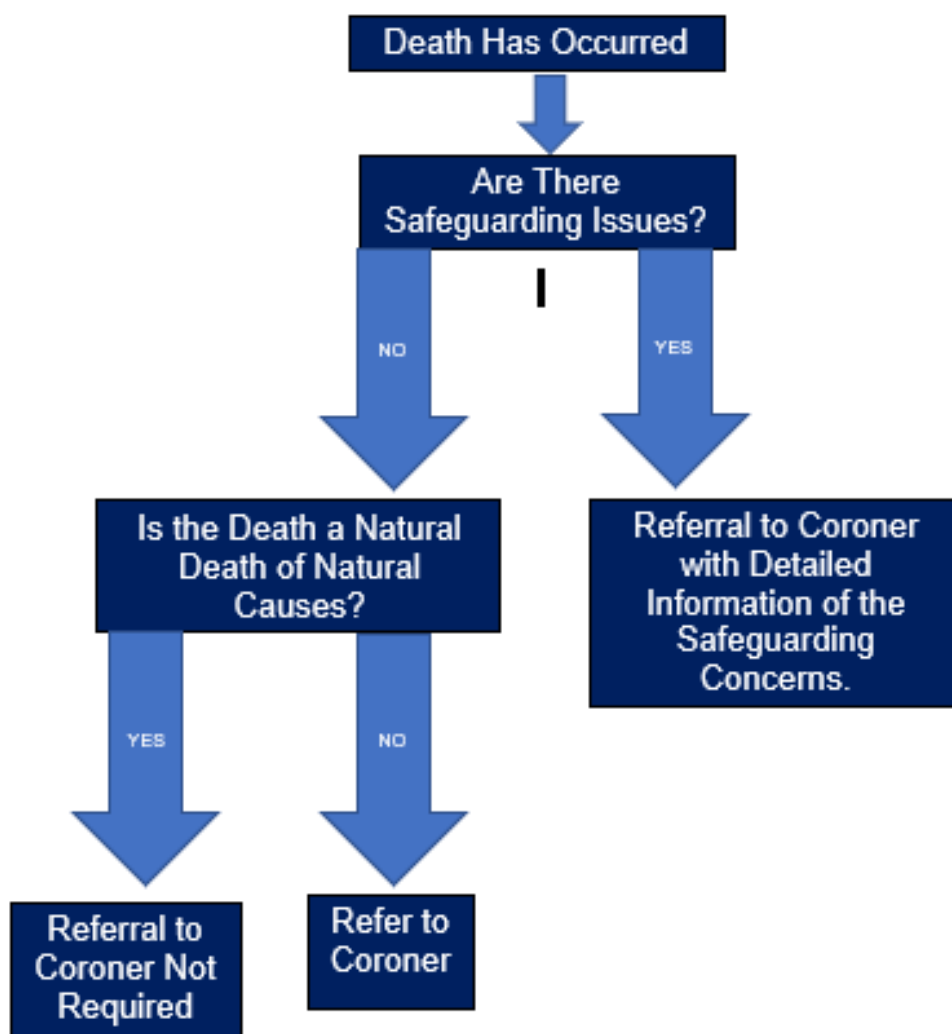
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Consequently, the Coroner should be notified of all deaths where safeguarding issues exist.

In order to decide whether an investigation and or inquest is necessary, a Coroner must, from the start, have detailed information regarding the safeguarding issues.

As part of the investigation or inquest the Coroner must receive a copy of the full and unredacted report of any safeguarding investigation that has taken place.

Flowchart notifying the Coroner of a death



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Safeguarding concerns identified after funeral

There will be occasions where safeguarding concerns have been identified after a funeral has taken place. In most of such cases the coroner will not have been notified of the death.

In such circumstances the coroner should be informed of the death and the safeguarding concerns.

Burial

If the deceased has been buried the coroner can commence an investigation into the death. If the safeguarding concerns suggest a crime has been committed in respect of the death the coroner may order an exhumation of the deceased to enable a post-mortem examination to take place.

Cremation

If the deceased has been cremated the coroner can apply to the Chief Coroner of England and Wales to commence an investigation into the death in circumstances where the body has been destroyed, lost or absent.

Contact details

- **Derby Coroner's office**
 - Tel: 01629 535050
 - email: derby.coroner@derbyshire.gov.uk

- **Chesterfield Coroner's office**
 - Tel: 01629 533405
 - email: chesterfield.coroner@derbyshire.gov.uk

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