Adult Social Care

and Health

**Responding to incidents of harm between adults at risk in a provider setting**

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*With thanks to Sunderland, East Sussex, and Kent Safeguarding Adults Boards on whose work we based this guidance.*

# Introduction

Conflict can happen in all relationships. This includes people with care and support needs who live or spend a lot of time together. Sometimes their behaviour towards one another can become abusive or cause harm.

We need to recognise that all abuse is serious. If we allow abuse or bullying from any source to happen or continue, it will lead to a culture that is damaging. There should be a zero tolerance of abuse, regardless of the perpetrator.

Incidents between adults in a service can include any interaction between two or more adults in any setting. It can involve physical, psychological or emotional, sexual, financial, or discriminatory abuse or behaviour, which results in the risk of harm, or actual harm.

Not all incidents between adults in a service will require raising a safeguarding concern. Agencies must use their own internal incident policy and processes. They also need to make sure that all incidents are reported using the appropriate procedures. Each incident needs to be considered on a case-by-case basis, and a professional judgement reached.

# Purpose

This guidance aims to provide advice about:

* organisational responsibilities
* actions that can be taken to support and protect both the adult at risk and the alleged person thought to be the cause of risk
* preventing abuse of this nature happening in the future
* when to raise a safeguarding concern and report a possible crime
* how the Local Authority (LA) will respond when a safeguarding concern is raised with them

**Note:** The term ‘adult at risk’ used in this document means an adult with care and support needs. This could include a tenant, a patient, or a resident.

# Common types of abuse between adults at risk

| **Abuse type** | **Behaviour** |
| --- | --- |
| Physical | Hitting, slapping, kicking, pushing, biting, pinching, causing pain or physical harm |
| Emotional | Threats of harm, humiliation, intimidation, coercion, controlling, harassment, degrading treatment, verbal abuse |
| Sexual | Rape and sexual assault or sexual acts which the adult at risk has not consented to, or could not consent, or was pressurised into consenting, including sexual exploitation |
| Financial | Theft of money or property, misuse or exploitation of person’s money, coercion around finances or property |
| Discriminatory | Harassment, slurs, taunts, verbal abuse, bullying related to the person’s race, sex, disability, faith, sexual orientation or age |

# Preventing incidents between adults at risk

The following are examples of best practice in preventing harm occurring between adults at risk:

* Carry out a robust initial assessment of person’s needs and any risks. This is to make sure people are placed appropriately according to their level of need. Assessments should be reviewed as required.
* Placing team(s) and the provider should share potential risks both before a new placement or transfer of care, and on an ongoing basis.
* Make sure all relevant training is up to date. For example, in managing distress or behaviour of concern and safeguarding adults.
* Have appropriate policy and procedures in place. For example, on anti-bullying, managing distressed or challenging behaviours, safeguarding adults, domestic violence.
* Make sure all care plans and risk assessments are regularly reviewed and are up to date. Where risks are identified, there should be a clear plan how to manage these risks. Where appropriate they should be shared with relevant professionals.
* Make sure physical, procedural, and relational security has been considered. See [Appendix 1 - Security types](#_Appendix_1) for more information.
* Involve professionals who can help to manage distressed or challenging behaviours at an early stage.
* Make referrals into other procedures as appropriate. For example, MARAC for high-risk domestic violence cases and MAPPA for high-risk offenders.
* Make referral to GP or mental health services. For example, where challenging behaviour is occurring, possible factors, such as urine infections or a MH medication review, need to be considered.

# Provider responsibilities

## Responsibilities in relation to the alleged adult at risk

Alongside the decision to make a safeguarding adults referral, the provider should:

* Assess the risk of harm. Seek medical attention if required.
* Take action to keep the person safe.
* Consider if the incident should be reported to the Police.
* Consider if the person has any unmet needs.
* Consider the person’s mental capacity in relation to their ability to keep themselves safe.
* Consider whether a relative, representative or advocate needs to be informed and involved in decisions.
* Review care plans.
* Make sure support is provided. This is to understand and take part in safeguarding adults procedures and processes.
* Clearly record any actions and decisions.
* Offer an apology to the service user, relative or other representative where appropriate.

### Post-incident support

|  |  |
| --- | --- |
| **Types of support** | **Examples** |
| Practical support | * domiciliary support * closer oversight or monitoring * alternative accommodation * respite care * residential or nursing care * advocacy * medical treatment |
| Emotional support | * adult at risk support * psychology * counselling * therapy * psychiatric assessment or treatment |
| Legal / financial support | * money advice * legal advice about criminal or civil injury * compensation * preparation for court |
| Educational support | * assertiveness training * sexuality and relationship training * social skills training * understanding what abuse is and what are the protective measures * understanding the implications of making unfounded accusations |

## Responsibilities in relation to the person alleged to be the cause of risk

Alongside the decision to make a safeguarding adults referral, the provider should:

* Assess the risk of further incidents.
* Review the person’s care plan and risk assessment.
* Consider the person’s mental capacity in relation to them causing harm to others.
* Consider whether a relative, representative or advocate needs to be informed and involved in decisions.
* Consider whether the person has any unmet needs.
* Make sure support is provided to understand safeguarding adults procedures.
* Make sure support is provided to take part in safeguarding adults process.
* Clearly record any actions and decisions.

### Post-incident support

|  |  |
| --- | --- |
| **Types of support** | **Examples** |
| Practical support | * longer term residential care * additional or closer monitoring and/or supervision * alternative accommodation |
| Emotional support | * counselling * advocacy * psychiatric or psychological input * special support (if the person has been wrongly accused of abuse) |
| Legal / financial support | * legal advice * money advice or debt counselling |
| Educational support | * sexuality and relationships training * understanding about issues of abuse * support to develop social skills |

## If a crime occurred

If the incident appears to have been a crime (for example physical assault, theft, sexual assault) then it **must** be:

* reported to the Police, **and**
* referred to the LA as a safeguarding concern.

If the person is placed in East Sussex from a different area, then ESCC is the hosting authority. See [Inter-authority safeguarding arrangements](#_Inter-authority_safeguarding_arrang) for more details.

Call 999 if the incident is ongoing and so serious that police attendance is required immediately. For example, there is an immediate risk to the safety of any party that the care establishment cannot deal with themselves.

OR

Call 101 to report the incident if it has been de-escalated by care staff and there is no longer an immediate risk. This may not result in police attendance. However, the record allows for monitoring and sharing information with partner agencies.

If there is an identifiable incident scene or scenes, make sure that they are left undisturbed and secured.

Make a comprehensive record of what has happened as soon after the event as possible but before the end of the shift.

Make sure comprehensive notes are made after any discussion with the individuals involved. This should include a record of any injuries using a [Body Map](https://portal.oxfordshire.gov.uk/content/publicnet/other_sites/SafeFromHarm/professional/body_map.pdf), respecting the dignity of those involved.

Make sure that any disclosure is recorded, and information is clarified through basic open questions, such as when, where, what, who and how. However, no further investigation of the incident should take place until police have considered what actions they will be taking.

Consider capturing photographic evidence of any damage to property. If this is a personal property, make sure:

* individual’s consent is sought, or
* a best interest decision is made and documented.

Consider if CCTV captured the incident and arrange for retention of the footage.

## Other actions

1. Discuss with relevant professionals and LA (HSCC) around key decisions.
2. Consider any risks to other adults at risk or patients.
3. Provide support for any person, including staff, who raised the concern.
4. Log incidents in order that patterns or trends can be identified.
5. Make sure there are open and honest discussions with the alleged adult at risk and their relatives or representatives (where this has been consented to).
6. Inform the contracting or placing local authority.
7. Inform the regulator, for example Care Quality Commission (CQC).
8. Discuss with the manager and the wider team.
9. Identify any organisational learning to prevent and respond to such incidents in the future. This may need to include:

* any neglect and acts of omission which meant that abuse was allowed to happen, or
* actions of staff that led to the incident happening which may also result in need to investigate staff conduct.

See [Appendix 2 - Post-incident reflection and learning](#_Appendix_2_-) for more details.

**Remember:** It is important that the **immediate** safety of all parties takes priority. However, the above actions should ensure that the ongoing safeguarding of all parties can be considered at a multi-agency level.

# Making a safeguarding adults referral

It is important to consider whether a safeguarding adults referral needs to be made.

A safeguarding adults referral may not be needed where:

* no harm or low-level harm has occurred (including emotional harm),
* it is the first time such an incident has happened,
* actions have been taken to manage any risks, and
* relevant professionals (such as Social Workers, Community Psychiatric Nurses, Care Managers in Continuing Healthcare, GPs) have been notified where appropriate.

A Safeguarding adults referral should be made if any one of the following apply:

* significant harm or repeated low-level harm has occurred,
* there have been previous incidents involving the alleged person thought to be cause of risk and/or the alleged adult at risk,
* there was deliberate intent, or
* the abuse is also a crime.

For more information and guidance please see [Appendix 4 - Thresholds table](#_Appendix_4_-) and [Sussex Safeguarding Adults Thresholds: Guidance for Professionals (eastsussexsab.org.uk)](https://www.eastsussexsab.org.uk/wp-content/uploads/2022/02/Sussex-Safeguarding-Adults-Thresholds-Guidance-Print-Version.pdf).

Judging whether the incident was a deliberate or an intended act can be difficult.

There are some questions to consider:

* Was the act planned?
* Was the act directed at a particular person or people?
* Have there been previous incidents?
* Was there a transitory, treatable factor which may have contributed to the behaviour, for example acute delirium?

To assist the risk assessment please see [Appendix 3 - Risk assessment table](#_Appendix_3_–).

## Information to include when reporting to the police and LA

* Names, dates of birth and contact details of all parties involved (including direct witnesses)
* Nature of the abuse
* Factual details of what happened (including whether this was a one-off incident or part of a pattern)
* Details of immediate safety actions carried out
* Confirmation if [Body Map](https://portal.oxfordshire.gov.uk/content/publicnet/other_sites/SafeFromHarm/professional/body_map.pdf) has been completed
* Confirmation if photographs have been taken
* Confirmation if CCTV is retained
* Details of any mental impairment, or disturbance in the functioning of the mind or brain, for any of the adults involved, that may affect their ability to make decisions in relation to what has happened
* The relationship between the involved parties

For instance, whether the involved parties live together (for example as residents) or are temporarily placed together (for example in a hospital)

* Whether the abuse was based on any of protected characteristics
* The impact on all parties involved (including any witnesses)
* Any children that need to be considered
* Wishes and opinions of all parties involved

**Remember** to explain to all parties that you will need to report this matter but that their wishes will be recorded and considered

* Risk assessment and risk management plans
* Preventative actions taken

# After a safeguarding adults referral has been made

Once a safeguarding adults referral has been made to the LA, it must be decided whether the concern needs to progress further.

Low-level harm resulting from service user on service user abuse incidents may not progress beyond the Initial Enquiry stage if:

* it is a one-off incident,
* evidence that appropriate actions have been taken to manage the risk is provided,
* there is evidence that information has been shared with all relevant professionals for:
* the alleged adult at risk, and
* the alleged person thought to be the cause of risk.

Incidents which did result, or could have resulted, in significant or serious harm will progress to a safeguarding adults enquiry.

Where there have been several less serious concerns relating to the same alleged adult at risk within six-months:

* there will be additional scrutiny of the concerns, and
* the case will progress to the next stage.

It can be more difficult for the LA to identify repeated abuse. That is abuse perpetrated by the same alleged person thought to be the cause of risk against different alleged adults at risk. It is therefore important that referring agencies clearly include any information or knowledge they have in relation to the alleged person thought to be the cause of risk. They should include this in multi-agency referrals for consideration.

It is also difficult for the LA to identify recurring incidences. That is incidents of service user on service user abuse within a care, health, or support setting where there are different alleged adults at risk and alleged person thought to be the cause of risk involved. This may suggest that the service is not managing risks appropriately. For this reason, safeguarding adults procedures would need to progress beyond the initial alert stage. Referring agencies must clearly include any information or knowledge that suggests that there are repeated concerns about service user on service user abuse.

Please see [Appendix 3 - Risk assessment table](#_Appendix_3_–) to help you:

* carry out the risk assessment, and
* decide whether the concerns received should continue to an inquiry.

# Safeguarding enquiries

The specific objectives of an enquiry into abuse or neglect are to, where possible:

* establish facts,
* learn about the adult’s views, wishes and desired outcomes,
* protect the adult(s) at risk from abuse or neglect, in line with their wishes,
* make decisions on what action should be taken about the person or organisation.

The purpose of the safeguarding enquiry is to work out with the adult and/or their representative(s):

* what action, if any, is required in relation to the concern, and
* who should take such action.

The main priority should always be to ensure the safety and well-being of the adult. However, this should be carefully balanced with the adult’s views and wishes and any risks to others. The adult should experience the safeguarding process as empowering and supportive.

You can find more information on:

* [Sussex Safeguarding Adults Thresholds: Guidance for professionals (eastsussexsab.org.uk)](https://www.eastsussexsab.org.uk/wp-content/uploads/2020/07/Sussex-Safeguarding-Adults-Thresholds-Guidance.pdf)
* [Making decisions on the duty to carry out Safeguarding Adults enquiries (local.gov.uk)](https://www.local.gov.uk/making-decisions-duty-carry-out-safeguarding-adults-enquiries)

When carrying out enquiries, the LA will want to see the evidence as described in the [Information to include when reporting to the police and LA](#_Information_to_include) section.

The LA may also consider:

* relational, procedural, and physical security that is in place
* any gaps in practice, learning and assurance for implementation
* Mental Capacity assessments and advocacy
* more information which may be required such as communication with police, CQC and ICB

The LA may send a report to the provider to gather more information. This should clearly set out what information and evidence is required.

## Inter-authority safeguarding arrangements

An adult may be temporarily in a LA area where they are not ordinarily resident, or the adult may have been placed in a residential or nursing care in another LA area.

**Note**: This also applies to incidents that occur in hospital settings where there may not have been a placing local authority.

Where a safeguarding concern is raised for that adult the host authority (meaning the area where the abuse or neglect occurred) will:

* take the lead in terms of responding to the safeguarding concern, and
* use their local safeguarding adult procedures.

The placing authority or Integrated Care Board should be involved in, and contribute to, any enquiry made. In some situations, discussions will need to take place between the host and placing authorities. This is to decide who is best placed to take the lead in responding to the concern and coordinate any enquiry.

For more guidance please refer to [the Association of Directors of Adult Social Services (ADASS) Inter-authority Safeguarding Arrangements guidance](https://www.adass.org.uk/media/5414/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf).

# Appendix 1 – Security types

| Physical security | Physical security refers to the protection of building sites and equipment from issues such as theft, inappropriate access and/or exit, and accidental damage.  Example considerations:   * Are doors that should be locked, locked? * Is medication securely stored? * Are ligature points removed? * Are the keys secure? * Is the water the right temperature? * Are knives kept securely? * Have dangerous substances been kept securely (COSHH)? * Has Fire safety been maintained? |
| --- | --- |
| Procedural security | Procedure security measures are the rules and processes that are in place to ensure safety and security and prevention of incidents. It allows risks to be assessed and dealt with appropriately.  Example considerations:   * signing in and out * mealtime procedures * medication management * observations and recording systems * staff understanding safeguarding procedures and how to report concerns * fire safety procedures in place |
| Relational security | Relational security is the knowledge and understanding staff have of a resident or patient and of the environment. This information should lead to appropriate responses and care.  Example considerations:   * Being aware of who is friends with whom. Has that changed? * Is someone being targeted? * Have professional boundaries become less robust? * Is personal space being invaded? * Is there on-call support in the event of managers not being on shift? * Would facilitated resident meetings work? * Could families be involved? * Help to promote the voice of residents. * Supervision should monitor professional boundaries. |

# Appendix 2 – Post-incident reflection and learning

Possible questions to consider:

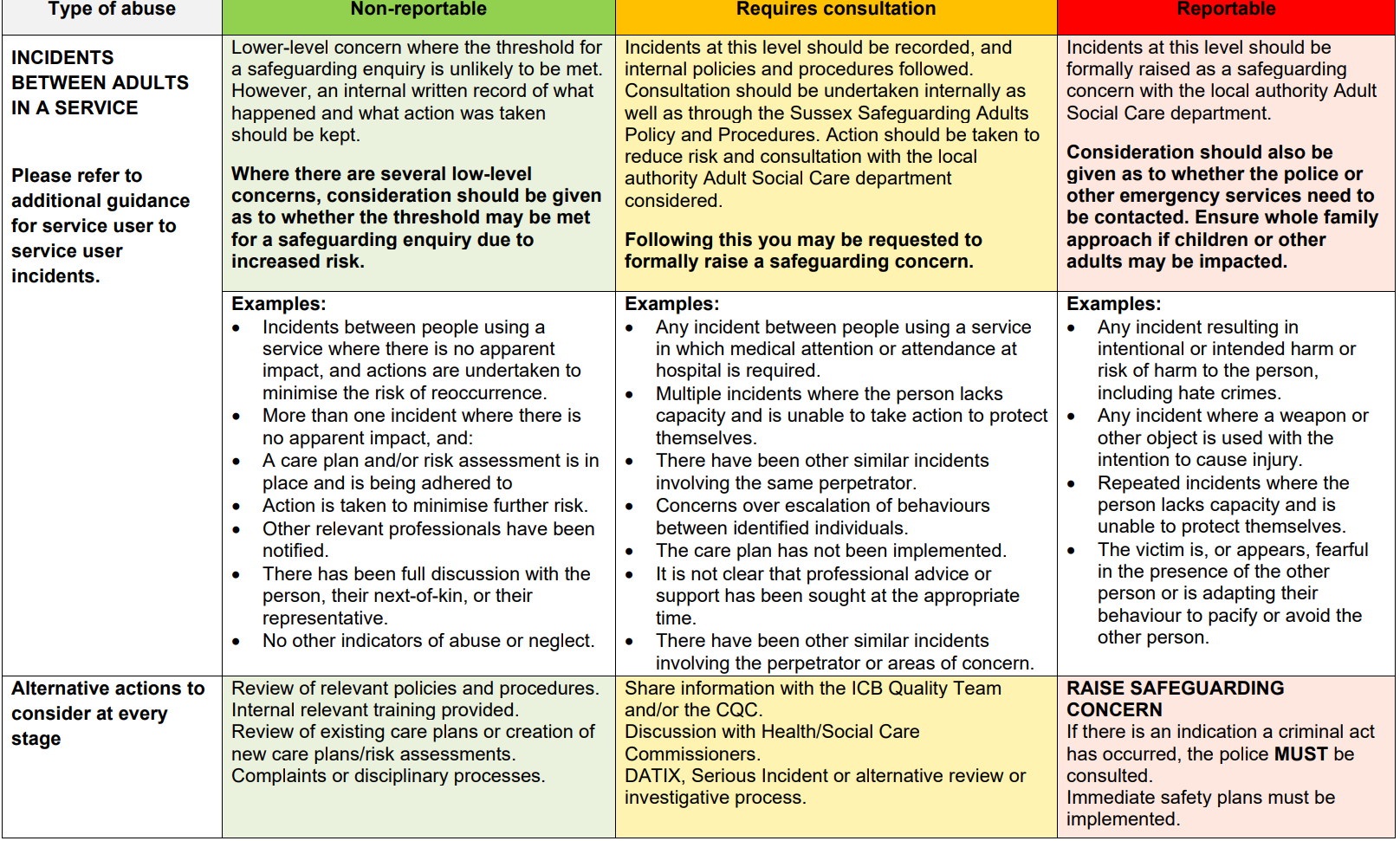
* Could this incident have been prevented? What was the antecedent?
* Has this happened before? Was the risk a known risk and was the plan robust enough to prevent incidents?
* Were there signs of a change in the relationship before the incident? What was done about this?
* Has there been a review of the management and practice to protect anyone at risk in the future?
* Is there a clear protection plan in place for the individual and other adults at risk, including the person deemed responsible and children?
* Was the appropriate action taken at the right time about the incident?
* Did both parties receive the support needed as documented in the protection plan?
* Was there wider support needed for other adults at risk and the provider?
* Have post-incident risk assessments been carried out and updated?
* Was the Making Safeguarding Personal response taken to the needs/rights of both the person harmed and the person deemed responsible?
* Were the actions taken to reduce the risk of reoccurrence recorded?
* To ensure safety and reflect learning from the incident: Was there a review? Were the care plans updated? Were relevant documents available? What were the training and staffing levels?
* Was any learning identified? What worked well? Is there anything that should happen differently next time to reduce the risk of reoccurrence? Who will monitor this?
* Have policies and procedures been followed, reviewed or updated? How have these been shared? Are they reflected in training and development?
* Are there any lessons that need to be shared more widely?

# Appendix 3 – Risk assessment table

The risk assessment table should be used to assist your assessment when considering the thresholds. Consider how many green, orange or reds you have scored.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Factors** | | | | **Guidance and Considerations** | |
| **1. Vulnerability of the adult at risk** | **Less vulnerable More vulnerable** | | | Does the adult have needs for care and support? Can the adult protect themselves? Does the adult have the communication skills to raise an alert? | Does the person lack mental capacity? Is the person dependent on the alleged person thought to be the cause of risk? Has the alleged adult at risk been threatened or coerced into making decisions? |
| **The abusive act** | **Less serious More serious** | | | Questions 2 to 9 relate to the abusive act and/or the alleged person responsible for abuse and/or neglect. Less serious concerns are likely to be dealt with at initial enquiry stage only, whilst the more serious concerns will progress to further stages in the safeguarding adults process. | |
| **2. Seriousness of abuse** | **Low** | **Significant** | **Critical** | Refer to the threshold matrix table. Look at the relevant categories of abuse and use your knowledge of the case and your professional judgement to work out the seriousness of the concern. | |
| **3. Patterns of abuse** | Isolated incident | Recent abuse in an ongoing relationship | Repeated abuse | Most local areas have an escalation policy in place. For example, where safeguarding adults procedures will continue if there have been a repeated number of concerns in a specific time. | |
| **4. Impact of abuse on adult at risk** | No impact | Some impact but not-long lasting | Serious long-lasting impact | Impact of abuse does not always match the extent of the abuse. Different people will be affected in different ways. Views of the adult at risk will be important in working out the impact of the abuse. | |
| **5. Impact on others** | No one else affected | Others indirectly affected | Others directly affected | Other people may be affected by the abuse of another adult. Are relatives, other residents or service users distressed or affected by the abuse? Are other people intimidated and/or is their environment affected? | |
| **6. Intent of alleged person thought to be cause of risk\*** | Unintended / ill-informed | Opportunistic | Deliberate / targeted | Is the act/omission a violent/serious unprofessional response to difficulties in caring? Is the act/omission planned and deliberately malicious? Is the act a breach of a professional code of conduct?  **\*The act/omission doesn’t have to be intentional to meet safeguarding criteria** | |
| **7. Illegality of actions** | Bad practice – not illegal | Criminal act | Serious criminal act | Seek advice from the Police if you are unsure if a crime has been committed. Is the act/omission poor or bad practice (but not illegal) or is it clearly a crime? | |
| **8. Risk of repeated abuse on adult at risk** | Unlikely to recur | Possible to recur | Likely to recur | Is the abuse less likely to recur with significant changes (such as training, supervision, respite, support) or very likely even if changes are made and/or more support is provided? | |
| **9. Risk of repeated abuse on others** | Others not at risk | Possibly at risk | Others at serious risk | Are others (adults and/or children) at risk of being abused: Very unlikely? Less likely if significant changes are made? | |

# Appendix 4 - Thresholds table



For more information please see [Sussex Safeguarding Adults Thresholds Guidance (eastsussexsab.org.uk)](https://www.eastsussexsab.org.uk/documents/sussex-safeguarding-adults-thresholds-guidance/)