**West Glamorgan Safeguarding Board**



**Adult at Risk (AAR) Decision Making Tool**

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**The Adult at Risk (AAR) Decision Making Tool**

The Adult at Risk (AAR) Decision Making Tool is to support decision making alongside practitioners using their professional judgement. This document should be used in conjunction with the Wales Safeguarding Procedures and covers the following areas of practice:

* Neglect
* Self-neglect
* Financial
* Physical
* Emotional/psychological
* Sexual
* Organisational and Multiple Abuse Protocol
* Discriminatory/Hate crime
* Modern Slavery
* Domestic Abuse
* Safeguarding allegations/Concerns about practitioners and those in positions of trust
* COVID-19 Safeguarding Concerns

This decision-making tool is not an exhaustive list and nor does it, or could it, cover every eventuality. Those using this tool are reminded of the complexity, unpredictability and uncertainty at play in decision-making in social care and of the importance of professional judgement. As the complexity and uncertainty increases it is important for practitioners to seek advice and guidance from colleagues, line managers and partner agencies when making decisions. The recording of the decision is critical.

**NEGLECT**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Actions taken to address concerns and prevent reoccurrence  • Consider alternatives to safeguarding e.g. case management, complaints, disciplinary, review of needs/services, staff training  • Recurrence or escalation of concerns requires a safeguarding enquiry | | • Safeguarding Report required  • If there is any indication a criminal act has occurred the Police must be contacted  • Unsafe discharge protocol (hyperlink) | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • One missed home care visit - no harm  • Adult not assisted with a meal/drink on one occasion - no harm occurs  • Adult not bathed as often as would like – possible complaint  • Adult on one occasion does not receive timely health professional checks or necessary non-emergency medical care and no harm occurs | • Inadequacies in care provision leading to discomfort or inconvenience - no significant harm e.g. occasionally left wet.  • Adult occasionally not having access to aids to independence (if regular, consider restraint)  • Adult living with family carer who is failing with caring duties (support for carer) | • Recurrent missed home care visits where risk of harm escalates, or one missed call where harm occurs  • Carer/staff failure to seek appropriate medical support/follow medical recommendations in a timely manner resulting in harm  • Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence  • Care plan does not address risk of harm and harm occurs  • Failure to support the adult at risk to access appropriate medical appointments or care which causes adverse impact to the person’s health, or there is high risk that this will be the case due to prolonged lack of access | • Failure to arrange access to life saving services or medical care  • Failure to intervene in dangerous situations where the adult at risk lacks the capacity to assess risk  • On-going lack of care or inaction which leads to serious injury or death |
| **Pressure areas/ulcers** | | | |
| • Adult is not known to be susceptible to pressure ulcers (or where there is a care plan in place and there is no indication this has not been followed) has experienced minor tissue damage (grade 2 pressure ulcer or below) but not significantly impacted on health. | • Grade 3 & 4, Unstageable and Suspected Deep Tissue Injury or multiple grade 2 pressure ulcers where:   * A care plan is in place * Action is being taken * Other relevant professionals have been notified * There has been full discussion with the adult, their family or representative * There are no other indicators of abuse or neglect | • Grade 3 & 4, Unstageable and Suspected Deep Tissue Injury pressure ulcers or multiple grade 1 and 2 pressure ulcers where there is mismanagement:   * The care plan has not been fully implemented * No professional advice or support has been sought at the appropriate time. e.g. Tissue Viability Nurse * There have been other similar incidents or areas of concern * There are other indicators of abuse or neglect | • Grade 3 & 4, Unstageable and Suspected Deep Tissue Injury where:   * Adult at risk has been assessed as not having mental capacity, susceptible and treatment and prevention not provided * No assessment and care planning has not been completed or is of very poor quality * No professional advice or support has been sought at the appropriate time, e.g. Tissue Viability Nurse * There are other indicators of abuse or neglect * Evidence demonstrates this is part of a pattern or trend |
| **Falls** | | | |
| • Isolated incident where no harm occurs  • Unwitnessed fall where 111 are called but do not recommend external medical treatment  • Fall occurs where there is known falls risk, existing care plans and risk assessments have been followed appropriately  • Fall occurs which may or may not result in injury, but where there has been no previous indication of falls risk and appropriate steps are taken to reduce risk in future | • Isolated incident where 111 recommend external medical treatment e.g. hospital attendance and no other form of abuse or neglect is suspected.  • Multiple incidents where no significant harm occurs and the following are in place:   * A care plan is in place * Action is being taken to minimise further risk * Other relevant professionals have been notified * There has been full discussion with the adult, their family or representative * There are no other indicators of abuse or neglect | • Number of falls resulting in minor injury, and there is no evidence of any steps taken by the service provider to reduce the risk, such as undertaking or updating risk assessments/care plans  • Any fall where there is suspected abuse or neglect by a staff member or other person - failure to follow relevant care plans, policies or procedures | • Any fall resulting in significant injury or death where there is suspected abuse or neglect by a staff member or other person - failure to follow relevant care plans, policies or procedures.  • Fall results in a serious injury (such as fracture), where the adult is known to be at risk of falls, and there is no evidence that the service provider has taken adequate steps to reduce risk  • Fall occurs resulting in injury and there is evidence that existing falls care plan or risk assessments are not being followed appropriately |
| **Hospital discharge** | | | |
| • Hospital discharge without adequate planning, procedures not followed - no harm occurs | • Hospital discharge without adequate planning and lower level harm occurs | • Discharge from hospital where harm  occurs that does not require readmission | • Discharge from hospital where harm  occurs that does require re-admission |

**SELF-NEGLECT**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
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| • A multi-agency response is more effective that using the safeguarding process for self-neglect  • The level of harm increases with each combining factors – risk to themselves and/or others  • Mental Capacity will need to be considered  • Please refer to Self-Neglect Policy and Procedure (hyperlink once available) | | • Only exceptional cases of self-neglect will trigger adult safeguarding. All standard interventions must be used first to manage risk (unless serious/immediate risks) | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Self-care/living conditions causing some concern - no signs/no major impact health/safety of harm or distress  • Poor management of finances leading to health, wellbeing or property risks  • Some insight and willingness to change, likely to accept help  • Refusal of care and support without significant impact on physical/emotional wellbeing | • Indication of self-neglect e.g. personal hygiene, dishevelled presentation  • Adult living in poor conditions and neglecting themselves  • Indication of potential impact on health  • Chaotic substance misuse | • Indication/evidence of self-neglect e.g. personal hygiene, dishevelled presentation **and**  • Adult living in poor conditions and neglecting themselves **and**  • Evidence of impact on health (pressure sores, wounds, dehydration, malnutrition) **and**  • Unsanitary living conditions **and/or**  • Cognitive impairment, sensory impairment, poor mobility or substance misuse **and;**  • Potential fire risk **and;**  • **Offer of assistance and /or services –resisted or declined** | • Evidence of self-neglect impacting health and well-being e.g. personal hygiene, dishevelled presentation **and;**  • Adult living in poor conditions and neglecting themselves, **and**;  • Evidence of impact on health, **and**;  • Unsanitary and unfit living conditions, **and**  • Cognitive impairment, sensory impairment (impacting insight), poor mobility or substance misuse, **and**;  • Identified potential fire risk/health and safety, **and;**  • **Clear evidence of risk to self and others**  **and; Offer of assistance and /or services –resisted or declined** |

**FINANCIAL**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Actions taken to address concerns and prevent reoccurrence  • Consider alternatives to safeguarding e.g. case management, complaints, disciplinary, review of needs/services, staff training  • Adult’s capacity in respect of making financial decisions  • Recurrence or escalation of concerns requires a safeguarding enquiry | | • Safeguarding Report required  • If there is any indication a criminal act has occurred the Police must be contacted | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Money not managed safely or recorded properly – isolated incident and no evidence of misuse of money  • Isolated incident staff personally benefit from users funds e.g. accrue ‘reward’ points/buy one, get one free  • Adult is routinely sending money to competitions/charity  • Isolated incident of a person who holds Lasting Power of Attorney for Property and Finances, has used the donor’s finances inappropriately involving a small amount of money, where no harm has been caused. Advice and guidance in relation to the Code of Practice for Attorneys under the Mental Capacity Act 2005 (Chapter 7, specifically 7.50-7.74), should be re-enforced. | • Money is not managed safely or recorded properly on more than one occasion  • Non-payment of care home fees - placement is not at risk (preventative actions required)  • Adult not routinely involved in decisions about how their money is spent or kept. Capacity in this respect is not properly considered and no evidence of undue pressure or coercion  • Lasting Power of Attorney claimed to exist but unregistered | • Personal finances removed from adult’s control without legal authority or consent  • Ongoing non-payment of care fees/charges and adult at risk experiences distress or harm through having no personal allowance or risk of eviction/termination of services (ascertain actions already taken to prevent this escalating to this stage)  • Concerns over Lasting Power of Attorney for property and finances may be consistently misusing the adult’s finances and not acting in their best interests and/or may be benefitting financially from their position as attorney and seem not to be acting in accordance with the Mental Capacity Act’s Code of Practice for Attorneys. | • Misuse/misappropriation of property or possessions or benefits by a person in a position of trust, control or coercive  • Fraud/exploitation relating to benefits, income, property or will  • Theft of money or property  • Doorstep crimes/financial scams |
| **Direct Payments** | | | |
| • Direct payment financial returns show payments for unauthorised expenditure.  One off mistake – payment returned  • Isolated incident of direct payment recipient benefitting from interest from direct payment account  • Isolated incident of direct payment recipient benefitting from interest from direct payment account  • Direct payment used flexibly to meet user needs but not as described on support plan  • Excess float in direct payment account is being used for purposes other than on support plan, e.g. utility bills or equipment. Possible misunderstanding or if fraud suspected then escalate as possible criminal offence  • Suitable person Personal Assistant found to be illegally working in the country. No harm caused but, suitable person responsibility removed, PA dismissed. | • Large excess in user accounts indicating care may not being provided  • Direct payment not set up correctly despite advice and guidance e.g. Personal Assistant not set up with Her Majesty's Revenue and Customs (HMRC); no audit trail for payments (i.e. no authorised timesheets, no wage slip or proof of invoice payment); no liability insurance  • Cash payments made against advice with no evidence of payment and care not provided  • Information obtained that suitable person or Personal Assistant has criminal conviction which gives rise to concerns about their role-suitability | • Pattern of unauthorised expenditure by person acting on behalf of adult at risk with inadequate explanation  • Pattern of repeated non-payment of bills/personal assistant wages, meaning care is withdrawn  • Payments made from direct payment account for unauthorized expenditure by suitable person, not on support plan  Suitable person not able to provide evidence to demonstrate they are managing the direct payment  • Direct payment is not being spent on some or all care on support plan, leading to neglect  • Irregularities on financial returns leading to requests for further evidence which are continually ignored by suitable person or evasive action is taken, including avoidance of attempts to review person on direct payment | • Misuse / misappropriation of direct payment by another, including:  Person in a position of trust or suitable person, e.g. suitable person is using some of the Personal Allowance or agency time for their own needs, and person is neglected  • Creation of fictitious Personal Assistant where payment is actually going to suitable person  • Adult at risk is misusing/ misappropriating direct payment by recipient, but under coercion by another |

**PHYSICAL**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Actions taken to address concerns and prevent reoccurrence  • Consider alternatives to safeguarding e.g. case management, complaints, disciplinary, review of needs/services, staff training  • Recurrence or escalation of concerns requires a safeguarding enquiry  • Medication errors – themes for adults at risk and staff member  • Medical - Continue to report events under Care Inspectorate Wales process  • Service user and service user – capacity and care planning | | • Safeguarding Report required  • If there is any indication a criminal act has occurred the Police must be contacted | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Staff error causing no/little harm, e.g. skin friction mark due to ill-fitting hoist sling  • Minor event that meets criteria for ‘incident reporting’  • Moving and handling procedures not followed on one occasion - no harm  • Adult does not receive recommended mobility assistance on one occasion not resulting in harm  • Bruising caused by family carer due to poor lifting and handling technique. No harm intended. Immediately resolved when given correct advice/equipment | • Inexplicable light/minor marking found where there is no clear explanation as to how the injury occurred on one occasion  • Isolated incident of carer falling asleep on duty. No harm caused – remains a disciplinary/management issue | • Inexplicable injuries/marking or lesions, cuts or grip marks on one occasion/more than one occasion  • Accumulation or escalation of minor event that meet criteria for reporting under Care Inspectorate Wales  • Adult is injured through disregarding policies/procedures. Harm occurs  • Inappropriate restraint/over medicating adult to manage behaviour outside of a specific care plan or disproportionate to the risk  • Withholding of food, drinks or aids to independence | • Physical assaults-injury/death  • Inexplicable serious injuries  • Assault by another resident requiring  medical treatment  • Any potential physical criminal act against an adult at risk  • Grievous bodily harm with/without weapon leading to irreversible damage or death, including Female Genital Mutilation |
| **Medication** | | | |
| • Adult does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs  • Isolated incident causing no harm that is not reported by staff member  • Isolated prescribing or dispensing error by GP, pharmacist or other medical professional - no harm occurs  • MAR Chart not signed, adult receives medication – no harm occurs | • Recurring missed medication or administration errors in relation to one or more adult that caused no harm (number of medication errors for adult at risk/staff member) | • Medication error that results in harm/ potential serious consequences  • Misuse of/over-reliance on sedatives to control challenging behaviour  • Recurrent errors/missed medication that affect more than one adult and result in actual or potential harm to one or more adults  • Recurring prescribing or dispensing errors by GP, pharmacist or other medical professional that affect more than one adult and/or result in harm to one or more adult  • Covert administration without medical authorisation outside the Mental Capacity Act 2005 | • Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death  • Deliberate maladministration of medications or failure to follow proper procedures, e.g. controlled medication  • Deliberate falsification of records or coercive/intimidating behaviour to prevent reporting |
| **Service User and Service User** | | | |
| • Isolated incident/dispute between service users resulting in no harm, quickly resolved and risk assessment in place  • One incident where no significant harm occurs and:  o A care plan is in place  o Action is being taken to minimise further risk  o Relevant professionals have been notified  o There has been full discussion with the adult, their family or representative  o There are no other indicators of abuse or neglect | • Multiple incidents, no harm occurs but pattern of difficulty in managing behaviour/incidents  • Isolated incident involving service user on service user low level harm occurs | • Any incident requiring medical attention or  attendance at hospital  • Multiple incidents where:   * The care plan has not or cannot be fully implemented * Professional advice or support has been sought at the appropriate time * There have been other similar incidents involving the adult responsible or areas of concern * There are other indicators of abuse or neglect | • Any incident resulting in intentional or intended harm/risk of harm to the adult at risk  • Any incident where a weapon or other object is used with the deliberate intention of harm  • Repeated incidents where the adult at risk lacks capacity and is unable to take action to defend themselves  • Predictable and preventable incident between two adults at risk where injuries have been sustained or emotional distress caused – staff fail to prevent |

**EMOTIONAL/PSYCHOLOGICAL**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Actions taken to address concerns and prevent reoccurrence  • Consider alternatives to safeguarding e.g. case management, complaints, disciplinary, review of needs/services, staff training  • Recurrence or escalation of concerns requires a safeguarding enquiry | | • Safeguarding Report required  • If there is any indication a criminal act has occurred the Police must be contacted | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Isolated incident where adult is spoken to in a rude or inappropriate way, respect is undermined - No distress caused  • Isolated taunt or verbal outburst – No distress caused  • Isolated threat of abandonment e.g. threat to withdraw visits/support – No distress caused | • Occasional taunts or verbal outbursts which do not cause distress  • Occasional repeated denying or failing to recognise an adult’s choice or opinion  • Occasional repeated treatment that undermines dignity and esteem  • Occasional repeated threats of abandonment e.g. threats to withdraw visits/social contact and support | • Frequent taunts or verbal outbursts which cause ongoing distress  • Persistent denying or failing to recognise an adult’s choice or opinion causing harm  • Persistent treatment that undermines dignity and damages esteem  • Frequent humiliation of adult at risk  • Persistent/ongoing threats of abandonment/harm causing harm or distress  • Persistent withholding of information to disempower and harm or distress adult  • Producing and distributing inappropriate photos via any social media | • Vicious/personalised verbal attacks  • Persistent intimidation or bullying causing distress and attempts to resolve have failed (adult at risk and adult at risk)  • Denial of basic human rights/civil liberties, over-riding advance directive, forced marriage, modern slavery  • Incident(s) perpetrated by staff member resulting in harm e.g. distress, demoralisation, loss of confidence (professional concerns route)  • Allegations or concerns relating to  ‘cuckooing’ |

**SEXUAL**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
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| • All sexual abuse concerns to be reported  • Actions taken to address concerns and prevent reoccurrence  • Preserving of any evidence/medical examination/Adult’s capacity to consent  • Consider alternatives to safeguarding e.g. case management, complaints, review of needs/services  • Recurrence or escalation of concerns requires a safeguarding enquiry | | • Safeguarding Report required  • Strategy Meeting to determine way forward  • If there is any indication a criminal act has occurred the Police must be contacted | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Isolated incident involving inappropriate sexualised remark made to an adult with capacity and no distress is caused  • Isolated incident of low level, unwanted sexualised attention to one adult by another, whether or not capacity exists. No harm or distress is caused | • Minimal verbal sexualised teasing or harassment  • Two adults whom there is cause to suspect may lack capacity are engaged in a sexual activity or relationship (Legally best interests assessment cannot be undertaken in this respect). No distress to either | • Sexualised attention between two adults at risk where one lacks capacity to consent  • Sexualised touch or masturbation without valid consent  • Being subject to indecent exposure  • Contact or non-contact sexualised behaviour which causes distress to the adult at risk  • Two people whom there is cause to suspect may lack capacity are engaged in a sexual activity or relationship (Legally best interests assessment cannot be undertaken in this respect) and harm or distress occurs to either party.  • Being made to look at pornographic material against their will or where valid consent cannot be given | • Penetration/attempted penetration by any means (whether or not it occurs within a relationship) without valid consent (Rape or attempted rape)  • Sex in a relationship characterised by power imbalance, coercion or exploitation,  e.g. staff and adult at risk  • Voyeurism |

**ORGANISATIONAL AND MULTIPLE ABUSE PROTOCOL**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • This is neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation, resulting in ongoing neglect or poor care  • This does not replace any duties to refer incidents to commissioning bodies outlined in contractual arrangements  • WBSAB Escalating Concerns Policy  <http://www.wgsb.wales/media/13643/wgsb-resoultion-of-professional-differences-17th-april-2020-docx.pdf?v=20200610132239> | | • Safeguarding Report required  • If there is any indication a criminal act has occurred the Police must be contacted  • Consideration for organised and multiple abuse protocol with Safeguarding Principal Officer being informed to consider a Scoping Strategy Meeting.  <http://www.wgsb.wales/media/13061/complex-abuse-protocol.pdf?v=20200225160838> | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Lack of stimulation/opportunities to engage in social and leisure activities - No harm  • Service design where groups of adults living together are incompatible - No harm occurs and risk assessments are place and followed  • One off incident of insufficient  staffing due to unpredictable circumstances, effort made to maintain staffing levels – No harm occurs  • Absence of policies or procedures or training/supervision in relation to key aspects of practice but do not result in harm.  • Poor quality care or professional practice that does not result in harm, albeit an adult may be dissatisfied with the service  • In the short term, adult is not given sufficient voice or involved in the running of service | • Denial of individuality and opportunities for adult to make informed choices and take responsible risk  • Care planning documentation not person-centred  • Poor, ill-informed or outmoded care practice. No significant harm  • Lack of stimulation/opportunities to engage in social and leisure opportunities - No improvement after advice  • Denying adult access to professional support and services, such as advocacy.  • More than one incident of low staffing levels, no contingencies in place. No harm caused | • Rigid/inflexible routines that are not in the adult at risk’s best interests  • Punitive responses to challenging behaviours  • Adult at risk’s dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing possessions, underclothing, dentures etc.  • Repeated incidents of insufficient staffing resulting in harm to one or more adults  • Failure to whistle blow on serious issues when internal procedures to highlight issues do not resolve/are exhausted  • Failure to report disclosure of abuse  • Poor practice not being reported and going unchecked  • Ill-treatment of one or more adults as risk, such as unsafe manual handling – harm occurs  • Failure to report, monitor or improve poor care practices  • Unsafe and unhygienic living environments  • Failure to support an adult at risk to access health and/or care treatments  • Service design where groups of adults living together are incompatible and harm occurs | • Staff misusing position of power over adult at risk  • Over-medication and/or inappropriate restraint managing behaviour  • Widespread consistent ill-treatment or neglect  • Stark or sparse living environments causing sensory deprivation  • Deprivation of liberty not authorised by legal process  • Low staffing levels which result in serious injury or death to more than one person (corporate manslaughter) |

**DISCRIMINATORY/HATE CRIME**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Actions taken to address concerns and prevent reoccurrence – Care Plans update  • Preserving of any evidence/medical examination/Adult’s capacity to consent  • Recurrence or escalation of concerns requires a safeguarding enquiry | | • Safeguarding Report required  • Strategy Meeting to determine way forward  • If there is any indication a criminal act has occurred the Police must be contacted | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Isolated incident of an inappropriate prejudicial remark is made to an adult and no distress is caused | • Isolated incident of care planning failing to address an adult’s diversity and associated needs for a short period which causes no/little distress  • Isolated incident of teasing motivated by prejudicial attitudes - service user to service user | • Inequitable access to service provision as a result of diversity issue  • Recurring failure to meet specific care/support needs associated with diversity  • Persistent and frequent targeting by others in the community who take advantage of the adult at risk  • Humiliation, threats or taunts on a  regular basis  • Teasing by person in a position of trust  • Refused access to essential services  • Denial of civil liberties e.g. voting, making a complaint  • Denial of individuals appropriate diet, access to take part in activities related to their faith or beliefs, or not using the persons chosen name  • Making an adult at risk partake in activities inappropriate to their faith or beliefs | • Hate crime resulting in injury/emergency medical treatment/fear for life  • Hate crime resulting in serious injury/attempted murder/honour-based violence  • Exploitation of an adult at risk for recruitment or radicalization into terrorist related activity  • Female Genital Mutilation |

**MODERN SLAVERY**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • All concerns of modern day slavery are deemed to be of a significant level  • Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person. It is taking advantage of another person or situation usually, but not always, for personal gain.  • Young People turning 18 who have been identified at Risk of Child Exploitation or Human Trafficking. | | • Safeguarding Report required  • Strategy Discussion/Meeting to determine way forward  • If there is any indication a criminal act has occurred the Police must be contacted  • WGSB Exploitation Guidance – Part 3 Adult Exploitation  <http://www.wgsb.wales/media/13381/wgsb-exploitation-guidance-final.pdf?v=20200429102250>  • Anti-Slavery or Human Trafficking MARAC  • Referral under the National Referral Mechanism (NRM) – duty to report victim of slavery or human trafficking (guidance under WGSB Exploitation Guidance for reporting procedures including MS1 form.  • The Western Bay Anti-Slavery Forum (WBASF) forum  [http://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms](mailto:http://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms)  Completed forms should be sent to the MSHTU Competent Authority via e-mail at [nrm@nca.gsi.gov.uk](mailto:nrm@nca.gsi.gov.uk) | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • All concerns about modern slavery are deemed to be of a significant/critical level | • No direct disclosure of slavery but:   * Appears under control of another * Lives in work place * No health and safety in work place * Long hours at work * Poor living conditions/low wages * Risk of physical/psychological harm * Adult being encouraged to   participate in unsafe or criminal  activity | • Any direct disclosure of slavery  • Limited freedom of movement/access to food or shelter  • Being forced to work for little or no payment/wages used for debt  • Limited or no access to medical and dental care  • Being regularly moved to avoid detection (Human Trafficking)  • No access to appropriate benefits  • Removal of passport or ID documents.  • Lives in sheds/lockup/containers  • Subject to violence/threats/ fearful | • Sexual exploitation  • Starvation  • No control over movement/Imprisonment  • Forced marriage  • ‘County Lines’/Cuckooing exploitation  • Risk of fatality or serious injury  • Exploitation of Human Tissue (Organ Harvesting) |

**DOMESTIC ABUSE**

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • Where domestic abuse is the only presenting factor and adult does not meet AAR criteria, no report to safeguarding. If it becomes apparent that the individual has or may have care and support needs and is experiencing domestic abuse then a safeguarding report is made.  • DASH Risk Assessment Checklist – determine the level of risk  • Where there are Children (under 18s) in household or present a report must be made to Children’s Safeguarding  • Violence against Women, Gender Based Violence, Domestic Abuse and Sexual Violence (Wales) Act 2015 legislative framework, Key component is the ‘Ask and Act’. | | • Safeguarding Report required  • Referral to MARAC where appropriate  • If there is any indication a criminal act has occurred the Police must be contacted/101  • If efforts to gain access to AAR are exhausted, consider APSO (Adult Protection and Support Orders) | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Isolated incident of abusive nature, no harm or distress caused and adequate protective factors in place/between adults without care and support needs  • Adult has no current fears and there are adequate protective factors, and it is:  o One off incident with no injury or  harm experienced  o Occasional taunts or verbal outbursts  where the adult has capacity to  decide whether to consent to report | • Limited access to medical and dental care  • Unexplained marking or lesions, cuts or grip marks  • Accumulation of minor incidents | • Indicators or concerns about coercion and control e.g. having their contact with others controlled and being prevented from attending appointments alone  • Frequent physical/verbal outbursts that cause distress or harm  • Experiences occasional episodes of fear  of the alleged perpetrator  • No access / control over finances  • Adult at risk denied access to medical treatment/care/vital equipment to maintain independence by alleged abuser  • Subject to regular violent behaviour  • In constant fear of being harmed  • Stalking/harassment | • Threats to kill, attempts to strangle choke or suffocate  • Imprisonment/confinement  • Sex without valid consent (rape)  • Forced marriage  • Female Genital Mutilation (FGM)  • Honour Based Violence and/or forced marriage |

**SAFEGUARDING ALLEGATIONS/CONCERNS ABOUT PRACTITIONERS AND THOSE IN A POSITION OF TRUST**

* Social Services and Well-being (Wales) Act 2014
* Social Services and Well-being (Wales) Act 2014: Working together to Safeguard People: Volume 6 – Handling Individual Cases to Protect Adults at Risk
* Keeping learners safe: managing allegations of abuse against teachers and others engaged in education services in Wales 2015

| **Prevention via alternative action** | | **Protection via the safeguarding process** | |
| --- | --- | --- | --- |
| • All professional abuse concerns to be reported  • The definition of ‘work’ includes:-  o those in paid employment, including temporary, students/trainees; casual, agency staff and those who are employed as Personal Assistants under the direct payment scheme  o Individuals undertaking unpaid voluntary work  o Individuals who are self-employed and work directly, or are contracted to work, in the provision of services to adults at risk  • Poor professional practice may be more appropriately dealt via agencies’ own internal process through providing appropriate advice, guidance or training. | | • Strategy Discussion/Meeting to take place with the Police  • The employer must seek advice from the Police/LADO/DOS about how much information can be disclosed to the subject of the concern person(s).  • Complete appropriate risk assessment to ensure adults at risk are protected.  • The employer/voluntary organisation or professional body may need to consider suspending the employee without prejudice, or putting in place support or restrictions to safeguard the adults at risk. This also safeguards the employee and organisation.  • Ensure that adults who are not suitable to work with adults at risk are prevented from doing so by notification to the Disclosure and Baring Service and other relevant and professional bodies | |
| **No harm or low risk of harm/**  **Lower level concern alert**  **-Does not require report-** | **Possible harm or moderate risk of harm**  **-Requires consultation-** | **Likelihood of significant harm or risk of significant/critical risk of harm** | |
| • Poor professional practice i.e. staff member does not adhere to manual handling policy – agencies’ own process  • One off staff member swears in presence of adult – agencies’ own process | • Context to circumstances where staff member may not have followed usual process whilst caring for the adult - No harm occurs.  • Member of public reports adult has been restrained in public, in context this is part of the adult’s PBM Plan. | • Been the subject of procedures that indicate a risk of harm to an adult at risk  • Caused harm or possible harm to an adult at risk and there is a risk in them working, volunteering, or caring environment  • Contravened or continued to contravene their agency’s Safeguarding Policy and Procedures  • Failed to understand or comply with the need for clear personal and professional boundaries in the work place  • Behaved in a way in their personal life which could put an adult at risk of harm  • Behaved in a way that undermines the trust placed in them by virtue of their position  • Their children are subject to child protection procedures and they work with adults in a caring or position of trust.  • Has caring responsibilities for an adult who is subject to Adult Protection Procedures.  • Historical concerns/allegations raised about the person and that person continues to work with adults at risk | • Behaved in a way that has harmed or may have harmed an adult at risk  • May have committed a criminal offence against an adult at risk or that has a direct impact on an adult at risk  • Behaved towards an adult at risk in a way that indicates they are unsuitable to work with both children and adults |

**COVID – 19 Safeguarding Concerns**

| **Prevention:**  **No harm or risk thereof**  **Low risk of harm** | **Prevention:**  **Possible harm or risk thereof**  **Moderate risk of harm** | **Requires consultation with:**   * **Public Health Wales** * **Environmental Health** * **Commissioning Teams** * **Care Management Teams** * **CIW/HIW**   **All issues in respect of infection control or access to/use of PPE will be dealt with via the appropriate Public Health/Environmental Health/Commissioning/Care Management Teams/CIW/HIW**  The examples below may trigger Enforcement action, Regional Care Home Escalation Procedures | **Protection**   * **Requires consultation with Designated Safeguarding Person/Team in your organisation** * **Police (potentially)**   **Safeguarding procedures will only be triggered in situations where an adult at risk (defined under SSWBA) has knowingly been put at risk, abused, or neglected by an individual or organisation**  The examples below may trigger Wales Safeguarding Procedures, Regional Care Home Escalation Procedures/Police involvement |
| --- | --- | --- | --- |
| **Infection prevention and control** | | | |
| • One off occurrence of lack of access to PPE, all reasonable steps taken  • One off occurrence of inappropriate waste management, all reasonable steps taken | • One off occurrence of not wearing PPE that could cause risk but does not currently  • One off occurrence of inappropriate waste management that could cause risk but does not currently | • Restricted/lack of PPE that may have caused harm  • Inappropriate waste management that may have caused harm  • Lack of and/or inappropriate use of PPE across service  • Continued lack of timely response to PPE issues  • Lack of compliance with appropriate PPE use that potentially puts people at risk | • Knowingly restricted access to care or medical treatment for someone who lacks capacity to make that decision that has caused harm or likely to have caused harm  • Continued and persistent disregard and failure to follow official advice, guidance and regulations in respect of COVID 19. |
| **Social distancing** | | | |
| • Adult with care and support needs who lacks capacity to adhere to social distancing and is being supported appropriately with relevant risk assessment and care plan | • Adult with care and support needs who lacks capacity to adhere to social distancing and there is no relevant risk assessment and/or care plan | • Lack of adherence to social distancing when caring for an adult with care and support needs  • Use of restrictions to ensure compliance with social distancing for someone who may lack capacity and have not been appropriately assessed or not been part of a best interest decision making process.  • Lack of adherence to social distancing by someone with care and support needs who does have capacity and is potentially putting others at risk  • Lack of adherence to social distancing when caring for an adult with care and support needs who lacks the capacity to make that decision | • Death following inappropriate use of DNACPR  • Incidents of staff continuing to work with adults with care and support needs who have tested COVID-19 positive and/or are knowingly COVID-19 symptomatic  • Knowingly putting others at serious risk of harm |
| **Care given by carer breakdown** | | | |
| • Carer experiencing difficulties in caring role, no risk of harm or abuse to adult with care and support needs | • Carer experiencing difficulties in caring role, no risk of harm or abuse to adult with care and support needs | • Concern that difficulties in caring role and harm may be caused and that risk is likely to escalate  • Harm has been caused as a result of carer breakdown as a consequence of COVID-19 |  |
| **Neglect** | | | |
| • One off concern regarding lack of staff or access to care but all appropriate steps have been taken to resolve  • One off incident of adult with care and support needs facilitated to have contact with family and friends | • Repeated concerns regard lack of staff or access to care but all appropriate steps have been taken to resolve yet additional support is required | • Lack of access to care or medical treatment for someone who lacks capacity to make that decision  • Concern regarding staffing levels during COVID-19 that may have caused harm  • Multiple incidences of adult with care and support needs not facilitated to have contact with family and friends  • DNACPRs that may have been put in place due to COVID-19 only and not relevant to the person’s current health diagnosis  • Swabbing a person with care and support needs without capacity assessment where the person potentially lacks capacity and demonstrates distress  • Hospital discharge process not followed correctly | • Knowingly/repeatedly disregarding Hospital discharge process resulting in serious harm |