West Midlands Safeguarding Adults Threshold Guidance

Introduction

This guidance is for practitioners and partners and explains the processes involved in making a decision about whether an "alert", regarding an adult who appears to be at risk of harm or is being harmed, is progressed through the safeguarding adults' procedures. Such "threshold decisions" are crucial in ensuring that people who meet the definition of "vulnerable adult / Adult at Risk" (No Secrets 2000) receive the assistance they need. Once an alert has been accepted and further information is gathered there may be situations where the threshold needs to be reconsidered.

Identifying the following will assist the decision making process:

- The harm – always take account of the individual's perception. What impact has it had on the person?
- The individual's capacity to understand what has happened and to make decisions in relation to the Safeguarding Adults concerns.
- Whether duress or coercion is an influence.
- Whether the incident is one of a pattern or trend in respect of the adult at risk, the person causing the harm, the location of the abuse or the nature of the abuse. Consider whether it is indicating a systemic abuse issue.
- The relationship between the adult at risk and the person causing the harm. Does it involve a person in a position of trust?
- What the risk factors are and the principles of positive risk taking.
- Whether any measures or actions have been put in place to minimise risk and protect the individual or other adults at risk.
- How likely is it that the abuse will reoccur?
- Is there a likelihood others were exposed or could be exposed to the harm or abuse?
- What evidence and information you have used to inform you decisions.
- Ensure everything is fully recorded.
- Has a crime been committed against the adult at risk?

Threshold decision making can be complex. Often the presenting abuse type on further investigation is one of a number of abuses which must be factored into decision making. Or the incident may constitute several abuse types for example some medication errors could be an indicator of institutional abuse but could also fall within the physical, psychological abuse or neglect. Forced marriages are also likely to encompass more than one type of abuse.

DOING NOTHING IS NOT AN OPTION

IF IN DOUBT ➔Initiate Safeguarding Adults Procedures with a Safeguarding Adults Alert ➔ Discuss with senior manager ➔Record decision and reasons for the decision.

You should always use your professional judgement, bearing in mind the circumstances presented, and seek advice from your line manager or the Safeguarding Adult Team.

If the Local Authority as the lead agency for Safeguarding decides the alert requires no further action under safeguarding procedures then other processes must be used to address the concern. For example a single medication error which has caused no harm may still require staff training on medication procedure. This must still be reported to the contract and commissioning team responsible for the provider concerned. Other processes and options could be:

- Care Management
- Referral to the regulator – Care Quality Commission
- Increased Care Contracts monitoring which may lead to:
  Employers actions including:
  - Training
  - Reviewing practices or procedures
  - Staff disciplinary procedures
- Incident or Serious Incident procedures
- Complaints procedures
- Referral to another agency such as Department of Works and Pensions, Trading Standards, Health and Safety etc.
- Referral for Advocacy support.

In the course of these processes if further information comes to light that means safeguarding should again be considered a further alert should be made.

Please use this guide when considering if an incident requires a Safeguarding Adults Alert/referral or if it falls out of the multi agency procedures and requires action from the service where the concern or incident occurred. Consider:

- Was harm caused and how serious was the harm or abuse/risk of harm or abuse - the consequence/impact.
- How often has it actually occurred/or the risk of abuse or harm occurring - history/context.
- How many adults at risk were exposed or could have been exposed to the harm or abuse (vital interest or potential institutional abuse)?
- What is the likelihood of the abuse or harm reoccurring? Frequency.

Type of abuse	Isolated incident Not SAFEGUARDING No harm – low risk	Possibly SAFEGUARDING Possible harm – some risks	SAFEGUARDING Harm caused- medium to high risk *A Safeguarding Adults Referral MUST be made*		
Physical	• Staff causing no harm – e.g. friction mark on skin due to ill-fitting hoist sling. • Minor events that still meet criteria for 'incident reporting'. • Dispute between service users with no harm, quickly resolved and risk assessment in place. • Bruising caused by family carer due to poor lifting and handling technique. No harm intended Immediately resolved when given correct advice/equipment	• Inexplicable minor marking found where there is no clear explanation as to how the injury occurred. • Isolated incident involving service user on service user. • Unwanted physical contact from 'informal' carer with no harm and quickly resolved	• Inexplicable marking or lesions, cuts or grip marks on more than one occasion or to more than one individual.	• Physical restraint undertaken outside of a specific care plan or not proportionate to the risk. • Withholding of food, drinks or aids to independence. • Inexplicable injuries	• Physical assaults – injury, death. • Grievous bodily harm/assault with or without a weapon leading to irreversible damage or death. • Any potential criminal act against an adult at risk
	• Adult does not receive prescribed medication (missed/wrong dose) – no harm occurs	• Recurring missed medication or administration errors in relation to one service user that caused no harm	• Recurrent missed medication or administration errors that affect more than one adult and/or result in harm	• Deliberate maladministration of medicines (e.g. sedation). • Covert administration without proper medical supervision or outside the Mental Capacity Act	• Pattern of recurring administration errors or an incident of deliberate maladministration that results in ill-health or death.

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Sexual	• Isolated incident when an inappropriate sexualised remark is made to an adult with capacity and no distress is caused.	• Isolated incident of low level unwanted sexualised attention/touching directed at one adult by another whether or not capacity exists – no harm or distress. • Two people who lack capacity engaged in a sexual activity or relationship – no distress to either.	• Verbal and gestured sexualised teasing. • Sexualised attention between two service users where one lacks capacity to consent. •	• Recurrent sexualised touching or isolated/recurring masturbation by another person without consent. • Sexual harassment - unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature.	• Attempted penetration by any means (whether or not is occurs within a relationship) without consent. • Sexualised attention in a relationship between staff and a service user. • Sex in a relationship characterised by authority, inequality or exploitation e.g. staff and service user • Sex without consent / rape. • Voyeurism. • Being made to look at pornographic material against will/where valid consent cannot be given. • Being made to participate in a sexual act against will/where valid consent cannot be given. • Trafficking an adult at risk for sexual exploitation.

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Psychological	• Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined, but no distress is caused	• The occasional withholding of information to disempower	• Occasional taunts or verbal outbursts which cause distress. • Treatment that undermines dignity and damages esteem. • Denying or failing to recognise an adults choice or opinion • Frequent verbal outbursts to an adult at risk	• Humiliation • Emotional blackmail e.g. threats of abandonment or harm • Frequent and frightening verbal outbursts to an adult at risk.	• Denial of basic human rights or civil liberties, overriding advance directive, forced marriage • Prolonged intimidation • Producing and distributing inappropriate photos via any social media means. • Vicious/personalised verbal attacks

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Financial	• Inadequate financial records • Isolated incident of staff personally benefiting from the support they offer service users in a way that does not involve the actual abuse of money. E.g. accrue 'reward points' on their own store loyalty cards when shopping when the adult has capacity to know what has happened and has agreed.	• Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered. • Staff personally benefit from the support they offer service users. E.g. accrue 'reward points' on their own store loyalty cards when shopping – adult lacks capacity. • Failure by relative to pay care fees/charges where no harm occurs - but receives personal allowance or has access to other personal monies.	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of capital and interest. • Adult denied access to his/her own funds or possessions. • Failure by relative to pay care fees/charges and adult at risk experiences distress or harm through having no personal allowance or risk of eviction/ termination of service.	• Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control. • Personal finances removed from adult's control without legal authority.	• Fraud/exploitation relating to benefits, income, property or will. • Theft. • Doorstep crimes.
Direct Payment specific	Direct payment financial returns show payments for unauthorised expenditure. One off mistake – payment returned Isolated incident of direct payment recipient not sending in financial returns Isolated incident of direct payment recipient benefitting from interest from Direct Payment account.	Large excess in user accounts indicating care may not being provided, some reports of inadequate care. 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.	Pattern of unsubmitted financial returns by suitable person with inadequate explanation Payments made from direct payment account for unauthorised expenditure by suitable person, not on support plan Suitable person not able to provide evidence to demonstrate they	Direct payment is not being spent on some or all of care on support plan leading to neglect. Irregularities on financial returns lead 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. • Or creation of fictitious personal assistant where payment is actually going to suitable person)

	Direct payment used flexibly to meet user needs but not as described on support plan. Direct payment not set up correctly e.g. Personal Assistant not set up with Her Majesty's Revenue and Customs (HMRC), no audit trail for payments. Corrected following advice and support no harm caused. Excess or float in direct payment account is being used for purposes other than on the support plan e.g. utility bills or equipment. Not safeguarding possible misunderstanding or at worse intentional fraud by recipient (possible criminal offence). Suitable person or Personal Assistant found to be illegally working in the country. No harm caused but suitable person responsibility removed, Personal Assistant dismissed.	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.	are managing the Direct Payment Pattern of repeated non payment of bills/personal assistant wages meaning care is withdrawn.		Adult at risk is Misusing/misappropriating Direct Payment by recipient but under coercion by another

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Neglect	• Isolated missed home care visit where no harm occurs. • Adult is not assisted with a meal/drink on one occasion and no harm occurs.	• Inadequacies in care provision that lead to discomfort or inconvenience – no significant harm occurs, e.g. being left wet occasionally. • Occasionally not having access to aids to independence (if regular may be restraint). • Adult at risk living with family carer who is failing with caring duties. • Temporary environment restrictions but action to resolve is in place. • Occasional inadequacies in care from informal carers – no significant harm.	• Recurrent missed home care visits where risk of harm escalates, or one missed visit where harm occurs. • Poor transfers between services for example - Hospital discharge without adequate planning and harm occurs. • Inappropriate or incomplete DNAR (Do Not Attempt Resuscitation).	• Ongoing lack of care to extent that health and wellbeing deteriorate significantly e.g. dehydration, malnutrition, loss of independence or confidence.	• Failure to arrange access to life saving services or medical care • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk • Gross neglect resulting in serious injury or death.
	• One person one pressure ulcer of low grade (grade 1 or 2).	• Pressure ulcers multiple grade 2s	• Pressure ulcers grade 3 or 4.	• Mismanagement of pressure ulcer grade 3 or 4 by professionals / paid carers.	• Serious injury or death as a result of consequences of avoidable pressure ulcer development e.g. septicaemia.

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Institutional	• Short term lack of stimulation or opportunities for people to engage in meaningful social and leisure activities and where no harm occurs. • Short term - service users not given sufficient voice or involved in the running of the service. • Service design where groups of service users living together are inappropriate.	• Denial of individuality and opportunities for service users to make informed choices and take responsible risks. • Care planning documentation not person centered. • Denying adult at risk access to professional support and services such as advocacy. Poor, ill informed or outmoded care practice – no significant harm.	• Rigid or inflexible routines. • Service user's dignity is undermined, e.g. lack of privacy during support with intimate care needs, shared clothing, underclothing, dentures etc. • Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted. • Failure to refer disclosure of abuse • Inappropriate or incomplete DNAR (Do Not Attempt Resuscitation).	• Ill-treatment of one or more adults as risk such as unsafe manual handling. • Failure to report, monitor or improve bad care practices. • Unsafe and unhygienic living environments. • Failure to support an adult at risk to access health and or care treatments. • Punitive responses to challenging behaviours.	• Staff misusing their position of power over service users. • Over-medication and/or inappropriate restraint used to manage behaviour. • Widespread, consistent ill treatment. • Stark or spartan living environments causing sensory deprivation. • Deprivation of liberty not authorised by legal process
	• One off incident of low staffing due to unpredictable circumstances, despite management efforts to address. No harm caused	• More than one incident of low staffing levels, no contingencies in place. No harm caused.	• Single incident of low staffing resulted resulting in harm to more than one person	• Repeated incidents of low staffing resulting in harm to more than one person	• Low staffing levels which result in serious injury or death to more than one person (corporate manslaughter)

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Discriminatory	• Isolated incident when an inappropriate prejudicial remark is made to an adult and no distress is caused. • Care planning fails to address an adult's diversity associated needs for a short period	• Isolated incident of teasing motivated by prejudicial attitudes – service user to service user.	• Recurring taunts. • Recurring failure to meet specific needs associated with diversity. • Teasing by person in position of trust.	• Denial of civil liberties, e.g. voting, making a complaint. • Humiliation or threats. • Denial of an individual's appropriate diet, access to take part in activities related to their faith or beliefs or not using the individual's 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 or attempted murder/honour based violence. • Exploitation of at adult at risk for recruitment or radicalization into terrorist related activity • Female genital mutilation of an adult risk