April Scrutiny Appendix 2

An audit of Safeguarding Files in Adult Social Care

for

Leeds City Council

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Introduction

1. The report of the recent CSCI Thematic Inspection of Safeguarding in Leeds has yet to be published. Officers informed us that it indicated that Leeds had a long way to go in terms of safeguarding its vulnerable citizens. As part of its response to these findings, the Head of Policy and Performance in Adult Social Care commissioned *CPEA Ltd* to undertake an audit of case files.

2. The detailed specification was to assist Leeds City Council in developing an *adult social care audit quality assurance methodology for its fieldwork services,* by auditing 20 case files in November 2008 with a view to:

   [a] reflecting on CSCI's recommendation 2 regarding the strengthening of *frontline QA arrangements to ensure that minimum standards of practice and recording are implemented routinely in responding to adult safeguarding alerts;* and

   [b] providing a written commentary on the adequacy of practice vis-à-vis adult safeguarding, paying particular attention to the effectiveness of referral, reporting and recording systems.

3. Each case record will be audited for the purpose of establishing whether any of the contents would give rise to cause for concern in relation to the proper care and protection of the vulnerable adults to whom they related. The audit will be informed by the *Leeds Multi Agency Adult Protection Procedures 2002* (which are currently being updated), the Department's *Action Plan* in response to the inspection, and the *Annual Report* of the Local Safeguarding Board. In addition, the consultants were given a copy of the letter sent out to staff from the Chief Officer (Access and Inclusion) in August that restated 'expected standards of practice' when dealing with a safeguarding referral. It was envisaged that the audit would capture the essence of this letter: namely, greater attention to compliance with the agreed procedures and to accurate and systematic recording.

Methodology

4. *CPEA Ltd.* provided two consultants to undertake the audit, which took place in the weeks commencing 17th and 24th November with a commitment to providing a final report by the end of the month.

5. The consultants began by familiarising themselves with the relevant departmental documentation. They drafted a template against which to audit each file (see Annex B) and a copy of each such audit has been sent to the Head of Policy and Performance. The template categorises: the referral pathway, the response to the referral, partner roles, care management, the case record, and emerging themes. It was progressively refined as the audit progressed.

6. Further, the consultants sought to build in quality assurance through the second reading of two files: that is, two files were scrutinised by both consultants to ensure consistency within their work. A Director of *CPEA Ltd* provided quality assurance oversight of the final report.

7. In respect of confidentiality, the consultants did not store electronically the names of any clients or staff. The names featuring in three pen portraits are fictionalised.

8. The consultants kept the Head of Policy and Performance informed of progress during the course of the audit, including verbal feedback of the headline findings.

Some limiting considerations

9. Files are not prepared with audits in mind. They are not and cannot be a full or accurate representation of what has taken place, but they do give an indication of safeguarding activity.

10. People's lives are complicated and case files do not always do them justice. They tend to record the more problematic aspects of people's lives rather than providing a rounded picture. The use of pen pictures (see below) adds to the file audit and provides some balance.

The sample of safeguarding files

11. The Department identified 20 recent referrals that were marked 'adult safeguarding concern'. They chose two or three cases from each area and also sought to represent each client group: namely learning disability, mental health, older people and physical/sensory disability.

12. All 20 adults were white British and this immediately raises a query as to why people from other ethnic groups do not feature in the sample: are they not represented proportionally in the adult population that receives a service from the City Council? Or are safeguarding concerns not being identified for these groups?

13. Table 1 sets out information about the sample. There are more women than men and 14 people are over 65 years. This is in keeping with the figures in Leeds Safeguarding Adults Annual Report (2007/08), which states that the greatest number of referrals came from older people. This, in turn, reflects their dominance within Adult Social Care nationally. Of these older people, 11 had some form of cognitive impairment, including dementia. The group that generates the second highest number of referrals in Leeds is people with learning disabilities and this is replicated in the audit sample. We conclude, therefore, that the sample is a reasonable representation of the overall numbers of people who were the subject of a safeguarding referral.

14. We have identified people's most significant disability (see Table 1). The majority had more than one condition as shown in Annex A (that provides individual information about each person in the sample). The sample contains one adult who is the perpetrator of a physical assault. The remaining 19 are victims of an array of alleged abuses, including neglect, physical assault, verbal, sexual and financial abuse, and intimidation. We state 'alleged' abuse because in a number of cases it was not certain whether abuse had actually occurred because of the inconsistency in the reporting of the allegation; in others, the investigation had not been concluded.

15. Reference to Annex A shows that 11 people were living in some form of commissioned residential service at the time of the referral. The remaining nine people were living in their own homes. Nine referrals came from the managers or employees of commissioned residential services and three referrals were from people's relatives. The remaining eight were from a variety of sources, including neighbours, CSCI, the Police, an ambulance crew and day and home services.

Table 1: The 20 adults

	Under 65	Over 65	Male	Female	Total
Cognitive impairment	1	3	1	3	4
Dementia		7	2	5	7
Physical/sensory impairment		3	1	2	3
Learning disability	5		2	3	5
None		1	1		1
Total	6	14	7	13	20

The types of abuse

16. The term 'abuse' can appear to minimise serious crimes at one end of a continuum, while sensationalising disrespectful, minor infringements and relationship difficulties at the other. Table 2 summaries the forms of abuse addressed in the 20 case files.

Table 2: What incidents triggered the referrals?

Cognitive impairment	Inappropriate touching Bruising, cut face, sexual comments Financial exploitation and self neglect Intimidation and verbal abuse
Dementia	Attacked resident Lack of care by staff Alleged physical assault; neglect Slapped by partner Unsafe behaviour Alleged physical assault by neighbour Inappropriate touching
Physical/sensory impairment	International financial telephone scam Concern regarding financial exploitation
Learning disabilities	Alleged physical and sexual assault and verbal abuse Excessive teasing and bullying; compromising photographic images put on the internet; 'joke' texts sent Alleged physical assault Attacked by resident when unsupervised (2)
None	Intimidation to obtain financial 'loan'

17. In addition to the referrals described in Table 2, some people's prior and ongoing experiences come within the abuse continuum:

- Having paid 'well over the odds' for roof repairs
- Being dependent on the care-giving of an alcoholic
- Being physically assaulted by a violent sibling
- Making previous 'delusional claims'
- Failing to maintain appropriate boundaries
- Falling when drunk on many occasions
- Dementia, self neglect, excessive drinking and incontinence triggering a request for more home care assistance
- Becoming verbally aggressive as the dementia advanced
- Being taunted by young people for years
- History of poor relationships with parents
- Long history of alcohol dependence and binge-drinking
- History of demands for money being made with elements of intimidation

18. Thus the case files confirm that most of the abuses that resulted in referrals were not isolated events.

Three pen pictures

19. Before considering the detailed findings, we include three pen pictures of adults whose files were included within the audit. These may help to make the audit more meaningful and illustrate the complexity of safeguarding activities. It should be noted that many of the people who are the focus of the referrals have histories which have made them visible, if not to Adult Social Care, then to the NHS and, almost certainly, in their own neighbourhoods. (The names of the adults have been changed in order to maintain confidentiality.)

Norma
Norma is in her 60s. A single woman, she has been a family caregiver for many years. She visits her very frail, elderly aunt who lives nearby up to three times a day – a fact that Norma has shared with people with whom she is in daily contact. The wider family has been aware of Norma's alcohol problem for many years and, latterly, they have acknowledged that for much of her life, she is drunk. They are aware too that when she binge drinks she is indiscriminate in the men she chooses to associate with. Knowing that Norma is a caregiver, the owner of the local off-licence (who lives nearby) has contacted Adult Social Care to express concern that on Norma's recent visits to his premises a man has accompanied her whom she has introduced as her 'boyfriend.' This man has been very directive in suggesting what Norma should purchase, not merely for herself but for her aunt, who she has been told has become bed-bound. The items are always the most expensive and the purchasing is unlike Norma's usual purchasing. When, in a state of drunkenness, Norma disclosed that she was investing £8k in her boyfriend's new business, alarm bells rang.

Sarah
Sarah has learning disabilities and has recently had operative treatment for a chronic health problem. She has had an unenviable early life characterised by violence, harsh and erratic discipline, substance misuse and separation from a loved parent. Sarah currently looks after her grandmother who has dementia. While her care giving is rudimentary – she can only prepare simple foods and she struggles to keep her grandmother, herself and their home clean – Sarah is committed to continuing to care for 'Gran.' In turn, she receives daily support with household tasks, most particularly money management. Since 2006 Sarah has told her support workers about a neighbour she dislikes. In the last 12 months, Sarah alleges that the neighbour has: followed her; sought out opportunities to hurt her physically; told others about her; and most worryingly, has sexually assaulted her. Separately, she has a complicated sexual relationship with an 'on/off' boyfriend. Intensive social work involvement has included identifying accommodation for Sarah in a locality in which she will feel safe that will also suit her Gran; and unravelling Sarah from the purchases her boyfriend makes on her behalf. Only very recently the police, who have arrested the neighbour on two occasions, have concluded that Sarah's allegations regarding her neighbour may be without foundation.

Wendy
Wendy, 44 years, has paranoid schizophrenia with alcohol dependency and an eating disorder. She lives in a hostel for people with mental health problems. There is a history of her being bullied by another resident but previously Wendy has not wanted to pursue a complaint. Eventually, after a particularly serious incident, the other resident (who is also very vulnerable) was moved from the hostel for two weeks' respite and the hostel manager referred the situation to Adult Social Care. On interviewing Wendy, the social worker learned of a serious level of ongoing verbal abuse and intimidation. At the point of the file audit, the matter had not been resolved: a care plan was drawn up aimed at protecting and supporting Wendy in the future. However, yet to be resolved is whether the other resident can safely be allowed to return to the hostel: what are the implications for her of disrupting the placement where she has settled well? Equally, can Wendy realistically live alongside someone who verbally abuses and intimidates her? Could action have been taken sooner to diffuse the situation?

Findings

Response to the referral

20. Overall, the Department responded to safeguarding referrals in a timely manner; staff contacted other relevant agencies and personnel

appropriately to gather information, and there was evidence of team managers becoming appropriately involved in managing the referral.

21. In most cases, we concluded that the Department had taken matters referred to them very seriously and initiated appropriate action to safeguard the subject of the referral. In saying this, we cannot be definitive in all instances because some cases were ongoing and, hence, the outcome was not finalised. However, there were two cases that we referred back to the Department for reconsideration because of specific concerns about the management of the case: one where we judged that the Department had not taken a sufficiently rigorous approach to neglect that occurred in a care home; the other where it was not possible to conclude what action had been taken to ensure the individual's safety. (see Annex C).

22. The Multi Agency Adult Protection Procedures of 2002 identify the required response to an alert or report of abuse. This includes:

- **referral** to an Adult Protection Enquiry Coordinator;
- a **decision** as to whether the procedures apply in the particular case and the level of urgency;
- the adult protection process is planned (the **strategy**);
- a **protection plan** is agreed about how, if necessary, to reduce the risk of abuse within two weeks of the enquiry being completed; and
- the protection plan is **reviewed** within an agreed time scale.

23. The first stage of the adult protection inquiry *'should always be to interview the adult who, it is alleged, is experiencing abuse'.* There is a proviso that this may not be appropriate or feasible in all cases. Staff made positive efforts to interview the subject of the referral in most instances, or had recorded why they did not (appropriately) consider it necessary to do so. Bearing in mind the number of people in the sample who have a cognitive impairment, this was not an easy undertaking. However, in two case files, it is unclear whether or not the person had been seen and, in another case, there was an unreasonable delay in making a visit. As the Department is the lead agency in adult protection cases, it is essential that their staff have first-hand knowledge of the alleged abuse. The interview may provide evidence for powers to be gained to protect a person, for a criminal investigation, staff disciplinary procedures or information for service commissioners. It may be appropriate to undertake interviews with another agency (usually the Police or Health staff) in the interests of collaboration and to avoid the adult concerned being subjected to more than one interview – as has happened.

Strategy meetings

24. Once it is established that a referral requires investigation, the procedures require staff to hold a strategy meeting. The purpose is to bring together the relevant staff from within the Department and other

agencies to share information and decide on action to investigate the incident and seek to ensure the safety of the subject of the referral. However, the letter that went out to staff in August states that a strategy meeting is to be held *'in all cases where an investigation has taken place'*, the purpose being to record the outcome of the investigation, what action is to follow and who should be doing what, and also to note where an adult does not want any further action taken. This advice is conflicting as it is not clear at what stage the strategy meeting is to be held: that is, before the investigation or after it. In our view, it is essential that when the Department decides that it is necessary to respond to a referral, staff should plan any investigation in a coordinated manner with other relevant staff and other agencies.

25. Strategy meetings to plan the investigation are not happening routinely. In some cases, we concluded that a meeting was not required: (for example, the young adult resident in a special school for whom a protection plan already existed; the physical injury (by another resident) was not serious; and a review was subsequently held to reconsider the plan). In such instances, a decision based on a strategy discussion with a manager and recorded on the file would suffice.

26. However, there were other instances where the absence of a strategy meeting to plan the investigation had negative consequences: in particular, a failure to involve other agencies, share information and reach agreement as to what should happen next, which led to delay and inconsistency in the action taken to safeguard the adult at risk.

Assessing risk and protection planning

27. In deciding the response to a safeguarding referral, staff have to weigh up the level of risk in a particular situation and a person's capacity to decide how they will live their life, including making decisions that others deem to be unreasonable and against their best interests. These are difficult and complex matters to decide, hence the need to share the decision-making in supervision and in strategy and planning meetings. As well as the lack of shared decision-making via strategy meetings, there was an absence of risk assessments evident on file. This meant deducing the reasons for decisions from the daily case record rather than being able to read an analysis of the situation and conclusions based on the evidence. The following case study illustrates the difficulties and underlines the importance of coordinated action.

Case study 1
Mary, who is an adult with learning difficulties, arrived at the training centre after several days' absence with the marks of two black eyes, caused, she said, by her father with whom relations were problematic. The matter was referred to the Police who were not able to respond immediately. As a consequence, Mary returned home where the Police interviewed her with the support of her mother. No one from the Department saw her that day but agreed with the Police that she

should remain at home. However, following a further interview the next day with a social worker acting as appropriate adult, it was decided that Mary should not go home and she moved to a residential unit. The father was interviewed and released on police bail. The evidence was not conclusive and so, pending further investigations, Mary went home. On the basis of the evidence on the file, at no time was there a meeting to agree the level of risk and coordinate a response. The case is ongoing and the final outcome is not known.

28. In a number of cases, a safeguarding or planning meeting was held some time after the event in order to agree a protection strategy. In principle, this represents good practice and complies with the August management letter. However, the protection plans lacked rigour: they were not specific enough about future action and who was responsible within what timescale. For example, it is not sufficient to state that a care home will monitor progress; it requires clearer reporting arrangements. Finally, there was no clear sense of how the plan would be monitored or reviewed.

Multi-agency cooperation

29. Positive multi-agency cooperation is essential to effective safeguarding. Where there are good relationships based on a shared understanding of the task and each other's role, it is more likely that staff will work together in an effective manner in the interests of the adult at risk. This includes sharing information and agreeing what action to take. There are some excellent examples of effective collaboration as the following case study demonstrates.

Case study 2
Martha was the subject of an international telephone scam and paid out hundreds of pounds. She continued to be pestered for additional payments. Although the matter was outwith Police jurisdiction, they worked with Adult Social Care and the person's family to arrange a change of telephone number that was ex-directory and put a bar on international calls. It also emerged that she had seriously overpaid for some repairs to her house so the Police checked out the company responsible for having undertaken the work. The Department provided information about the local Care and Repair scheme for use in the future and encouraged Martha to seek help from her GP for her evident memory loss. However, case study 1 (above) illustrates a situation in which the Police acted independently from the Department, thereby prejudicing a concerted and consistent response to the adult concerned, and there were other such instances. As a consequence, there was delay and a lack of coherence in the action taken. The Department does not bear sole responsibility for this lack of collaborative working. There was evidence of the Department making efforts to work in concert with colleagues with limited success.

Managing cases proactively

30. As indicated earlier, there was evidence of timely and effective responses to referrals that ensured highly vulnerable adults were protected. The following case study is a good example.

Case study 3
Stanley was the subject of scapegoating by support staff in his Extra Care Housing: for example, waking him in the early hours to say he had overslept and would be late for work; staff let him get dressed before telling him that it was in fact only 2.00am. The Department followed up this referral on the day it was received and held a strategy meeting two days later after discussion with a senior manager. The investigation confirmed evidence of unprofessional behaviour. The work was characterised by urgency and a clear determination to persist, irrespective of the fact that Stanley reported that staff were engaging in 'pranks.' In addition, as a consequence of the investigation, the Department found out that Stanley was receiving no support, irrespective of the contract to provide him with assistance in his daily routines.

31. Another case study illustrates the difficulty of providing a service to someone who is resistant to any form of intervention from agencies.

Case study 4
Beth, 84 years, is partially sighted and has dementia with an associated personality disorder. She lives on her own but her daughter, who is her main carer, lives a few streets away. The

situation has been deteriorating over the past two years with Beth behaving in an increasingly unsafe manner: getting into cars with strangers; walking about naked; threatening a neighbour's child with a knife; setting fire to her kitchen.

Her daughter was finding the situation increasingly stressful and difficult to manage, partly because Beth refused to accept any services. Day care was offered and home care provided but both were discontinued because of Beth's lack of cooperation. Instead, she expected her daughter to provide for all her needs. Her daughter wanted her to be placed in residential care but the psychiatrist judged that Beth had capacity and the level of risk was acceptable.

Earlier this year, the daughter went on holiday and stayed away longer than anticipated. It is not clear what arrangements she had made, if any, to ensure her mother was looked after in her absence. A neighbour made a referral to Adult Social Care after seeing Beth standing in the middle of the road trying to hitch a lift. Following a reassessment, Beth was eventually sectioned and placed in a secure setting.

32. Whilst both case studies provide examples of sound professional practice, they both raise questions as to whether action could have been taken sooner. The Department had considerable involvement with Beth and her family. Staff undertook a carer's assessment of her daughter and knew the level of stress under which she was operating. Yet, they closed the case and there is no evidence of a planning meeting to discuss with colleagues in other agencies what more they might do to support the situation. Nor did the staff keep the matter under review. Rather, they reacted to a situation where we surmise that the daughter may have stayed away from home in desperation to allow matters to take their course regarding her mother.

33. In the other case study (3), there was no evidence that the Department monitored its contract with a care provider who was clearly not fulfilling its contractual terms. There are other examples where the protection plan recommended monitoring of the situation but the arrangements for doing so were not adequately defined and, hence, run the risk of failing to provide the intended level of oversight and protection.

Management oversight

34. Management oversight as recorded in the files was variable. There were examples of team managers being actively involved in decisions about the management of the case and (appropriately) taking responsibility for aspects of it. There was evidence of managers 'signing off' decisions and agreeing case closure. There were also cases where there was no evidence on the file of any involvement by the team manager. This did not necessarily mean that the manager had had no involvement but none was recorded on the file.

35. The lack of recorded management oversight lays the Department open to criticism, particularly when something goes wrong, as the case file represents the only definitive record of what has occurred. It is also the means by which the Department can itself audit its work and manage the performance of staff. At the same time, it is a cornerstone of good practice for the team manager to provide supervision, both to ensure compliance with agency policies and procedures and give support to their staff in dealing with these complex cases.

The organisation and quality of the case records

36. The Department operates currently with electronic and paper files. A dual system presents challenges in terms of ensuring that either record is up-to-date. The audit was of the paper file but we also had the case notes (the daily record) from the electronic records.

37. The files have dividers that indicate what records should go in which section. There was no consistent adherence to this arrangement. In addition, there was an array of different documents that featured on the files and there was a lack of consistency in their use. In a few cases, there was a helpful summary of events at the front of the file that gave the reader a ready understanding of the case and many workers had made use of the Adult Protection Monitoring form, which again provided a useful summary of events. However, overall, we had to work hard in order to establish what was happening in the case and this is clearly not useful.

38. The daily case notes were good or satisfactory with the exception of one case that was ungrammatical to the point of being very difficult to read. All but two had been recorded contemporaneously. In one case, events were recorded six months after they happened which has to raise concerns about their accuracy.

39. We have already referred to the absence of formal risk assessments (that is, something that sets out explicitly the nature and level of risk in a particular case). We also did not find evidence of reassessments being undertaken, of up-to-date care plans or reviews. This limits the evidence of how the cases were analysed and conclusions made about the level of risk and what action might appropriately follow.

Conclusions

40. Although conducted as a freestanding audit of case files, this report's findings mirror many of the concerns the review of *No Secrets* (Department of Health 2008) seeks to address: abuse is not a neat phenomenon that can be remedied in the short term, and deciding on appropriate interventions is not straightforward.

41. The understanding of adult abuse has increased since the original guidance from the Department of Health (*No Secrets)* was drawn up in 2002. Leeds own multi-agency procedures date from that time and were in the vanguard of developments. However, a heightened awareness of the extent and consequences of adult abuse has led to a steep rise in the numbers of cases referred to Adult Social Care Departments nationally and Leeds is no exception. As is evident from this audit, the spectrum of abuses and types of situations in which they occur are extensive. The referrals are complex and require consideration within a framework of policies and procedures that reflect the latest research and thinking about adult abuse and take account of recent legislation, specifically the Mental Capacity Act.

42. There was evidence of a strong commitment to responding to referrals defined as safeguarding – and a wide range of situations fell appropriately into this category. However, there were inconsistencies in the approach taken to referrals, reflecting uncertainty about the threshold at which to intervene, the nature of the intervention and, in particular, how to work in a coordinated manner with other agencies.

43. Finally, there was very limited evidence to indicate that the Department's contracts section was informed of abuse incidents that occurred in residential establishments. We assume that the Department will have commissioned the service for the majority of the people in the sample and, hence, has an interest in ensuring that the service, which they are funding is provided to a satisfactory standard.

Recommendations

44. The Department has drawn up an extensive Action Plan in response to the recent inspection. We offer the following recommendations that flow directly from this audit and which add support to that Plan. They are not directed solely at the Department as effective change can only occur within a multi-agency context,

- The Adult Safeguarding Board should review its thresholds for intervening in cases referred as adult abuse.
- The Board should review and agree its expectations of its member agencies for collaborating in safeguarding work.
- The Board should ensure that staff understand their role and expectations of their performance in safeguarding work.
- The Board should institute regular auditing of a sample of cases.
- The Department should undertake a regular audit of its case files to ensure compliance with the multi-agency and its own internal

procedures and to enhance its understanding of the changing nature of the work.

- The Department should clarify the role and expectations of its contracts section in safeguarding matters.

References

Department of Health (2008) *Safeguarding Adults: A consultation on the Review of 'No Secrets' Guidance,* London: DH

Leeds City Council (2008) *Draft: Independence, Wellbeing and Choice Inspection Action Plan*

Leeds Multi-Agency Adult Protection Procedures (2002)

Leeds Safeguarding Adults Partnership *Annual Report 2007-2008,* Leeds: City Council Communications (Social Care)

Annex A: The sample

Initial	Age	Gender	Nature of disability	Living circumstances	Source of referral
AA	19	F	LD/autism	Special school	CSCI
BB	84	F	SI/dementia	Care home	Care home
CC	96	M	Dementia	Lives with wife	?Community matron
DD	44	F	MH/alcohol dependency/eating disorder	Hostel	Hostel OiC
EE	87	F	Parkinson's disease/?dementia	Care home	Care home OiC
FF	36	F	LD	Home	ATC manager
GG	36	F	LD	Lives with brother	Social worker/Home care service
HH	73	F	MH/cognitive impairment	Care home	1. Care home 2. Hospital
II	85	F	SI/memory loss	Lives alone	Police
JJ	86	M	SI/poor mobility	Lives with daughter	Anonymous (probably neighbour)
KK	57	M	LD	Extra care housing	Anonymous TC from former staff member
LL	72	F	Korsakoff's syndrome	Lives alone	Daughter
MM	83	M	Cognitive impairment/alcohol misuse/arthritis	Lives alone	Niece
NN	80	M	MH/?dementia	Care home	Care home
OO	57	M	LD/autism	Care home	Care home manager
PP	76	M	None	Lives with wife	Step son-in-law
QQ	81	F	EMI	Care home	Manager
RR	88	F	Dementia	Care home	Manager
SS	96	F	Dementia	Care home	Ambulance crew
UU	84	F	SI/ dementia/ personality disorder	Lives alone	Neighbour

Annex B: The file audit pro forma

LEEDS SAFEGUARDING STUDY: AUDIT OF FILES

The purpose of the case file audit is to ensure that minimum standards of practice and recording are implemented routinely in responding to adult safeguarding alerts.

Format for looking at service user social care files

User identifier (file reference number):

DoB: Age:

Gender:

Ethnic group:

Religion:

Disability:

Lives alone, in relationship or in accommodation with others:

Theme	Question	Response
Referral pathway	Where did the referral come from: referral agent and method of referral? What is the reason for the referral? What triggered the referral as abuse; what is the nature of the abuse/neglect? Is it abuse in a regulated service/other service or within the family/community? How is the abuse described (i.e. the terminology used by the referrer? Is there any history of previous abuse or concerns? Was the abused adult in receipt of a service at the time of referral? Is there an alleged abuser or is it seen as 'system' abuse? Was there any element of mutual abuse?	

Response to referral	What was the response to the referral? Was it timely? Has the subject of the referral been seen? If not, is the reason for this clearly recorded? Was a strategy meeting held? If so, who was involved? How was the investigation managed? What was the outcome? Was an advocacy offered or involved, or IMCA?	
Partner roles	Are other agencies currently involved or previously involved? If so, in what role? Have they cooperated in the investigation and any planning thereafter?	
Care management	Is there a care plan? How is it reviewed? How is risk assessed and managed? Is there a clear focus on giving the user choice and control as part of the process? How is the family involved? (Note if family member is or suspected of being the perpetrator) What is the range of interventions & services on offer? What has been offered to the user and their family/carer? Is there evidence of preventative services? Is there a reasonable balance evident between prevention and safeguarding? Is the range of services sufficient? Does the user, their family or friends or an agency initiate interventions?	
Case record	What is in the case record: referral; assessment; care plan; review? Is the user and carer perspective evident from	

	the case record? Does the file make sense: is it clear what has happened and the nature of any current intervention? Is there evidence of team manager oversight: in providing supervision, having a discussion; agreeing the care plan and signing off the record? Are assessments, care plans and reviews undertaken according to the required time-scales? What is the quality of record keeping and of individual documents: care plan?	
Emerging themes from the case	What themes are evident from this case that might form recommendations for the final report?	

Annex C

THE TWO FILES

The principal authors of the two files identified during the audit were invited to comment on the concerns and observations of the *CPEA Ltd.* consultants. Both 'cases' were active.

In respect of neglect that occurred in a care home, the hospital social work file was offered to complement the information within the Adult Social Care file. The latter addressed the matters raised, acknowledging that: some notes arising from a strategy meeting were not recorded as such; the investigation remained to be concluded; and not all of the decisions taken were recorded in the notes. The two files convey a fuller picture of events, decision-making and actions than a single file - prompting a question about the merit of having separate and dispersed files.

Regarding the file from which it was not possible to determine the actions taken, the availability of a complementary file (regarding the relative of a frail elderly person) is less than reassuring. While both files confirm the complexity of safeguarding work, legal advice should have been sought. The purpose of the 'monitoring,' the form the oversight was to take and the frequency of reporting envisaged were not specified e.g. *"to help them protect their finances"* did not engage with the accumulating evidence of *parasitic* abuse (including the concerns expressed to personnel regarding financial exploitation). Minimally, the recent removal of a large sum of money from the elderly person's account should feature in the 'Chronology of events.' "