SAFEGUARDING ADULTS WITH CARE AND SUPPORT NEEDS

Review Frequency: 3 yearly

Person Responsible for this Policy: Designated Safeguarding Leads

CHANGE	Version	NAME	DATE
New policy created	1	J Lloyd-Jones	Sept 2020
Policy expanded to include YPSA & additional information	2	B Parrott	Sept 2021
Substantially re-written in line with safeguarding audit recommendations	3	H Morison	May 2022
Reviewed following OY safeguarding audit	4	T Blackstock & N Petryszyn	Oct 2022
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Reviewed following failure to act incident	6	T Blackstock	July 2023
1. Changes to format included 2. Updated in line with Charity Commission guidance regarding Board trustee role 3. Training requirements for DSL level 3	7		June 2024
1. Changes to DSL process and escalation of SI 2. Changes to SI and NTK process and definition 3. Changes to Safeguarding traffic light definitions 4. Changes to SG meetings structure and Map 5. ON call OOH changes dude to outsourcing on call to 360 6. Changes to SG trustee information 7. Paginated, and review frequency aligned	8	Natalie Petryszyn	Septem ber 2025

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1. Overview

Oxfordshire Youth is committed to safeguarding adults with care and support needs (also referred to throughout this policy as adults) in line with national legislation and relevant national and local guidelines. We will safeguard adults by ensuring that our activities are delivered in a way that keeps all adults safe.

Oxfordshire Youth is committed to creating a culture of zero-tolerance of harm to adults which is essential in the recognition of adults who may be at risk and the circumstances which may increase risk; knowing how adult abuse, exploitation, or neglect manifests itself; and being willing to report safeguarding concerns.

This extends to recognising and reporting harm experienced anywhere, including within our activities, within other organised community or voluntary activities, in the community, in the person's own home, and in any care setting such as a GP surgery.

Oxfordshire Youth is committed to best safeguarding practices and to upholding the rights of all adults to live a life free from harm from abuse, exploitation and neglect.

The aims of this policy are:

- To stop abuse and neglect where possible.
- To safeguard adults and support them in a way that allows them to make choices and have a sense of control over how they want to live.
- To promote an approach that focuses on improving life for the adults concerned.
- To provide information and advice in accessible ways to help people understand the different types of abuse, how to stay safe and well, and what to do to raise a concern about themselves and others.
- To address what has caused the abuse or neglect.
- To ensure that all staff are aware of their safeguarding duties and responsibilities.
- To ensure that all staff contribute to multi-agency partnerships to provide effective and timely responses to abuse and neglect, proactively attempting to prevent abuse and neglect from occurring.

Failure to comply with this policy may result in a risk to the health and safety of adults with care and support needs as well as a negative reputational and financial impact on the organisation.

2. Purpose

The purpose of this policy is to demonstrate the commitment of Oxfordshire Youth to safeguarding adults and to ensure that everyone involved in Oxfordshire Youth is aware of:

- The legislation, policy and procedures for safeguarding adults
- The role and responsibility for safeguarding adults
- What to do or whom to speak to if they have a concern relating to the welfare or well-being of an adult with care and support needs.

To keep adults with care and support needs safe and establish safety for them, Oxfordshire Youth will:

- provide a setting where people feel listened to, safe, secure, valued, and respected.
- appoint Designated Safeguarding Leads to ensure a clear line of accountability with regard to safeguarding concerns.
- ensure all staff have been provided with up-to-date and relevant information, training, support, and supervision to enable them to fulfil their role and responsibilities in relation to safeguarding and protection for adults with care and support needs.
- provide a clear procedure to follow when safeguarding concerns arise.
- ensure effective and appropriate communication between all staff, volunteers and trustees.
- build strong partnerships with other agencies to promote effective and appropriate multi-agency working, information sharing, and good practice.

To ensure that its member organisations keep adults with care and support needs safe, Oxfordshire Youth will:

- ask our members to confirm that they have a safeguarding policy.
- provide our members with up-to-date policy templates.
- provide advice and guidance as and when requested, signposting to all referral pathways in our policies.
- record any concerns raised by our members and ensure that there has been follow-up as needed.
- encourage our members to complete a quality mark.

3. Scope

This Safeguarding Adults Policy and associated procedures apply to all individuals involved in Oxfordshire Youth, including Board members, staff and volunteers, freelance and agency staff, members, and to any person who accesses Oxfordshire Youth's services. This will include non-residents of YPSA, for example, visitors to Response properties.

We expect our partner organisations, including, for example, Changemakers, delivery partners and subcontractors, suppliers, and sponsors, to adopt and demonstrate their commitment to the principles and practice as set out in this Safeguarding Adults Policy and associated procedures.

4. Background

Oxfordshire Youth is in contact with adults with care and support needs throughout their day-to-day activities and is required by law, its regulator, and its organisational objectives to have clear policies and procedures on safeguarding and working with local agencies.

The Care Act 2014 states that local authorities must promote wellbeing when carrying out any of their adult care and support functions. Wellbeing is a broad concept and relates to areas which include protection from abuse and neglect, personal dignity and control, physical, emotional and mental health, suitable accommodation, and domestic and social wellbeing.

Local authorities have the lead responsibility for safeguarding adults. Their role is to ensure that there is a local Safeguarding Adults Board (see below), that they provide services to people who need care and support, and that they respond to concerns about harm and abuse. Adult services directors and lead councillors play a leadership role in safeguarding across councils, organisations, and communities.

Oxfordshire Safeguarding Adult Board (OSAB) is the lead agency with responsibility for coordinating safeguarding and conducting case management and reviews. It has expertise in handling cases of abuse, providing support and counselling to victims, and assisting the police with any criminal investigations.

The police and criminal justice system take the lead when a crime is suspected. The police also have a key role in promoting community safety (working with Community Safety Partnerships). Police and Crime Commissioners act to ensure that their force is effectively offering protection and access to justice for adults in need of care and support. The police are also statutory members of the OSAB.

5. Commitment and Actions

Oxfordshire Youth will aim to safeguard adults who have care and support needs, in order to protect and maintain their safety, wellbeing and dignity.

Oxfordshire Youth will achieve this by implementing a trauma-informed approach to safeguarding and working with our partners to apply their policy standards to the six principles as defined in the Care Act 2014 Statutory Guidance (empowerment, prevention, proportionality, protection, partnership, and accountability), which underpin safeguarding work. (See Appendix E the Care Act 2014)

6. Legal Framework

The legal framework that underpins the safeguarding adults with care and support needs are supported by the following statutory documents:

The Care Act 2014
The Mental Capacity Act 2005
The Rehabilitation of Offenders Act (1974)
The Police Act (1997)
Public Interest Disclosure Act (1998)
Criminal Justice and Court Services Act (2015)
Care Standards Act (2015)
The Protection of Vulnerable Adults Scheme
Safeguarding Vulnerable Groups Act (2006)
Equality Act (2010)
Oxfordshire Local Threshold of Needs
DOH Care & Support Guidance (2014/17)
Human Rights Act (1988)

Sexual Offences Act (2003)

7. Roles and Responsibilities

All staff must:

- Understand the different types of abuse and recognise the possible indicators (Appendix D).
- Undertake the required level of training for their role: Levels 2 and 3 Adults Safeguarding for all YPSA staff, Level 3 Adults Safeguarding for Trustee Lead, Lead DSL, and 2 x DSLs, on-call training and OY internal safeguarding training (available four times a year).
- Understand their responsibility to report any concerns that an adult with care and support needs is being, or is at risk of being, abused or neglected. This includes reporting any concern they may have regarding another staff member or volunteer's behaviour towards adults with care and support needs. All concerns should be raised to the organisation's Lead Designated Safeguarding Lead (DSL) or Local Authority Designated Officer (LADO) (Appendices A & B).
- If appropriate, liaise with other agencies, contribute to safeguarding assessments and attend relevant meetings / core groups / conferences.
- Record and store information legally, professionally and securely in line with organisational policies and procedures.
- Understand the line of accountability for reporting safeguarding concerns and be fully aware of the organisation's Designated Safeguarding Leads and their role within the organisation.
- Never assume that others are monitoring an adult with care and support needs. Others may have doubts, but you could be the only person taking action.

All individuals working on behalf of Oxfordshire Youth will follow the Oxfordshire Adult Safeguarding Board procedures/local authority guidance in all cases of abuse or suspected abuse. (These can be found at https://www.osab.co.uk.)

Board of Trustees

Oxfordshire Youth's Board of Trustees is ultimately accountable for ensuring the safety of all services provided by Oxfordshire Youth, including the implementation of effective safeguarding procedures. Safeguarding is an agenda item at every Board meeting.

The Charity Commission states that safeguarding is the responsibility of all trustees.

In addition, the Lead Trustee for Safeguarding has three main sets of duties related to safeguarding in addition to their wider responsibilities as a trustee. These are outlined in the National Council Voluntary Organisations guidance:

https://www.ncvo.org.uk/help-and-guidance/safeguarding/specialist-guides/certain-roles/trustees/lead-responsibilities/ and cover:

- Strategic duties
- Effective policy and practice duties
- Creating the right culture duties

The Lead Trustee provides a link between the Lead Designated Safeguarding Lead (Lead DSL, CEO) and the Board. The Trustee Safeguarding Lead chairs the Safeguarding, Quality and Performance (SQP) subcommittee.

This subcommittee receives and disseminates bi-monthly safeguarding reports to the Board. The report contains a resume of all safeguarding activity for each quarter, serious incidents, concerns, referrals, policy updates, and training. The committee also ensures that any concerns are cross-referenced with the risk register and reviews any actions taken.

The Lead DSL (CEO) is responsible for overall safeguarding oversight.

- This includes GDPR compliance, oversight of all safeguarding and risk escalation processes, referrals, and ensuring all policies, procedures, and practice guidance are adhered to. Reviews of these will take place annually.
- They will report at least bi-monthly to the Trustee Safeguarding Lead, or in the event of an adult safeguarding referral or a criminal investigation.
- They are the individual management review author for cases of domestic homicide, sudden death, and/or mental health reviews.
- They will monitor and review staff and volunteer training and induction.
- They must be notified immediately when significant safeguarding issues arise.

Designated Safeguarding Leads (Head of Youth services, YPSA Team managers, YPSA operations manager)
have responsibility for:

- Chairing a monthly safeguarding meeting and reporting to the SQP subcommittee
- Triaging safeguarding concerns when they arise
- Ensuring that safeguarding actions are established, recorded, and completed.
- Overseeing that safeguarding concerns are appropriately referred to the Adult Safeguarding Board.
- Maintaining detailed and accurate written records of safeguarding and protection concerns.
- Supporting staff with debriefing after safeguarding concerns are raised.
- Supporting compliance with safer recruitment practices.

- Ensure constituent members/partners have access to the Oxfordshire Youth safeguarding adults policy and establish a clear set of expectations for constituent members internal safeguarding arrangements and carry out due diligence processes as stipulated in the due diligence guidelines
- Establishing, maintaining, and ensuring robust safeguarding practices for young people and staff are in place and regularly reviewed in line with policy change and OSAB guidance.
- Overseeing the practical actions to support safeguarding, such as moving young people into available voids, reviewing risk assessments and support plans, raising safeguarding referrals, liaising with relevant agencies, and providing regular communication and updates for relevant staff (during the day and at night).
- Recognising that promoting the welfare and safeguarding of children, young people, and adults is everyone's business, and accessing training and supervision as appropriate to the role.
- Supporting the organisation in ensuring young people and adults are protected from abuse or the risk of abuse and their human rights are respected and upheld.
- Ensuring concerns are responded to appropriately in line with OY's Safeguarding Adults Policy and Safeguarding & Child Protection Policy and interagency safeguarding procedures.

Active and serious safeguarding concerns are reviewed regularly. Please see Appendix C, Oxfordshire Youth Need to Know, for meeting structures throughout the charity.

Progression Coaches have responsibility for:

- Recognising that promoting the welfare and safeguarding of young people and adults is everyone's business and accessing training and supervision as appropriate to the role.
- Supporting the organisation in ensuring young people and adults are protected from abuse or the risk of abuse and their human rights are respected and upheld.
- Ensuring concerns are responded to appropriately in line with OY's Safeguarding Adults Policy and Safeguarding & Child Protection Policy and interagency safeguarding procedures. See Appendix F – OY INFORM (CRM) Safeguarding Process.

All visitors in a professional capacity will have access to a copy of this policy and will have the opportunity to consider and discuss the contents. The policy will also be available to parents, carers and guardians on Oxfordshire Youth's website.

8. Organisational Policies and Procedures

This policy should be read alongside the following organisational policies and guidance:

- Safeguarding and Child Protection Policy
- Confidentiality Policy
- Code of conduct for staff and volunteers
- Media Policy
- Data Protection and GDPR Policy
- Oxfordshire Youth Privacy Notice
- Incident Threshold Matrix
- Whistleblowing Policy
- Lone Working Policy
- Serious Incident Policy
- OY Incident Management Plan
- DSL and Internal Safeguarding Escalation Flowchart

9. Whistleblowing

We recognise that adults with care and support needs cannot be expected to raise concerns in an environment where staff fail to do so. All staff should be aware of their duty to raise concerns about dangerous or illegal activity, or any wrongdoing within their organisation. (Please see Oxfordshire Youth's Whistleblowing Policy.)

10. Allegations against Staff/Volunteers

If any allegation is made or suspicions emerge regarding any member of staff/volunteer of the organisation, this should be reported to the Lead Designated Safeguarding Leads. The concern must also be reported to the staff member's line manager, who should take advice from the Lead Designated Safeguarding Lead and HR.

If an allegation concerns a Designated Safeguarding Lead, the report should be made to the CEO. If the allegation concerns the CEO, then the report should be made to the People and Culture Manager, who will contact the trustees.

Full details of the process that would be followed for allegations against staff or volunteers can be found in the Allegation Management Policy.

11. Confidentiality

We will respect confidentiality at all times and will not share any information given in confidence unless justified by the assessed risk to the adult at risk or required by law.

We will discuss our approach to confidentiality with the adult where there are safeguarding concerns. We will be honest and explain that information might need to be shared with other organisations in order to resolve a safeguarding issue.

We will ensure that all staff members have received GDPR training and that GDPR legislation is followed when sharing information.

12. Complaints

Service Users who do not feel satisfied with our service in relation to safeguarding may wish to make a formal complaint. Oxfordshire Youth has a Complaints Policy providing information about how to complain about our services. Alternatively, a Service User may also wish to contact Oxfordshire Safeguarding Adults Board if they feel that Oxfordshire Youth has not provided an adequate service.

13. Safer Recruitment

Safe recruitment is central to the safeguarding of adults and children. All organisations which employ staff or volunteers, to work with adults with care and support needs and children and young people, have a duty to safeguard and promote their welfare. This includes ensuring that the organisation adopts safe recruitment and selection procedures which prevent unsuitable persons from gaining access to vulnerable children and adults.

Oxfordshire Youth's approach to safe recruitment is set out clearly in the Oxfordshire Youth Safer Recruitment Policy which explores this topic in more detail and should be read and used in conjunction with this policy.

14. Monitoring and Review

This policy will be reviewed every three years. All staff have access to this policy and familiarise themselves with the policies during induction into OY and throughout their tenure.

Safeguarding processes, procedures, and logs will be reviewed every year by Oxfordshire Youth's Designated Safeguarding Leads and Lead Safeguarding Trustee.

Oxfordshire Youth will complete an annual self-assessment to appraise their safeguarding practice against OSCB standards.

OCC will complete a yearly audit which will include a full safeguarding review

This safeguarding policy is adopted on behalf of the Trustees by:

Name: Eluned Harris

Position: Safeguarding Trustee reporting to the Programs and Impact Sub-Committee

Signature:

Date

Active and serious safeguarding concerns are reviewed regularly. Please see Appendix D, Oxfordshire Youth Need to Know, for meeting structures throughout the charity.

Safeguarding Escalation

OY Safeguarding Incidents

- To be reported to DSL – Head of service/CEO or senior manager
- Head of service will report all NTK Incidents to CEO and Programs and Impact subcommittee
- CEO will report all to Trustee board committee

YPSA Safeguarding - Serious Incidents

- To be reported to DSL's – YPSA Operations manager and YPSA Team managers. Head of Youth services will have overall DSL/SG oversight
- The Head of Youth services will then report all SI/NTK to the Programs and Impact committee / Response and OCC, if deemed necessary.

Appendix A

Incident threshold matrix

	Reportable to:	Deputy Manager/Shift lead for information	Operations/Team Manager	Operations Manager/Head of Service Delivery
Major Category	**Sub-Category**	**Near Miss or CCIA** to be completed and added to Inform and handovers if necessary	**Requires consultation or Safeguarding alert being raised.** CCIA to be raised and action taken and logged on Inform and add to day/night handovers	**Reportable.** Immediate Email Notifications; All SI/NTK to be reported to DSLs- Follow SI Policy
Accident	Amputation			Amputation of an arm, hand, finger, thumb, leg, foot or leg
Accident	Burn (Heat, Chemical and Radiological)	A burn or pinch which does not require any medical attention or first aid. or a near miss	A burn which covers less than 10% of whole body, requires medical attention or first aid from OY	A burn which covers; 10% of the whole body, causes signifcant damage to sight, respiratory system or other vital organs.
Accident	Entrapment / Pinch		Incident causing injury to staff as a result of entrapment or pinch, example fingers caught while transporting a load, hand or arm trapped between objects etc. Injury to staff member as a result, or environmental issues that if not rectified suggest change of recurrence	Any significant injuries, Resident or staff member unable to return to work for >7 days as a result
Accident	Fracture	Fracture to finger, thumb or toe - Resident and/ or staff member	A diagnosed or suspected (Confirmed by a doctor only) broken bone - Resident and/ or staff	

Accident	Impact, Collision & Crush injury		Any incident involving impact or collision, any vehicular incidents. Suspected injury to staff member as a result of the incident.	Any significant injuries to Staff and/ or Residents, including injuries to the brain, internal organs which are a result of a work - related crush injury
Accident	Injury leading to loss of sight			An injury which that causes permenant loss of sight or a reduction in sight in one of both eyes
Accident	Loss of consciousness caused by head injury or asphyxia			Any accident where staff and/ or Residents have loss of conciousness Attempted suicide resulting in hanging - NTK
Accident	Manual Handling		Any incident involving manual handling, irrespective of load and process. Suspected injury to staff members as a result of the incident.	Any significant injuries to Staff and/ or Residents
Accident	Needlestick		Any needlestick injury.	Any needlestick injury with suspected exposure to blood borne viruses.
Accident	Scalping			Any incident where staff and/ or Residents have experienced scalping. For example, this involves traumatic separation or peeling of skin from the head due to an accident

Accident	Slips, Trips & Falls		Any fall that results in injury or changes required to the working environment (staff, visitor or Resident). Any fall where significant injury or where recurrence is highly suspected due to the environment. Multiple incidents where: The care plan has not been fully implemented. It is not clear that professional advice or support has been sought at the appropriate time. e.g. Care Home Support Service/Falls Service. Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures.	Any significant injuries to staff and/ or residents. Any fall resulting in significant injury or death where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures.
Accident	Struck By		Struck by a falling or moving object, e.g. a door left to swing back into someone, heavy objects falling off unsafe shelving. Injury to staff members as a result, or environmental issues that if not rectified suggest chance of recurrence.	Any significant injuries, Resident or staff member unable to return to work for >7 days as a result
Data Breach	Data breach		A breach of security leading to the destruction, loss, alteration, unauthorised disclosure of, or access to, data that is commercially but not personally sensitive. A breach of security leading to the destruction, loss, alteration, unauthorised disclosure of, or access to, data that is personally sensitive. COMPLETE Breach report and CCIA if relevant	A breach of security leading to the destruction, loss, alteration, unauthorised disclosure of, or access to, data that is personally sensitive and is likely to result in a high risk to the rights and freedoms of individuals.Complete breach form and CCIA if relevant
Incident	Breaches of security – linked to H&S		Unknown visitors repeatedly being found in the communal area/Resident room. Unwanted visitors to the property. Lax access management leading to home invasion/unwanted visitors entering property.	Forced entry attempt into services, Resident properties or staff rooms. People cuckooing in property and illegal activty taking place. Any needle related injury or finding of a needle in a communal space/Resident

				room.
Incident	onmental / W		Incidents which could have effects on the environment e.g. unsafe disposal of chemicals. Any incident where waste is disposed of incorrectly, e.g. clinical waste not in appropriate waste streams. Injury to staff member as a result, or environmental issues that if not rectified suggest change of recurrence.	Any significant injuries, Resident or staff member unable to return to work for >7 days as a result. Or significant environmental events.
Incident	Exposure		Any uncontrolled exposure to substances hazardous to health, these include biological agents and bodily fluids. Suspected injury to staff member as a result of exposure to hazardous substance.	Any significant injuries.
Incident	Controlled Substances	Non-class a paraphernalia noted in room where substance misuse is already understood, and risk assessments exist	Witnessed exchanges of dubious substances between or to Residents. Needles found on site. Resident with known BBV infection acting neglectfully with bodily fluids. Use of drugs in Response property. Witnessed a drug deal. Sequence of class A paraphernalia being found in Resident room.	Sequence of class A controlled substances in communal areas. Evidence of cuckooing or county lines involvement.
Incident	County Lines		Resident discloses events that suggest involvement in county lines e.g. new clothes, rent paid in advance. Visitors are known to police, staff or other to be involved in county lines. Significant evidence of county line involvement.	Police prosecute county lines behaviour. Serious ASB resulting in arrests or neighbour complaints resulitng in police visit

Incident	Criminal behaviour	Resident discloses criminal exploitation to others. Threat of a violent act that is not against another vulnerable person, if not a risk previously covered and managed via their RMP or very out of character.	Any criminal act not covered under other categories such as verbal aggression or discriminatory behaviour or destruction of property by visitors. Resident discloses involvement in criminal behaviour due to coercion or exploitation. Resident discloses fear if they do not comply with demands.	Forced entry attempts made on staff rooms with intent to harm. Injury/harm to Residents or staff.Significant involvement in criminal behaviour. Any act of actual or attempted physical violence. Any situation where a Resident or staff member is held hostage or kept against their will. Death of a Resident or staff member. Preparation of a violent act e.g. Possession of a weapon or implement ready for use as a weapon. Approaching others with a weapon or implement ready for use as a weapon.
Incident	Discriminatory & Verbal Abuse	Isolated/ one off incident of verbal abuse, which is motivated by prejudicial attitudes towards a person's protected characteristics but no distress caused to recipient, and where this is outside of someone's usual presentation.	Any other act of prejudicial behaviour that causes distress to the recipient or is considered in breach of legal definition of hate speech/protected characteristic. Persistent and ongoing targeted discriminative behaviour towards another vulnerable adult or staff. Denial of civil liberties e.g. voting, making a complaint.	Discriminatory abuse that results in the victim seriously harming themselves. Systematic and or organisational levels of abuse. Hate crime resulting in injury/emergency medical treatment/fear for life. Hate crime resulting in serious injury/attempted murder/honour-based violence. Inequitable access to service provision as a result of diversity issue. Being refused access to essential services.

				Humiliation, threats or taunts on a regular basis.
Incident	Domestic Abuse - witness		Resident is witness to a domestic abuse/violence incident.Resident is witness to sustained domestic abuse/violence events.	Resident is witness to significant or major domestic abuse/violence event. GBH/Serious assualt
Incident	Domestic Abuse	One off incident with no injury or harm experienced. Occasional taunts or verbal outbursts where the service user has capacity to decide whether to have the case referred on.	Unexplained marking or lesions or grip marks on a number of occasions. Controlling or coercive behaviour is witnessed . Frequent verbal outbursts that cause some distress or some level or harm. Sexual assault or humiliation where the service user has capacity and does not want to be referred. Experiences occasional episodes of fear of the alleged perpetrator. Subject to severe controlling behaviour e.g. finances/medical.	Subject to regular violent behaviour. In constant fear of being harmed. Sex without valid consent (rape). FGM female genital mutilation. Honour based violence &/or forced marriage. Service user denied access to medical treatment/care/vital equipment to maintain independence by alleged abuser. Frequent physical outbursts that cause distress or some level or harm. Subject to stalking/harassment.
Incident	Fire Actual		Any fire (including evidence of fire) regardless of cause where no harm results. Any fire (including evidence of fire) regardless of cause where no harm results but there is significant damage.	Any fire regardless of cause where harm results. Any fire resulting in the disruption of services or arson - NTK Report to CEO
Incident	Financial Abuse	Failure to comply with policies and guidance not resulting in loss of money	Failure to comply with policies and guidance resulting in loss of money. Evidence or suspicion of financial abuse of a Resident by a third party. Any evidence of financial impropriety resulting in loss of money.	Provable theft or fraud from a Resident, others or organisation. Evidence of financial abuse of Resident by staff.
Incident	Fire Safety		Any incident that involves damage to safety equipment, covering of smoke detectors, blocking fire exits etc. Unwanted/ Recurrent fire alarms due to ASB/ fault/ misuse	Recurring neglect or damage to fire safety equipment increasing risk to life in the event of a fire. Fire

Incident	Grooming	Resident has been targeted in past	Sexualised behaviour, language or and understanding of sex that is not appropriate for age. Going missing for periods of time. Real threat is identified – overheard or text/email.	Significant and harmful activity linked to grooming.
Incident	Hoarding		Excessive accumulation of items posing potential risk to Health & Safety	Excessive accumulation of items prevents safe access and exit from the property, blocking fire escape routes, and posing risk to structural safety of the building.
Incident	Infestation		Evidence of any insects, rodents, or other pests such as; Bed bugs, cockroaches, rats.	Presence within or around accomodation of any insects, rodents or other pests in such a number as to constitute a menace to the health, safety or welfare of the occupants or the public.
Incident	Medication errors	Staff failed to prompt resident to take appropriate medication and no harm was caused. Staff prompted or assisted a Resident with incorrect medication, incorrect dosage or at the incorrect time and no harm was caused. Resident made a self-administration error with medication, which does not result in harm.	Staff failed to prompt resident to take appropriate medication and harm was caused. Resident missed medication or gave incorrect medication due to problems with medication or prescription inside the project's control. Resident missed medication or gave incorrect medication due to problems with medication or prescription outside project's control. Resident made a self-administration error with medication, which results in harm. Medication which cannot be accounted for during stock/ checks and auditing. Pattern of recurring errors. A MAR chart error which has resulted in a near miss or resulted in harm. Administrative errors, including issues with storage, out of date mediation being in	Falsification of medication records A medication error that has resulted in serious harm (Regardless of which agency administered it) A systematic failing (By Response or the dispenser) which has resulted in harm

		A single missed MAR chart signature	circulation, failure to implement medication changes within our control.	
Incident	Missing Person	Resident location is unknown for 24 hour period, but the risk assessment indicates that they are not believed to be at risk of harm to self or others	Resident location is unknown, for more than is considered safe given their individual risk profile; particularly where there is known risk of harm to/from self or others. Resident location is unknown and there is a forensic aspect to their risk profiles that requires alerting their clinical team.	Resident location is unknown, for up to 24 hours where there is a serious or forensic risk of harm to/from self or others according to their risk profile. Any Resident whose whereabouts is unknown for 48 hours and this is considered highly unusual, and there is a known risk of suicide or serious harm to self or others.
Incident	Modern Slavery		Any direct disclosure of slavery e.g. appears under control of another, lives in the work place, risk of physical/psychological harm.	Any direct disclosure of slavery e.g. Resident being encouraged to participate in unsafe or criminal act. Regularly moved to avoid detection. Not in possession of ID or passport (when they previously had this) Subject to forced marriage. Unable to access medical treatment/care/equipment required to maintain indeOIKpendence. Under control of others e.g. dealers or pimp for prostitution.
Incident	Online Safety Incident		Resident discloses incident online that puts them at risk (sexualised content, bullying etc).Continued exposure to online content that puts the person at risk.	Significant events online that lead to risk of harm or trauma

Incident	Organisational Abuse	Lack of stimulation/ opportunities to engage in social and leisure activities. Resident not enabled to have a say in how the service is run. Denial of individuality and opportunities to make informed choices and take responsible risks. Support/care-planning documentation not person-centred/does not involve the Resident or capture their views. Single incident of insufficient staffing to meet all Resident needs in a timely fashion but causing no harm	Rigid/inflexible routines that are not always in the Resident's best interests. Resident's dignity is occasionally undermined e.g. lack of privacy during support with intimate care needs, pooled under-clothing. Recurrent bad practice lacks management oversight and is not being reported to commissioners/the safeguarding service. Unsafe and unhygienic living environments that could cause harm to the Residents or have caused minor injury requiring no external medical intervention/consultation	Staff misusing position of power over Residents. Over-medication and/or inappropriate restraint managing behaviour. Recurrent or consistent ill-treatment by Response to more than one Resident over a period of time. Recurrent or consistent incidents of insufficient staffing resulting in harm requiring external medical intervention or hospitalisation of Resident. Recurrent incidents of insufficient staffing resulting in some harm
Incident	Overcrowding		Evidence of people who are not listed in the tenancy or licence agreement using the accommodation as their principal home.	
Incident	Partnership issues		Clinical team not taking responsibility for supporting teams where police feel unable to arrest due to signs of mental illness. Unsafe unplanned discharge. Repeated cancellation of professional meetings with Residents or staff following escalation of concerns/safeguarding issues.	Out of hours teams not responding to red RAG incident. Partner not responding to an urgent Red RAG issue as expected and agreed due to their role/responsibility/authority.

Incident	Prevent radicalisation		Residents have engaged with online or in person content that seeks to indoctrinate them in extremist viewpoints. Residents have attended extremist or radicalised meetings (i.e. political or religious view points) or are actively part of an online community that spreads and incites extreme messages.	Significant involvement in extremist communities or actions
Incident	Physical Health & Abuse	An ambulance called for a resident due to deterioration detected. Resident admitted to general hospital due to physical health problem(s)	Signs of physical abuse of the Resident detected (e.g. bruising or cuts). Residents declined medical intervention and capacity to do so is uncertain or has a history of fluctuation in capacity when tested. Assault by another resident/ Resident – not serious/ no injury required	Residents sustains significant injury resulting in hospitalisation. Serious assault by another resident/Resident. Death of a Resident. Staff fail to seek NHS primary or secondary care intervention for known physical health problems or where capacity may be in question
Incident	Psychological & Emotional abuse incl. Bullying	Resident discloses unkind comments that have an emotional impact. Unkind comments are witnessed. Resident is rude to staff or other Residents – frequency irrelevant unless severe and sustained.	Severe and sustained verbal outbursts that cause distress to others. Credible threats to harm staff or other Residents. Bullying of a Resident regardless of source that results in a noticeable and concerning change in victims behaviour/outlook e.g. withdraws, isolation, not eating or sleeping. Treatment or lack of action that undermines dignity.	Denial of basic human rights. Bullying that results in the victim experiencing physical and/or emotional harm. Cuckooing.
Incident	Self-Injury	Self-injurious behaviour by Resident with previous history resulting in superficial harm. Suicidal ideation discussed with staff	Occasional self-harm behaviour resulting in moderate harm. Support in place to manage incident and risks	Self-injurious behaviours by any Resident resulting in severe harm; permanent or not. Serious injury which is life-threatening (attempting suicide) - NTK-SI. Death of a Resident - NTK Report to CEO Credible evidence of suicidal intention e.g. plan, note, equipment.

Incident	Self-neglect	Isolated incidents of self-neglect where the Resident is aware and will engage with staff to resolve. Ongoing low level self-neglect that is understood to be a part of the presentation and preference of the individual where there is no immediate risk of harm.	Low level self-neglect that is understood to be a part of the presentation and preference of the individual where there is immediate risk of harm, and the Resident does not have capacity. Self-neglect that presents a serious risk of harm to the Resident regardless of capacity.	Self-neglect oriented RIDDOR reportable infections. Neglect that results in serious harm to the Resident where the service was aware but did not respond.
Incident	Sexual Abuse	Resident makes inappropriate sexualised remarks to staff or another Resident.	Deliberate indecent exposure with apparent sexual intent. Non contact sexualised behaviour which causes distress. Sex between Residents with apparent exploitative characteristics. On-going sexual harassment of another Resident. Any allegation of attempted sexual exploitation.	Alleged Rape, sexual assault, paedophilia whether Resident or another person. Allegation of sexualised behaviour to a Resident from a person in a position of trust.
Incident	Staff neglect	Unplanned breaks in support or care that are identified and will be rectified with no harm or concerns raised by Resident	Unplanned break in support or care programming where the Resident has concerns or is harmed in some way by the omission. Signs of lack of care-e.g. dehydration, malnutrition. Refusal of medical treatment. Insanitary property conditions. Self neglect causing health and safety risks. Repeated safeguarding alerts on the same issue not being responded to by the safeguarding team or senior management. Referral to Safeguarding team - CCIA	Danger to life (self or others) due to self-neglect. Deliberate witholding of food/drink or care. Repeated safeguarding alerts on the same issue not being responded to by safeguarding team or senior management and resulting in harm to the Resident(s). Failure to arrange access to life saving care. Failure to intervene in dangerous situations where Resident lacks capacity.

Incident	Tenancy management	One off or very occasional issues relating to anti-social behaviour (ASB) as defined in ASB policy noise disturbance e.g. noise, unsavoury behaviour.	Lax front door management leading to home and other Resident being at risk. Unknown visitors and/or drug dealers repeatedly being found in property or service. Damage to property (intentional or not) with impact on the benefit and welfare of self or others. One or more concerns relating to ASB. Formal complaint (s) received regarding ASB.Issuing of Acceptable behaviour contract. Formal warning process commences.	Issue of NTQ. Forced entry into services and Resident homes. Damage (intentional or not) to property leading to disruption of services. Other legal proceedings e.g. injunction, closure orders, possession.
Incident	Media or press	Issues related to ASB but being managed - CCIA one off	ASB or neighbour complaints which result in on going concerns with YP and impacts to the local community.	Sharing of videos within the service which causes negative press or attention to media or MP/councils. A serious incident which causes negative media attention - NTK Report to CEO

Serious Incident

The definition - High risk incidents are defined as those where there is a significant degree of potential or actual harm caused, including serious injury or death. Criteria include the need for an ambulance or other emergency service to be called, or incidents requiring DSL or Board involvement, such as serious violence, the death or serious injury of an individual, serious misconduct, a significant loss of funds, significant public concern, or data breach.

Examples of a ‘red concern’ (Serious Incident) are:

- A young person/vulnerable adult is believed to be at immediate risk as they have been thought to have suffered abuse (physical, sexual, emotional) action needs to be taken now to remove them from the ris
- Anyone who is seen with or believed to be in possession of a weapon
- Any needlestick injury with suspected exposure to blood borne viruses
- A young person/Vulnerable adult has been person missing from home for over 72 hours
- A young person/vulnerable adult has experienced or witnessed intimate-partner violence (domestic and/or sexual violence)
- A young person/vulnerable adult has been the victim of violence and or aggressive behaviour.
- A young person/vulnerable adult is believed to be a victim of exploitation or Modern-day slavery (criminal, drugs, sexual, radicalisation or forced servitude)
- A young person/vulnerable adult requires emergency medical treatment either from an accident or deterioration in mental health that requires treatment.

360 to complete Serious Incident reporting Form

NTK –Serious Incident

The Lead DSL - CEO must be informed immediately:

- Concerns about safeguarding are likely to attract media interest.
- Death of a young person or anyone we are working with, including the death of a staff member, a serious incident, or a near miss that could have resulted in death or Sudden Death

Follow the serious incident process.
Call the relevant emergency services (police and ambulance services)

Do not rely on emails/voicemails.
A verbal conversation is required.

If disclosure is made, record information in writing. Do not presume or ask any leading questions. Seek clarity as required.

Never promise secrecy but assure the child/young person/vulnerable adult that they did the right thing by sharing information and make clear that you will be seeking advice/support/action.

Ask them how they would like information to be shared but do not make any promises.

Depending on the nature of the concern, you may need to call the police (999 for emergency response, 101 for non-emergency situations) or submit an intelligence- sharing form to the police.

All relevant professionals to be updated (i.e. social care, health)

All relevant information and actions are to be recorded and uploaded onto Inform CRM system. 360 to complete Serious Incident reporting Form

Appendix B - Child Protection and Safeguarding Procedures

What to do if you are concerned about a young person or adult

You may become concerned about the safety or welfare of a vulnerable young person or adult in a number of ways:

- The person may tell you.
- The person may say something that worries you.
- A third party may voice concerns.

If a safeguarding concern is suspected:

- Emergency Situations: Where an immediate police or medical response is required e.g. if the person at risk is in immediate danger of harm/injury, emergency services 999 should be immediately contacted and the Designated Safeguarding Lead is then contacted at the earliest opportunity once it is safe to do so.
- For all other safeguarding concerns, the safeguarding concern must be reported to a Designated Safeguarding Lead. The Designated Safeguarding Lead will triage the safeguarding concern and lead on ensuring follow up actions are assigned, documented and completed. The Designated safeguarding lead will make a professional judgement on what constitutes to significant harm by referring to the traffic light system chart and will triage the safeguarding concern and lead on ensuring follow-up actions are assigned, documented and completed.
- Observations, conversations or concerns will be recorded. These should include:

- Details of the concern and nature of risk
- Facts (who, what, where, when, how)
- Available supporting evidence, e.g. a summary of what has been disclosed
- Details of all actions taken
- A detailed outline of outcomes and follow-up actions required

Receiving a disclosure

- Receive - Stop and listen if someone wants to tell you about suspicions of abuse. Listen quietly and actively, giving your undivided attention. Allow silences when needed. Do not show shock or disbelief and take what is said seriously.
- Reassure – Stay calm and give reassurance to the person. Explain to the person that they have done the right thing by telling you and that what has happened is not their fault. Never promise confidentiality, but provide assurance that the person has done the right thing.

- React – Establish the facts of what has happened but do not ask leading questions. Keep questioning open, e.g. 'Is there anything else you want to say?' or 'Can you tell me more about that?' Ask "Who", "What", "When", "Where", and "How" questions. Do not criticise the perpetrator. Explain to the person what you will do next, e.g. you will need to pass this information to the Designated Safeguarding Lead. Make it clear whether you are seeking advice/support/action. Ask them how they would like information to be shared but do not make any promises. It is almost impossible to say what might happen in specific cases if there is a disclosure, so focus on exploring and mitigating fears, and being reflective and supportive.
- Record – If possible, make brief notes about what the person is telling you as they are speaking. If this is not appropriate, write down what was said as soon as the person has left. Record the date, time, place, your name and role, and what was said (rather than your interpretation of it). Use the person's language wherever possible. **Note**: In most cases it is more appropriate to listen and record immediately afterwards.

  Notes should include:

- The date, time and method of contact (i.e. telephone, in person, etc.).
- Any allegations recorded using the client's own words. Reflect the language and vocabulary of the person. Include who, what, where, when, how.
- The rationale behind any professional decision-making and actions. Clear recording of decisions is the basis of accountable practice.

If any other professionals across agencies are contacted to discuss safeguarding concerns relating to the disclosure, then it is important to keep records of the following:

- Date and time of contact
- Name and their job title
- The reason that you spoke to the professional
- Whether this was a consultation where you did or did not name the client
- What information was shared and what the key points of the discussion were
- What actions you agreed on the basis of the discussion, along with timescales and responsibilities attached to these
- Any decisions or plans to discuss/not discuss any further safeguarding actions with the client
- Whether it has been necessary for the conversation to occur without the client's knowledge or consent and reason for this decision
- Any follow-up to actions

- Report – Report the incident to your Designated Safeguarding Lead as soon as possible following the Incident threshold matrix. If the matter is regarded as critical it should be referred to Emergency Services 999.
- Discuss and Debrief - Discuss the disclosure with the Designated Safeguarding Lead. This is a valuable way both to gain knowledge and skills around safeguarding practice,

and an opportunity for clinical support. Further information about this process can be found in the Post Incident Support Policy.

It is always best practice to share information with the adult's knowledge and consent; however, there may be situations when confidentiality must be broken in order to safeguard others. Examples are given below of when confidentiality may be required to be broken.

- The adult is an imminent and violent threat towards themselves or others.
- There is immediate danger. If a person has clearly told you that they plan to take their life within the next 24 hours, or has already taken action which puts their life in danger, but does not want to seek support themselves and does not give their consent for you to do so – call 999.
- Sharing information is necessary to facilitate the person's care across multiple providers.
- Sharing information is necessary to treat the person.
- There is a safeguarding issue that concerns a child. Follow your safeguarding policy for children and young people.

Out of Hours

Oxfordshire Youth operates a duty manager system via 360, which means that there is someone available for you to contact regarding safeguarding concerns at any time of the day or night.

When a NTK/serious incident or emergency concern occurs outside normal working hours, it is expected that the staff member will contact 360. More information about what would constitute a serious incident or concern is included in the Need to Know guidance document (see Appendix C), Serious Incident policy and Incidents threshold matrix

In the event of a NTK and serious incident or emergency concern, you must report directly via telephone call to the 360 team when out of hours. The staff members should then follow the Incident and reporting process. See on call process and serious Incident policy, both are located in the G drive, Employee Policy Portal. All Serious Incidents must be reported to Response - Follow Serious Incidents policy for YPSA Incidents in the G drive and Employee Policy Portal

Appendix C: On Call Process

On Call Process for Young People's Supported Accommodation (YPSA)

Review Frequency: Every 3 years

Person Responsible for this Policy: Natalie Petryszyn – Head of YPSA

Overview

This procedure has been written to give all Oxfordshire Youth DSLs and Night progression coaches a clear and confident understanding of how the YPSA on-call system works and what to do in an emergency situation. It should be read in conjunction with the safeguarding policies, including the Need to Know process and procedure.

Purpose

The purpose of this policy is to demonstrate the commitment of Oxfordshire Youth to safeguarding adults in YPSA and to ensure that all Night progression coaches and 360 are aware of:

- The legislation, policy, and procedures for safeguarding adults
- The role and responsibility for escalating concerns with regards to NTK and serious incidents and supports managers to raise and report effectively, and to support night progression coaches during their shifts concerning incidents and escalation
- What to do or whom to speak to if concerns and serious incidents are raised during any on-call shifts.
- The Need to know process that needs to be followed.

Scope

The On-call policy and procedure sits alongside the safeguarding adult policy and applies to all managers and OY staff involved within the on call process.

- To establish a clear and efficient on-call management system that prioritizes the safety and well-being of young residents.
- To ensure timely response and resolution of emergencies or urgent situations during the designated on-call hours.
- To outline the communication protocols and escalation procedures for on-call managers and OY staff.
- It works in conjunction with the Safeguarding Adult Policy, reinforcing a comprehensive approach to safeguarding and support.

Compliance:

All OY and 360 Services staff are expected to adhere to the guidelines outlined in this policy. Non-compliance may result in disciplinary action in accordance with organisational policies and procedures.

On Call

360 on call contact number 01322 277 051

Oxfordshire Youth operates a duty manager system, which means that there is someone available for you to contact regarding safeguarding concerns at any time of the day or night.

Night Progression coach

When a NTK/serious incident or emergency concern occurs outside normal working hours, it is expected that the staff member will contact 360 Services. More information about what would constitute a serious incident or concern is included in the Need to Know guidance document (see Appendix C), Serious Incident policy, and Incidents threshold matrix

The Night progression coach will call 360 to inform them of the incident. 360 will then support the staff member to manage the incident and gain all relevant information needed to manage the incident.

Staff working at night time must directly call the out of hours on call service 360 to inform them of incidents/accidents/emergencies where immediate reporting needs to happen -

Need to Know (NTK) and Serious Incidents (SI)

When sending emails, please ensure that all messages begin 'Need to Know' in the subject heading, complete an CCIA report (please see OY In Form, CRM Safeguarding reporting Process for instructions.)

The night progression coach will ensure that they follow the necessary steps before the end of their shift in regards to reporting;

- Report verbally to 360 as soon as the incident occurs (follow guidelines and SG Policy)
- Complete CCIA and send NTK/SI email to 360 and include in the handover form
- Complete relevant updates for each Young person on Inform - risk assessments and safety plans
- Complete Night handover (Ensure all of the above actions/steps are taken before the end of your night shift)

360 - on call manager

Serious Incidents

- 360 should ensure they support the night progression coach to ensure the incident and risks are managed and monitored
- 360 to complete the Serious Incidents form and send to dsl@oxfordshireyouth.org
- 360 to receive any OOH on call emergency calls which are not answered by OY Night progression coach and addressed appropriately according to OY policies

NTK

- 360 should then ensure they support the night progression coach to ensure the

incident and risks are managed and monitored
- 360 will then call the CEO to update them of the NTK.
- 360 will complete the Serious Incidents form; G:\Shared drives\YPSA\Serious Incidents\SeriousIncidentsreportingfrom and send to dsl@oxfordshireyouth.org
- 360 to complete handover and send to dsl@oxfordshireyouth.org

A conversation needs to happen. Do not rely solely on email. You must be sure the message has been received and understood. Once a DSL is aware, they are responsible for assessing whether to alert others.

CEO - the CEO or the Head of youth services is then responsible for calling a NTK meeting following serious incidents policy and process
360 - to provide an update of each on call shift including all incidents

Lead DSL - Review meeting
- Will arrange a Serious incident review meeting the next day or within 24hours of the SI
- Serious Incident review meeting template to be completed and saved here; G:\Shared drives\YPSA\Serious Incidents

Response reporting
- Head of youth services or Operations manager to email response overview and actions emails for each SI/NKT to include Serious incidents review meeting document

DSL Escalation contact details

On call number

1. CEO Jodie Llyoyd Jones number (07718 476 074) - NTK
2. Head of Youth Services Natalie Petryszyn Number (07821 106 859)
3. Ademola Adediran number (07828 390 802)
4. Susan Hill number (07727 175 540)

Emergency calls

Oxfordshire Youth's on call system does not replace the emergency services and emergency calls should be given priority.

101 – Non emergency

You should call the non-emergency number to request a welfare check where you do not feel someone is in immediate risk of harm, report a young person missing where you do not feel there is an immediate risk of harm, report a crime that he already taken place and you do not feel poses as serious risk of harm.

999 – Emergency

You should immediately call 999 where there is an immediate risk of harm, a crime is being committed or if you ever instinct feel you have lost control of a situation. Staff to follow Need To Know process in this

situation with regards to incidents

Useful numbers

- Oxfordshire County Council Emergency Duty Team: 0800 833408
- AD Heating will be picking up all emergency repairs
  AD Heating can be contacted directly on 0333 567 2100
- 360 on call contact number 01322 277 051

Appendix D
Oxfordshire Youth Serious Incidents and Need to Know

Purpose

Serious Incidents

A serious incident extends beyond a standard incident in terms of potential impact on an individual or the organisation. This is defined as:

'High-risk incidents are defined as those where there is a significant degree of potential or actual harm caused, including serious injury or death. Criteria include the need for an ambulance or other emergency service to be called, or incidents requiring DSL or Board involvement, such as serious violence, the death or serious injury of an individual, serious misconduct, a significant loss of funds, significant public concern, or data breach.

Need to Know Incidents

This Need to Know (NTK) document provides simple guidance to ensure that the right people are alerted about serious incidents quickly. All areas in this document are classed as red rag rated, high risk, and are important to be raised with the relevant people within 12 hours, or immediately where stated below.

Why do they need to know?

- So that DSL, OY managers and OY Trustees can comply with legislative responsibilities and requirements relating to contract requirements, health and safety, data protection and safeguarding of children, adults with care and support needs, and staff.

- So that OY managers, DSLs, and OY Trustees are swiftly apprised of the nature and number of high-level risks and incidents being responded to by staff at any particular time.
- So that OY managers, DSLs, and OY Trustees are genuinely accountable, share the responsibility for taking appropriate action, and can provide support where necessary.
- So that any emerging patterns and trends can be spotted and trigger strategic action.

Guidance for OY staff

The alert system covers all areas of Oxfordshire Youth's work – including all sites such as YPSA dispersed properties and contingency buildings, OY office bases, all our work with children and adults with care and support needs, and families.

If you are not sure whether something is a serious incident or a NTK, be safe and alert your DSL

Tell a DSL immediately about:

1. Serious incidents involving a young person, which may include:
    - Serious injury or harm, i.e., life-threatening or potentially permanently disabling incidents of abuse or neglect affecting a child, young person, or main caregiver.
    - Hospital admission of a young person we look after or have oversight of (YPSA SP5) for significant/serious medical conditions, e.g., surgery or a life-threatening condition.
    - Serious incident of abuse perpetrated by a young person or adult.
    - Abuse involving several individual young people or perpetrators e.g., complex abuse or child sexual exploitation.
    - Missing young people – where there are concerns for a young person's immediate wellbeing and any of the following apply:
        - Where abuse or neglect is suspected whilst missing
        - Recent or current court proceedings
        - Missing for more than 48 hours
    - Anything else that has serious implications for young people, staff, partner agencies, that in your judgement should be known by managers and senior leaders.

The Lead DSL - CEO must be informed immediately:

- Concerns about safeguarding are likely to attract media interest.
- Death of a young person or anyone we are working with, including the death of a staff member, a serious incident, or a near miss that could have resulted in death or Sudden Death
- Death of a member of staff

The CEO must be informed immediately. Death in Service guidance should be followed where the death arises out of or in connection with work and may also require immediate reporting to the HSE.

Follow the serious incident process.

Call the relevant emergency services (police and ambulance services)

If any of the above NTK incidences occur during Out of hours – on call process to be followed by 360 – see appendices

2. Spiralling Risks
Cases involving high levels of risk that are spiralling, leading to significant harm, in spite of multi-agency work to address the problems. Consideration should be given to a referral to the Complex Case Panel for inter-agency senior-level assistance.

3.Serious accidental or non-accidental injuries and violent incidents to staff in the course of duties or threats to staff
Anywhere – YPSA property, public place, OY office etc. The incident also needs to be recorded on Inform.

Threats and violence include, but are not exclusive to, verbal aggression that undermines dignity at work, e.g. racism, sexism, homophobia, disablism. A risk assessment must be undertaken, and actions taken to mitigate harm and ongoing impact for the staff.

4. Fault of Oxfordshire Youth
Any incident of actual harm to a young person or staff member which you consider to be or which a reasonable bystander would consider to be the fault of Oxfordshire Youth.

5. Staff and volunteers

- Missing and concerns for safety
- Allegations of gross misconduct
- Arrested for offences which may impinge on the ability to do their job.
- Reduced mental capacity which may impinge on the ability to do their job.

6. Fire, flood, serious vandalism, burglary, or threat to a physical site.

- Life-threatening or major impact (e.g. building must be evacuated and closed) to be reported to the CEO immediately.

7.Controversies

- Cases (including future court hearings and inquests) where there may be local or national publicity/media interest, controversial legal issues or political implications.

- Controversial service problems or complaints likely to be raised with senior management by clients, MPs, councillors (County, District, Parish).
- Inter-partnership issues likely to be raised about the senior leadership team.
- Court cases where there is likely to be criticism of OY (particularly if by the 'court' itself – i.e. the magistrate or judge) and likely to attract negative publicity.
- Any other serious issue likely to attract intervention by any enforcement authority or negative publicity.

Things to consider when sharing information

A conversation needs to happen. Do not rely solely on email. You must be sure the message has been received and understood. Once a DSL is aware, they are responsible for assessing whether to alert others.

On-call

Staff working at night time must directly call the out of hours on call service 360 to inform them of incidents/accidents/emergencies where immediate reporting needs to happen - **NTK**

When sending handovers, please ensure that all messages begin **'Need to Know'** in the subject heading, complete an CCIA report (please see OY In Form, CRM Safeguarding reporting Process for instructions.)

360 should then ensure they support the night progression coach to ensure the incident and risks are managed and monitored, 360 will then call the CEO to update them of the NTK. See On call process for guidance

360 will then complete the night on call handover and send it to dsl@oxfordshireyouth.org

Normal service provision - If you cannot contact a DSL, please contact another DSL. All 3 Senior leaders count as the highest Need to Know contact. They can then make sure other relevant people are informed, if necessary, depending on the nature of the incident, other relevant agencies, and the CEO. The CEO will escalate to the Board of Trustees where appropriate.

Incidents may also trigger the involvement of other teams such as The Emergency Duty Team, the LADO service or the Health & Safety Team. **Do not rely solely on email.** Please check and record that the message has been received.

Of course, there will be other issues you need to talk to your manager about. This guidance is concerned with the most serious incidents that need to trigger the alert system. It is guidance however and cannot cover every type of incident. **If in doubt, discuss with your line manager.**

Guidance for DSLs

The CEO or Head of Youth services will call a Need to Know meeting and a Need to Know form will be completed by 360. Then quality assured and signed off by the CEO. In the event of a death, all of the senior leadership team and DSLs will be called and expected to be present in the meeting.

This should be done promptly to ensure no delay. Do not rely solely on email. Please check that the message has been received.
After an immediate alert, and where the actions taken do not resolve or reduce the risks within the planned timescale, the CEO should be kept informed. The CEO will ensure that Trustees are updated accordingly.

Depending on the nature of the concern, DSL should also consider alerting:

- Child Death Overview Panel – if a child has died. OCCG.cdopoxfordshire@nhs.net. Follow OSCB Safeguarding procedures on Child Death Reviews http://oxfordshirescb.proceduresonline.com/
- The Local Authority Designated Officer (LADO) LADO.SafeguardingChildren@Oxfordshire.gov.uk if allegations have been made that any person in a position of trust e.g. staff member/volunteer/foster carer may have abused or harmed a child or an adult with care and support needs.
- Fire & Safety and Public Health Directorates where the incident involves a specific location that may contribute to risk in the future.
- Adult Social Care if a vulnerable adult is involved in the incident. Emergency Duty team, if appropriate.
- A member of the Marketing & Communications Team – if there is or might be, press interest.
- Board of Trustees
- The Health & Safety Executive (HSE) if the incident is reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- The incident may also need to be recorded on OY's Health & Safety Incident Reporting.

Monthly 'Need to Know' (red rag rating) Report and Serious Incidents

The report provides a monthly briefing to DSLs, giving an overview of information on the issues, young people, and key dates and actions being taken on:

- Allegations against staff, carers, volunteers that reach a criminal threshold, relate to serious harm against children or adults with care and support needs, likely to attract public attention.
- Deaths, for any reason

- Ongoing serious case reviews or partnership reviews – progress update
- Other serious safeguarding matters involving risks to young people or staff.

Any reports are password protected or sent through Egress, and shared with all DSLs

All NTK/SI will be discussed in the monthly DSL meetings and all SI will be reported to Response via email by the Head of youth services

Sudden Death Protocol

In the event of a sudden death alert, the CEO and DSL must take the following actions:

- CEO and or Lead DSL must arrive within 12 hours.
- Inform the Chair of Trustees and OY Trustee Safeguarding Lead.
- Liaise with relevant agencies, emergency services, Coroners or any other senior authorities.
- It is the responsibility of the emergency services to communicate with family members and carers, so only share information with the appropriate agencies. If deemed necessary, immediate staff may communicate with family members or carers.
- Within 72 hours, convene an emergency meeting. Attendance of the CEO and all DSLs, to address everyone's well-being and to complete a full debrief of a death in service.

Safeguarding meeting structure for OY

All OY staff team meetings are to include safeguarding as a standard agenda item in their team meetings. Please note, concerns can only be closed at the County YPSA and Youth Development SG meetings and above.

Programs and Impact sub-committee

Quarterly Sub-Committee to OY Board, Chaired by OY Trustee with Safeguarding lead responsibility. This meeting feeds directly to OY board.

This is a high-level overview of OY's Safeguarding, where staff report to Trustees across Safeguarding of young people, staff and environment.

OY Safeguarding DSL Meeting

Monthly, chaired by Head of Youth services

This meeting is where all Need to Know incidents/accidents/ emergencies and Serious Incidents are reported on and all actions around policy, process and relationships are held to account. All DSLs and CEO will attend this meeting monthly. This meeting directly links into and oversees the actions from the SQI Sub-Committee.

YPSA managers meeting, and weekly team meetings review ongoing safeguarding.

Weekly, chaired by YPSA Managers

This meeting goes through all Safeguarding concerns raised that week, plus outstanding concerns.

Youth Development Safeguarding meeting

Monthly, chaired by Head of Youth Services

This meeting goes through all concerns raised that month to check that staff are satisfied with the actions associated with the concern. This is discussed as part of the monthly YD Team meeting

Group reflective practice available for all YPSA staff.

Monthly case management supervision for YPSA staff and all OY staff receive monthly (pro rata) supervisions which include Safeguarding as a standing item.

Appendix E: Definitions and Indicators of Abuse

Adults at risk

An adult at risk may become at risk of abuse because of their needs for care and support (whether or not the local authority is meeting those needs) and is experiencing, or at risk of, abuse and neglect. As a result of those needs, they are unable to protect themselves from either the risk of, or the experience of, abuse and neglect. This may include their ability to communicate or making known their wishes and needs.

Examples of adults who may become at risk of abuse may be because they have a high degree of dependency on others, are in need of community care or specialist services due to mental health problems, physical or learning disability, age or illness, and this may include their ability to communicate or make known their wishes and needs. Please note not all adults with care and support needs are at risk of abuse.

Abuse and neglect

Abuse and neglect take many forms and can be caused by single or repeated acts or a failure to act by any other person or persons, or in the case of self-neglect, the victim themselves. The circumstances of each individual case will be considered so as not to limit what constitutes abuse or neglect. Oxfordshire Youth will treat as a safeguarding concern cases in which an adult with care and support needs is suspected to be involved in any of the following: financial or material abuse, sexual abuse/exploitation, domestic abuse or violence, physical abuse, self-neglect, neglect and acts of omission, modern slavery, organisation abuse and discriminatory abuse. See below for further details.

Financial or material abuse

Includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or

financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Possible indicators:

- Change in living conditions
- Lack of heating, clothing or food
- Inability to pay bills/unexplained shortage of money
- Unexplained withdrawals from an account
- Unexplained loss/misplacement of financial documents
- The recent addition of authorised signers on a client or donor's signature card; or
- Sudden or unexpected changes in a will or other financial documents

Sexual abuse/exploitation

Includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Any sexual relationship that develops between adults where one is in a position of trust, power or authority in relation to the other (e.g. day centre worker/social worker/progression coach/health worker etc.) may also constitute sexual abuse.

Possible indicators

- Low self-esteem
- Feeling that the abuse is their fault when it is not
- Adult exhibits significant changes in behaviour or outlook
- Adult experiences pain, itching or bleeding in the genital/anal area
- Frequently going missing
- Increased self-harming, suicidal ideations or suicidal attempts

Domestic abuse/violence

Includes psychological, physical, sexual, financial, emotional abuse, 'honour'-based violence, Female Genital Mutilation, forced marriage, coercive control, harassment and stalking, and online abuse.

Domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening, degrading behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality, towards a person aged 16 or over.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work (that meets the criteria set out in Section 42 of the Care Act 2014) that occurs at home is, in fact, concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Possible indicators:

- Low self-esteem
- Feeling that the abuse is their fault when it is not
- Physical evidence of violence such as bruising, cuts, broken bones
- Verbal abuse and humiliation in front of others
- Fear of outside intervention
- Damage to home or property
- Isolation – not seeing friends and family
- Limited access to money

Physical abuse

Includes assault, hitting, slapping, pushing, kicking, misuse of medication, being locked in a room, inappropriate sanctions or force-feeding, inappropriate methods of restraint, and unlawfully depriving a person of their liberty.

Possible indicators:

- No explanation for injuries or inconsistency with the account of what happened
- Injuries are inconsistent with the person's lifestyle
- Bruising, cuts, welts, burns and/or marks on the body or loss of hair in clumps
- Frequent injuries
- Unexplained falls
- Subdued or changed behaviour in the presence of a particular person

- Signs of malnutrition
- Failure to seek medical treatment or frequent changes of GP

Self-neglect

Includes neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It is also defined as the inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care, with the potential for serious consequences to the health and wellbeing of the individual and sometimes to their community.

Possible indicators:

- Very poor personal hygiene
- Unkempt appearance
- Lack of essential food, clothing or shelter
- Malnutrition and/or dehydration
- Living in squalid or unsanitary conditions
- Neglecting household maintenance
- Hoarding
- Collecting a large number of animals in inappropriate conditions
- Non-compliance with health or care services
- Inability or unwillingness to take medication or treat illness or injury

Neglect and acts of omission

Includes ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill treatment and gross misconduct. Neglect of this type may happen within an adult's own home or in an institution. Repeated instances of poor care may be an indication of more serious problems. Neglect can be intentional or unintentional.

Possible indicators:

- Poor environment – dirty or unhygienic
- Poor physical condition and/or personal hygiene
- Pressure sores or ulcers.
- Malnutrition or unexplained weight loss
- Untreated injuries and medical problems
- Inconsistent or reluctant contact with medical and social care organisations
- Accumulation of untaken medication
- Uncharacteristic failure to engage in social interaction
- Inappropriate or inadequate clothing

Modern Slavery

Includes slavery, human trafficking, forced and compulsory labour, and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

A large number of active organised crime groups are involved in modern slavery. But it is also committed by individual opportunistic perpetrators.

There are many different characteristics that distinguish slavery from other human rights violations, however only one needs to be present for slavery to exist.

Possible indicators:

- Signs of physical or emotional abuse
- Appearing to be malnourished, unkempt or withdrawn.
- Isolation from the community, seeming under the control or influence of others
- Living in dirty, cramped or overcrowded accommodation and/or living and working at the same address
- Lack of personal effects or identification documents
- Always wearing the same clothes
- Avoidance of eye contact, appearing frightened or hesitant to talk to strangers.
- Fear of law enforcers

Discriminatory abuse

Includes unequal treatment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation (known as 'protected characteristics' under the Equality Act 2010), verbal abuse, derogatory remarks or inappropriate use of language related to a protected characteristic.

Hate crime can be viewed as a form of discriminatory abuse, although it will often involve other types of abuse as well. It also includes not responding to dietary needs and not providing appropriate spiritual support. Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse.

Possible indicators:

Indicators for discriminatory abuse may not always be obvious and may also be linked to acts of physical abuse and assault, sexual abuse and assault, financial abuse, neglect, psychological abuse and harassment, so all the indicators listed above may apply to discriminatory abuse.

- An adult may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices.
- Appearing withdrawn and isolated
- Making complaints about a service not meeting their needs

Organisational abuse

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, or where care is provided within a person's own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation. Such abuse violates the person's dignity and represents a lack of respect for their human rights.

Possible indicators:

- Lack of flexibility and choice for people using the service
- Inadequate staffing levels
- People being hungry or dehydrated
- Poor standards of care

- Lack of personal clothing and possessions and communal use of personal items
- Lack of adequate procedures
- Poor record-keeping and missing documents
- Absence of visitors
- Few social, recreational and educational activities
- Public discussion of personal matters
- Unnecessary exposure during bathing or using the toilet
- Absence of individual care plans
- Lack of management overview and support

Please note this is not an exhaustive list.

Safeguarding means protecting young adults' right to live safely, free from abuse and neglect. Oxfordshire Youth works closely with key partners, and other organisations to prevent and stop both the risks, and the experience of, abuse or neglect, whilst at the same time making sure their wellbeing is promoted and their preferences taken into account.

Additionally, within YPSA, staff must be:

- vigilant about their actions so that they cannot be misinterpreted and are aware of appropriate behaviour when working with vulnerable young people and adults (for example, appropriate boundaries of personal contact)
- aware that, through the services that Oxfordshire Youth provides, failures to act (such as lead partner Response leaving a vulnerable tenant without heating or water for extended periods) or failures to follow policy and procedures (such as not addressing their reports of anti-social behaviour correctly) may also constitute abuse; and
- aware of situations which may present risks and how to manage these (for example, if allocating a property to a registered offender, consideration must be given to the location)

Appendix F
The Care Act 2014

Within the Care Act 2014 (and Care and Support Statutory Guidance Issued under the Care Act), Sections 42-47 and 68 define what is meant by safeguarding adults, provide a definition of adults at risk, and detail the roles and responsibilities of a range of organisations and how they must work together to respond to adult safeguarding concerns. This includes Registered Providers. The Act sets out a new statutory basis for safeguarding adults and the legal duties that local authorities will have to fulfil in their lead and coordination roles.

The supporting Statutory Guidance on adult safeguarding replaces previous 'No Secrets' official guidance. As a Registered Provider, Oxfordshire Youth is not a statutory partner under this Act but is obliged to:

- attend and provide information for Local Safeguarding Adults Boards if necessary. Housing providers will also be asked to participate in relevant Safeguarding Adult Reviews.
- cooperate with local authorities in enquiries of suspected adult safeguarding concerns - these may result in us taking action to protect the adult from any actual or risk of abuse or neglect as part of a safeguarding plan.
- have a safeguarding policy and procedure.
- keep clear and accurate records of adult safeguarding allegations, responses and actions, then share these with appropriate organisations when in the best interest of the adult with care and support needs.
- have safe recruitment practices and training relevant to safeguarding adults policy and procedures.

The Statutory Guidance requires all housing providers to have 'clear operational policies and procedures that reflect the framework set by the OSABs in consultation with them'. Response attend the OSAB meetings and will disseminate best practice scenarios.

Appendix G
Serious Incidents

Oxfordshire Youth is responsible for the safety and wellbeing of children, young people, vulnerable adults, and our staff, employees, and volunteers. Full details of how Oxfordshire Youth addresses serious incidents can be found in our Serious Incidents Policy which should be read in conjunction with this document.

Definition of Serious Incidents

A serious incident extends beyond a standard incident in terms of potential impact on an individual or the organisation. This is defined as:

'High-risk incidents are defined as those where there is a significant degree of potential or actual harm caused, including serious injury or death. Criteria include the need for an ambulance or other emergency service to be called, or incidents requiring DSL or Board involvement, such as serious violence, the death or serious injury of an individual, serious misconduct, a significant loss of funds, significant public concern, or data breach.

A serious incident is an adverse event, whether actual or alleged, which results in or risks significant harm.

- harm to your charity's beneficiaries, staff, volunteers, or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)
- loss of your charity's money or assets
- damage to your charity's property
- Harm to your charity's work or reputation

For this policy, "significant" means significant in the context of your charity, taking account of its staff, operations, finances, and/or reputation.

The safeguarding traffic light guide should be reflected on when any SI or NTK needs to be reported – follow Incident threshold matrix (Appendix B)

What to report

This section tells you what types of incidents the Commission expects you to report and outlines the different authorities or agencies that may be involved. When making your report, you should follow the advice below.

You should report an incident if it results in, or risks, significant:

- harm to people who come into contact with your charity through its work
- loss of your charity's money or assets
- damage to your charity's property
- harm to your charity's work or reputation.

The main categories of reportable incidents are:

- protecting people and safeguarding incidents – incidents that have resulted in or risk significant harm to beneficiaries and other people who come into contact with the charity through its work
- financial crimes – fraud, theft, cyber-crime, and money laundering
- large donations from an unknown or unverifiable source, or suspicious financial activity using the charity's funds
- other significant financial loss
- links to terrorism or extremism, including 'proscribed' (or banned) organisations, individuals subject to an asset freeze, or kidnapping of staff
- other significant incidents, such as – insolvency, forced withdrawal of banking services without an alternative, significant data breaches/losses or incidents involving partners that materially affect the charity

Who to report into?

You should report the incident directly to the CEO.
If you decide not to make a report about something serious that has happened in your charity and the Commission later becomes involved, you will need to be able to explain why you decided not to report it at the time.

Where can I find more information?

You can find full information about serious incidents and what to do in the event of an incident in the Oxfordshire Youth Serious Incidents Policy which provides clear information about exactly what to do in the event of a serious incident.

Appendix H
Inform S/G reporting process

Appendix H
OY In-Form (CRM) Safeguarding Reporting Process & Operational Manual

InForm is set up to collect the data we need in a way we can access it easily, to ensure consistency and accuracy in reporting and to demonstrate the work of the Progression Coaches and to meet our obligations in supporting the Young People.

Incident reporting – including near misses

The staff member who witnesses the incident is to complete an incident form within 72 hours.

The incident form (CCIA) will then be sent to the area manager who will review the incident form and submit for approval.

The YPSA Operations manager will then review/approve and send incident forms to Response, and Response sends it to OCC.

The Incident and Safeguarding sections on In-Form will be discussed weekly in the YPSA managers' meeting and will be the main source of information for OY's monthly safeguarding meeting with Oxfordshire Youth Designated Safeguarding Leads. All Safeguarding and related CCIAs will be discussed in the weekly managers meetings

An incident may raise a safeguarding referral; in which case you must follow the process in In-Form which is entitled 'New Safeguarding Report'. Alongside this please use the Incident Threshold Matrix.

The Head of YPSA will follow the need to know escalation process to share relevant incident with DSLs.

This can also be found in the appendices in the Safeguarding Policy.

New Risk Assessment

All Young people who enter the service will have a a full Risk assessment completed and added to Inform

- Follow process in YPSA Inform manual to adding a New Risk assessment
- **YPSA manual**

Safety planning

Each individual Safety Plan should be developed in collaboration with the service user in order to draw on their own internal resources and external support when they experience suicidal thoughts and feelings. It is also important to engage other professionals supporting the service user, such as a Leaving care Personal ADVISOR, Care Coordinator from the community mental health team (CMHT) or a key worker from drug and alcohol services. Where appropriate, and where consent is given, it can be helpful to engage with friends or family members.

A Safety Plan should be added to the Risk Assessment section on Inform and should be in place to ensure all staff and the YP involved are aware of what steps to take to keep themselves safe. The guidance sets out the key areas that need to be covered in the Safety Plan and should be added to the risk assessment under 'Safety Plan'.

Please then add 'yes' or 'no' to the following question at the bottom of the Risk assessment – 'Is a safety plan required?'.

Follow safety plan guidance when setting a safety plan with YP and add to Risk assessment (safety guidance can be found here – Shared drive – YPSA – SOP – New paperwork – Safety planning guidance)

Safeguarding Reporting

When you add a new Safeguarding report, the status must be 'open' when submitting.

The staff member raising the SG referral should discuss with their line manager and raise with OASB / OSCB if it is felt the SG concern meets the risk requirements.
The staff member or manager who is reviewing the SG report will go into the SG report and edit – closed and then save.

All SG cases will need to be reviewed and closed or kept open depending on actions and status.

On-call

In regard to raising serious The On Call process should be followed, located as an appendix in the Safeguarding Adults with Care and Support Needs Policy.

Case Notes

Ensure that you add your case notes asap, or within 48 hours. If it is in relation to an incident which includes a SG concern it should be added immediately.

If you complete an incident form and the RA is required to be updated following an incident or change in risk you must update the RA within 72 hours, unless it is a SG concern then again it is to be updated within 24 hours.

Case notes need to be factual with no opinions - use only the facts of what occurred or happened.

Ensure that you tag the on- to-one support on In-Form for all one-to-one support sessions and ALWAYS link to the support plan and Goals.

Case management and logging general concerns

Case management supervision with every progression coach will take place monthly.

A case management spreadsheet will be completed by the progression coach and sent to the YSPA manager **three days** before the case management supervision.

During the case management supervision, the YPSA Manager will support the progression coach by working through each young person on their caseload and ensuring that all support, risks and concerns are considered and that a youth work approach is adopted focusing on EET, youth voice and engagement in positive activities. This will provide a supportive and collaborative approach to case management.

Note: please continue to record all day-to-day case management and logging of general concerns on In-Form .