



Multi-Agency Risk Management (MARM) Guidance

Document Control:

Purpose of document:	This document sets out a coordinated, multi-agency response designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed. It seeks to provide front line professionals with a framework to facilitate effective working with adults who are at risk; where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions. It is complimentary to and to be used in conjunction with the Safeguarding Adults Multi-Agency Policy & Procedure.
Type of document:	Guidance
Dissemination:	All new and updated policies and procedures are notified to adult social care staff in line with CCC & PCC internal communications policies. The document will be stored on the Cambridgeshire and Peterborough Safeguarding Adults Board Website.
Other documents which should this be read in conjunction with this guidance	Cambridgeshire and Peterborough Safeguarding Adults Board Multi-Agency Policy and Procedures (October 2017) Care and Support Statutory Guidance (current) The Care Act (2014) Articles and Protocols of the Human Rights Act (1998) Mental Capacity Act (2005) Data Protection Act 1998 (General Data Protection Regulations 2018)
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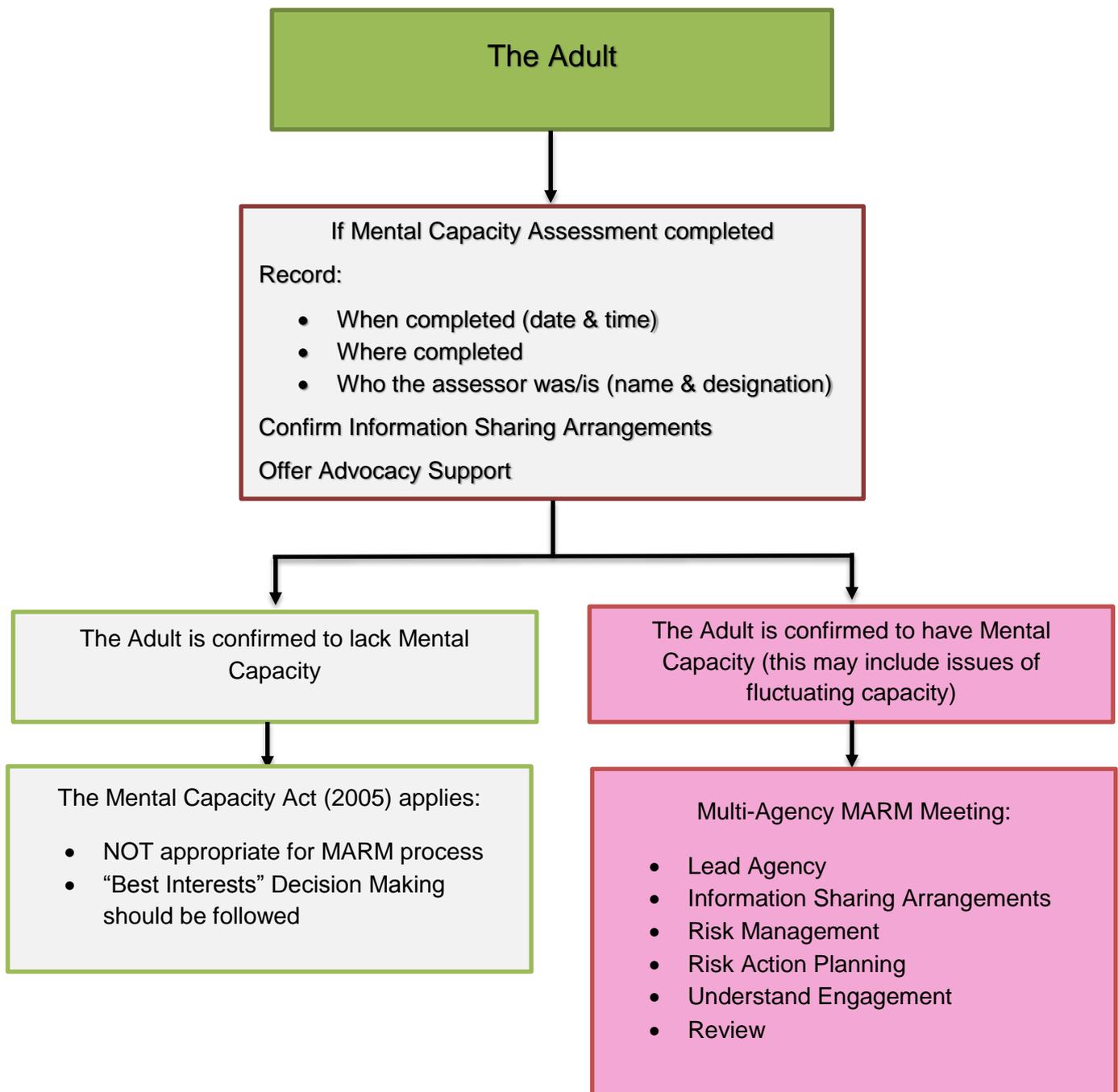
Revisions

Version	Page & Paragraph	Amendment	Date

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MARM Principles



Section	Subject
1.0	Introduction
1.1	This document describes guidance for conducting Multi-agency Risk Management (MARM) and should be read alongside the Cambridgeshire and Peterborough Multi-Agency Adult Safeguarding Procedures.
1.2	<p>This guidance must only to be used where the adult:</p> <ul style="list-style-type: none"> • has the mental capacity to understand the risks posed to them • continues to place themselves at risk of serious harm or death • refuses or is unable to engage with necessary care and support services.
1.3	<p>It is essential to note that the adult must be considered to have need for care and support in line with the definition contained within the Care Act (2014); Care & Support Statutory Guidance (09/07/2018) and the Care & Support (Eligibility Criteria) Regulations (2015):</p> <p>(a) the adult’s needs arise from or are related to a physical or mental impairment or illness</p> <p>(b) as a result of the adult’s needs the adult is unable to achieve two or more of the outcomes specified as a consequence there is, or is likely to be, a significant impact on the adult’s well-being.</p>
1.4	If the risk(s) is not at a level which may lead to serious harm or death the MARM process does not apply and should not be followed. Where the adult lacks capacity the Mental Capacity Act (2005) should take over and action should be taken under Best Interests (See the MARM Principles on Page 4).
1.5	<p>The definition and understanding of self-neglect can vary considerably; for the purposes of this guidance however, self-neglect can be any of the following:</p> <ul style="list-style-type: none"> • the inability or unwillingness to care for one’s self and/or one’s environment, including hoarding • a refusal of essential services • a failure to protect one’s self from abuse by a third party (where “mainstream” adult safeguarding processes are not applicable or sufficient to mitigate or eradicate the risk). <p>An example of this may be where the adult refuses to engage with care/support services and evidence suggests that the “friendships” they are keeping, or their social network are placing them at risk of serious exploitation, harm or death. Examples of this type of situation can include the exploitation of adults in situations of sexual abuse, the trafficking (commonly referred to as “county lines”), storage (“cuckooing”) testing and use of illegal substances.</p>

	<p>Case scenarios where the MARM Guidance may apply are included in Appendix A.</p> <p>Subject matter expertise, and the inclusion of the Police in these types of situation are vital in order that all available intelligence is shared to support the achievement of proportionate, accurate and effective decision making and forward risk planning.</p>
1.6	<p>The guidance should be used flexibly and in a way that achieves best outcomes for the adult. It does not, for example, specify which professionals need to be involved in the process, or prescribe any specific actions that may need to be taken as this will be decided on a “case by case” basis through coordinated multi-agency working; in line with the Making Safeguarding Personal (MSP) Principles (Appendix B), agreed information sharing protocols, the General Data Protection Regulations (GDPR) 2018, and in full compliance with the Articles and Protocols of the Human Rights Act (1998) and other applicable legislation. More information resources about the Human Rights Act (1998) can be found at:</p> <p>https://www.equalityhumanrights.com/en/human-rights/human-rights-act</p>
2.0	References (detail of the legislation and the guidance informing content)
2.1	<ul style="list-style-type: none"> • Peterborough and Cambridgeshire Safeguarding Adults Multi-Agency Policy and Procedures; • Human Rights Act 1998 • The Care Act 2014 • Data Protection Act 1998 (General Data Protection Regulations 2018) • The Mental Capacity Act 2005 • Care & Support Statutory Guidance (2018)
3.0	Information Gathering
3.1	<p>At CCC & PCC, the Adult MASH will be the ones that usually identify the MARM cases. The MASH worker will go through the usual process of information gathering to understand and decide what happens with a safeguarding concern. They may find out a lot of information (issues, possible MARM, MCA known/unknown, key stakeholders etc.) and make recommendations about next steps and allocate it to an appropriate ASC team to take forward.</p>
4.0	Scoping the MARM Risk Action Planning Meeting
4.1	<p>Where an adult meets the criteria for this guidance (essentially including formal confirmation that the adult has mental capacity in this regard, and information sharing arrangements), the practitioner initiating the MARM process) should refer to the applicable Adult Social Care (ASC) service via the local Multi-Agency Safeguarding Hub (MASH) in order that</p>

	progression of the MARM process be confirmed. At this point a lead ASC Social Worker will be allocated to coordinate the process and the key agencies who are required to be (or become) involved in the Risk Action Planning Meeting will be identified. It is important to note that ASC will lead and coordinate the MARM process; the Chair of the Risk Action Planning Meeting will be an ASC Team Manager or more senior representative.
4.2	Depending on the urgency of the case, it may be necessary for professionals to prioritise the MARM Risk Action Planning Meeting. Invitees will be determined on a “case by case” basis but would ordinarily involve representatives from all key agencies who are or should be linked to the case; this may include the Police as they may hold relevant intelligence, and other agencies such as, for example, health professionals, the Fire & Rescue or Housing services.
4.3	When scoping invitees, consideration should be given to which person might be best to engage with and work effectively with the adult - this person may not necessarily be a professional from one of the key agencies, for example, this could be someone from a voluntary agency, such as an outreach worker. When scoping attendees chose people that can make decisions at the meeting rather than taking them away to get approval.
4.4	In all cases the adult should be invited to attend the MARM Risk Action Planning Meeting, with an advocate or interpreter as appropriate. Where applicable, family members and/or other representatives directly involved with the adult should also be invited to attend or to submit any relevant information in advance if they are unable to attend for any reason.
4.5	The Head of Safeguarding is available for advice and guidance at any stage.
4.6	“There is strong professional commitment to autonomy in decision making and to the importance of supporting the individual’s right to choose their own way of life, although other value positions, such as the promotion of dignity, or a duty of care, are sometimes also advanced as a rationale for interventions that are not explicitly sought by the individual” SCIE Report 46 (2001).
5.0	The MARM Risk Action Planning Meeting
5.1	The MARM Risk Action Planning Meeting will be chaired by an ASC Team Manager or more senior representative (a Standard Agenda Template is included as Appendix C). Capacity or lack of capacity is a vital element in risk action planning with, or on behalf of, adults who are at risk of self-neglect. Therefore, the adult’s mental capacity in respect of the specific concerns associated with the case and their consent should be discussed and confirmed at the beginning of each MARM Risk Action Planning Meeting. This should be informed by any

	information gathered at the meeting where not able to complete a formal MCA.
5.2	<p>When a person's capacity has been established, planning can follow one of two routes, either:</p> <ul style="list-style-type: none"> • In the case of a lack of capacity—this process MUST not be followed and a best interest decision should be made. • In the case of capacity—follow this MARM Process.
5.3	<p>Once it is clear that the adult concerned has capacity to understand the consequences of refusing or disengaging from services, participants of the Risk Action Planning Meeting, in developing a MARM Risk Action Plan (an Example Template is included at Appendix D) should follow the framework factors given below:</p> <ol style="list-style-type: none"> 1. Confirm the coordinating ASC Social Worker and who will be the key contact with the adult concerned (these may not be the same person in both roles). 2. There will not always be an MCA assessment completed, there will be times when we assume capacity, therefore record discussions about capacity with any rationale why they have capacity. If a capacity assessment has been carried out record when, where and by whom the capacity assessment was carried out. Where the information suggests the person's capacity may have changed consideration of how to evidence capacity should be given and recorded. 3. Document evidenced based risk factors of significant harm and threat to life. 4. Document the adult's level of involvement and, where known, their desired outcomes. 5. Record what needs to change to support safety and reduce risk. 6. Consider and record all options for encouraging engagement with the adult. 7. Ensure that all applicable agencies are actively involved if they aren't already, this can include for example the General Practitioner (GP), Children's Services, Fire & Rescue, Housing, Shelter, Drug & Alcohol Services, Domestic Abuse Support (NB: this is NOT an exhaustive list) 8. Professionals should also consider and confirm, as applicable and appropriate, the support that carers, family members, children or other adults at risk might need, and again consider who is best placed to engage and support them. 9. Develop a MARM Risk Action Plan with clear actions, timescales and responsibilities 10. Document contingency planning arrangements to be instigated if the MARM Risk Action Plan is unsuccessful. 11. Set clear review dates and times. 12. Ensure notes from the meeting are accurately recorded and circulated to all participants and relevant others (eg: GP with the

	consent of the adult) within 10 working days of the meeting.
5.4	<p>Consider which person is best placed to engage with the adult</p> <p>The MARM Risk Action Plan should consider if the adult would/may respond more positively to a health, social care or a voluntary agency professional (or other person)?</p> <p>The Serious Case Review written following the murder of ‘F’ revealed a lifelong history of negative involvement from both the Mental Health Services and from the Social Services Children and Families Department. She had been detained under a Mental Health Act (1983) Section on several occasions and all her children had been removed from her care. In planning an approach towards ‘F’, this information would have been vital as she would have been unlikely to engage positively with either the Mental Health Services or Social Services in the first instance.</p>
6.0	Test of Engagement
6.1	Having established a MARM Risk Action Plan, the adult’s resistance or inability to engage and accept support, planning should be tested by the introduction of the Risk Action Plan by the person or the agency most likely to succeed (this will have been confirmed at the MARM Risk Action Planning Meeting – see Section 4 above).
7.0	Review
7.1	<p>If the plan is still rejected, the MARM Risk Action Planning Meeting should reconvene to discuss and review the MARM Risk Action Plan. The case should not be closed simply because the adult is refusing to engage with or accept the plan.</p> <p>Appropriate advice must be taken as to a reasonable review plan, including consideration of the timescales to be applied (for example from a Line Manager/Head of Service/Legal Services).</p>
8.0	Case Closure
8.1	<p>When working with an adult under the MARM guidance, there must be agreement by all professionals involved in the case that this is no longer required before this process is closed. It should be understood by all agencies that a case under the MARM may be open for a very long period of time.</p> <p>The main reasons for closure would be:</p> <ul style="list-style-type: none"> • The adult is now engaging with professionals to reduce the risks • The risk is reduced to a level that there is no longer a risk of significant harm or death • The adult is deceased

9.0	7 Step Summary
9.1	<ol style="list-style-type: none"> 1. Confirm if urgent actions have been taken or are further required: <ul style="list-style-type: none"> • to meet the needs of children, other adults at risk or animals living or involved with the adult • Public or Environmental Health concerns • Criminal activity 2. Establish and confirm mental capacity (including as applicable issues of fluctuations in capacity, and/or advance decision making), and information sharing arrangements 3. Ensure advocacy is available to the adult 4. Convene a MARM Risk Action Planning Meeting 5. Develop the MARM Risk Action Plan 6. Test Engagement 7. Review
10.0	Inherent Jurisdiction
10.1	Adults who have capacity to make decisions which may result in them placing themselves at risk of significant harm or death may require further judicial intervention to ensure their safety. This is most likely to occur if the adult continually fails to engage with professionals and all other options have been exhausted.
10.2	There may be occasions when the courts are prepared to intervene in the case of an adult, even when they have the capacity to consent. For example, where an adult is receiving undue pressure or coercion from a third party. The Court's purpose is not to overrule the wishes of an adult with capacity, but to ensure that the adult is making decisions freely.
10.3	Legal advice should always be sought when Inherent Jurisdiction may be a factor.
11.0	Timescales
11.1	It is important to agree timescales for each part of the MARM Risk Action Planning process to prevent drift. This will be different for each case dependent on individual circumstances.
11.2	It is also important to ensure that any decisions made are accurately recorded.
11.3	Within the MARM Risk Action Plan, it should be clear what the agreed actions are, who is responsible for carrying out the actions and the timescales involved. Disagreements should also be clearly documented.

12.0	Escalation of Concerns
12.1	The Chair of the MARM Risk Action Planning Meeting holds responsibility for the escalation of concerns as required.
12.2	<p>It is recognised that at times there will be disagreements over the handling of concerns. These disagreements typically occur when:</p> <ul style="list-style-type: none"> • The adult is not considered to meet eligibility criteria for assessment or services. • There is disagreement as to whether safeguarding adults procedures should be invoked. • There is dispute about the adult's mental capacity to make specific decisions about managing risks. • The adult is deemed to have mental capacity to make specific decisions and is considered to be making unwise decisions. • Professionals place different interpretations on the need for single/joint agency responses. • Professionals feel that meeting the needs of the adult sits outside of their work remit. • Resources are not appropriately available or allocated, it must be noted that at all times actions are required to be taken within the law and to not be constrained due to perceived limitations to organisational boundaries.
12.3	Professionals involved in this process should always try to work out their differences. Where there are irreconcilable and significant differences between professionals however, consideration should be given to including an agreed neutral third party. It may also be necessary to consider escalating the case to more senior decision makers within organisations.
13.0	Information Sharing
13.1	Information sharing will be in line with local Information Sharing Protocols.
14.0	Protection v Self Determination
14.1	The dilemma of managing the balance between protecting adults at risk from self-neglect against their right to self-determination is a serious challenge for all services. Example case scenarios are included within Appendix A.
14.2	This process does not, and should not, affect an individual's human rights, but seek to ensure that the relevant agencies exercise their duty of care in a robust manner and as far as is reasonable and proportionate.

14.3	Applying this robust process should ensure all reasonable steps are taken to ensure safety, by a multi-agency group of professionals. This model will be critical for the reasons outlined above, but in addition will anticipate the possible extension of the definition of adults who may be in need of safeguarding (to include those at risk of harm as a result of self-harm/self-neglect).
14.4	Where possible, the adult's views and wishes/desired outcomes should be included and if they are not present, there should be detailed reasons for this.

Appendix A – Case Scenarios Where the MARM Process May Apply

Scenario 1

Jennifer is 25 years old and has a mild learning disability; she experienced physical and sexual abuse as a child that was perpetrated by her stepfather and an uncle. This resulted in Jennifer being placed in the care of the local authority at the age of 12 – her mother retained shared parental responsibility. As an adult Jennifer moved to a sole tenancy flat (with housing related support and regular visits from a Learning Disability Nurse); she volunteers 3 days a week in the kitchen of a local school.

Welfare benefit payments are received each Monday, however Jennifer will regularly spend all of the money by Wednesday, and neglect her dietary needs (Standing Orders and Direct Debits are in place for all household bills). Jennifer will not cooperate with money management and budgeting support.

Jennifer is well known within her home community; this is generally positive however more recently she has, at times, behaved erratically when under the influence of alcohol (shouting in a threatening manner in the street), a Police Community Support Officer (PCSO) may have been involved.

Jennifer has told the Learning Disability Nurse that over recent months she has been using “internet dating sites” to meet males – at times she says that she engages in “unprotected sex” as this is what is required of her by the men she meets (she is prescribed and takes the contraceptive pill). More recently Jennifer has disclosed that “some men” have taken her to a flat and filmed her participating in sexual intercourse with them and that there have been occasions when she has been so drunk that she doesn’t really know what has happened. Although Jennifer refuses to give any details about who these men are, or where she is taken to, the Learning Disability Nurse feels that Jennifer is at risk of serious harm as she has sustained physical injuries recently which have required medical attention. It is confirmed by the Learning Disability Nurse that Jennifer has the mental capacity to make decisions about “safe sex” practices and to maintain her personal safety, but she remains deeply concerned.

Jennifer’s mother and maternal aunt live some distance away and have historically visited her on a monthly basis; however more recently this has increased to fortnightly due to their concerns about her safety and well-being; she has no further family or socially supportive network.

The key presenting concerns relate to hazardous and unwise life-style choices with the potential that Jennifer is being subjected to sexual exploitation/abuse and a perceived risk of physical violence.

Jennifer refuses to engage with ASC and has the mental capacity to do so. It would be appropriate in this situation for the Learning Disability Nurse to refer for a MARM meeting to be convened with all applicable agencies—those who are or should be involved. Invitees to the MARM meeting, in addition to Jennifer, ASC and the Learning Disability Nurse, could include the Police, GP, her mother and maternal aunt.

If Jennifer refuses to attend the MARM Meeting (even with the support of an advocate or representative) this should be clearly documented and she should be informed of the outcome and details of any agreed Risk Action Plan.

Scenario 2

Raj has a diagnosis of Motor Neurone Disease, he lives with his son (age 20) and his twin sons (age 11). Raj has a history of alcohol misuse and continues to drink alcohol daily, varying amounts.

Raj has a Community Psychiatric Nurse (CPN) who has made contact with Adult Social Care (ASC) as she has concerns regarding Raj's eldest son, his violent behaviour and his drug taking. The CPN made contact with ASC a year ago regarding the same concerns and following Raj having a broken arm, although there was no evidence that this was caused by the son at the time it was thought that the son was involved. This was investigated by ASC, however Raj refused to engage and the case was closed. The CPN also has concerns regarding the housing estate that Raj lives on and the son's involvement with other people on the estate and considers Raj to be at risk. He is known to owe money to someone and one of the windows in his house has been boarded over due to it being smashed.

Raj has capacity to make decisions and has not made any allegation regarding his son, however the CPN is concerned about the significant risk of harm to Raj from his son and the risk to Raj of being a target from the local community.

Raj has not agreed to this ASC referral.

In this situation the Safeguarding Adults (SGA) threshold is clearly met, however Raj is not engaging with ASC, he refuses an assessment and has the capacity to do so. It would be appropriate in this situation for the CPN or ASC to call a MARM meeting with all agencies involved to discuss how to move this forward. Likely agencies would include the CPN, Psychiatrist, GP, Housing, ASC, Police, Children's Services. Raj would be asked to attend but if he refuses he must be advised that the meeting is happening and that he will be informed of the outcome.

Scenario 3

Simon lives in his own house that he bought from the Local Authority many years ago. Simon has a history of a stroke and requires support with his mobility, personal care and accessing the community. Adult Social Care have been involved for some time and there is a care package in place, however several different care agencies have now pulled out of Simon's care and refused to go back. There is now only one care agency left who are starting to be reluctant to go into Simon's property for the following reasons:

Local known drug dealers frequent the property and are a risk to visiting care staff, also a risk to Simon is known to be verbally abusive and racist with the care staff. Simon spends his money on a local prostitute who is vulnerable in her own right and often presents at the local hospital with bruising, the police believe this is from her "violent boyfriends".

Simon contacts the police claiming that his wallet/money has been taken from his house but then retracts his statement, when the carers visit he will often make accusations of them interfering. The carers are unable to do any shopping due to no money being in the property.

Simon is at high risk of pressure sores and has had these before, the inability for the care agency to provide personal care is increasing this risk and Simon has diabetes that is adding to this risk. He will often ring the police stating he has no money and demanding a food parcel. Housing are not happy with the antisocial behaviour and complaints from the neighbours.

It is clear that the Safeguarding Adults threshold has been met, however Simon refuses to engage and agencies are unsure what can be done. As a result Adult Social Care arrange a MARM meeting and follow the MARM process. Agencies involved: Housing, Community Nurse, Police, New Futures, GP, a representative from the hospital, Adult Social Care and the domiciliary care provider. Simon is asked to all the meetings but refuses to attend and refuses an advocate.

Scenario 4

Alice lives in a council flat. She is known to be a woman who hoards but has not previously neglected her own hygiene and health needs. Housing officers have intervened in the past, following concerns raised by neighbours. They have advised Alice that she needs to keep her hoarding under control so that it does not become a fire or health and safety risk.

An immediate neighbour calls the housing office to complain about the smell coming from Alice's flat. She says that Alice seems increasingly unable to cope and is looking dirty and dishevelled. She is also not seen going out as much as before.

The housing officer, Don, visits. Alice answers the door and does look dirty and unwell. There are unpleasant odours coming from the flat. Alice will not allow Don entry to the house.

Don asks Alice why she thinks things might be getting more difficult for her. Alice says that her mother recently died. She was close to her mother, who also used to help her and encourage her to keep the hoarding under control. Don notices that the property is looking worse than his previous visits and that Alice has lost weight and does not appear well. He also noted that Alice appears to be smoking in the property, something that she did not do previously.

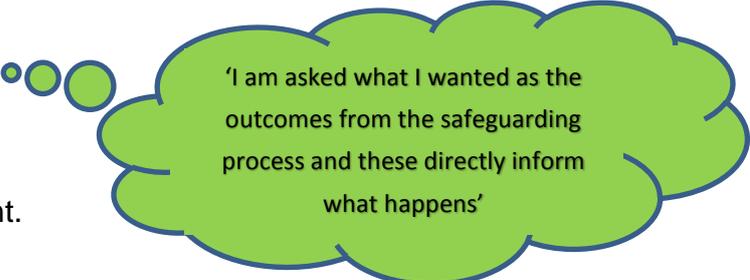
Alice refuses a referral to Adult Social Care or her GP. Don believes that the risk to Alice's health and well-being is increasing and there is evidence of significant fire risk. Don has no concerns about Alice's mental capacity.

Don contacts Adult Social Care, the GP, the fire service and housing support to arrange a MARM meeting. Don also ensures that Alice is invited and the reasons for the MARM explained.

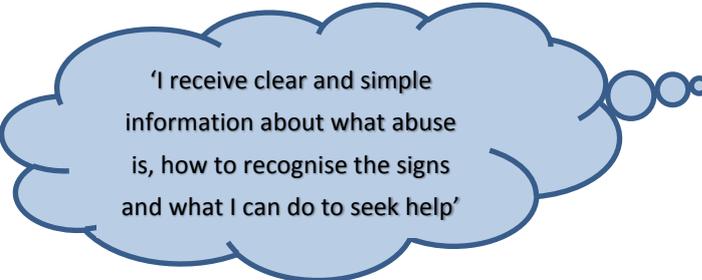
Appendix B – Making Safeguarding Personal PRINCIPLES

Empowerment

People being supported and encouraged to make their own decisions and informed consent.



'I am asked what I wanted as the outcomes from the safeguarding process and these directly inform what happens'



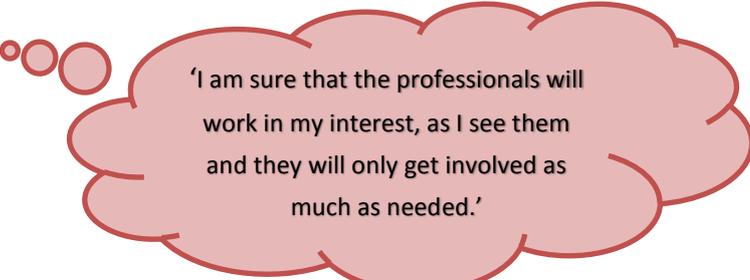
'I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help'

Prevention:

It is better to take action before harm occurs

Proportionality:

The least intrusive response appropriate to the risk presented.



'I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.'



'I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want'

Protection:

Support and representation for those in greatest need

Partnership:

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting



'I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together with me to get the best result for me'



'I understand the role of everyone involved in my life and so do they'

Accountability:

Accountability and transparency in delivering safeguarding

Appendix C - Standard Meeting Agenda Template

The issues discussed are confidential to the members of this meeting and, as applicable, the agencies they represent. They will only be shared with explicit agreement by the Chair.

Name of Adult	
Address	
Date of Birth	
Unique ID	
Date	
Time	
Venue	

Attendees (“Sign In” sheet to be completed with all contact details)

Name	Role

Apologies:

Name	Role

Item	Subject	Lead
1	Introductions	All
2	Reason for the MARM Meeting	Chair
3	Confirmation of mental capacity & advocacy/support arrangements	Assessor
4	Contribution by the adult (or advocate/representative)	
5	Contributions by involved family or friends	
6	Subject matter specialist contributions (eg: police, clinical, medical, etc)	
7	Risk Action Planning a) Confirmation of key contact with the adult b) Agreed Risk Actions (What, Why, When, Who, How) c) Resource requirements—confirmation of availability d) Review arrangements	Chair Membership
8	Confirmation of membership & deputizing arrangements	All
9	Any other issues or queries	All
10	Date, time, venue of next meeting	Admin

Appendix D - Multi-Agency Risk Action Plan Template

Name of person completing the plan:	Telephone Number:	Email address:	
Name of Key Contact:	Telephone Number:	Email address:	
Person to be supported			
Name: Jennifer (Scenario 1)	Date of Birth: **/**/****	Gender: Female	
Current Address: C/o Anytown Road, Anytown	Postcode: AT5 5JB	Email: Telephone Number: ****	
Unique ID:			
Date Risk Action Plan Implemented:			
Outcome desired	Action Required	Who	When
Jennifer to be supported in maintaining independence and her rights to privacy and family life; whilst ensuring that the agencies involved have effectively discharged their statutory duties.	Confirmation of Jennifer's executive decision making capacity	LD Psychologist with LD Psychiatrist	Immediate – date of plan
Confirmation if any criminal activity is known to have occurred within the area.	Police to interrogate local intelligence regarding sexual exploitation activity and confirm if criminal investigations should commence.	Police Officer	Immediate – date of plan
Jennifer to have access to subject matter expertise in relation to self-esteem, self-worth, and the impacts of sexual abuse	Jennifer to be encouraged to accept a referral to **** sexual abuse support agency	LD Nurse	Immediate – date of plan
Jennifer's involvement, control and co-production of immediate and future care/support planning arrangements.	Jennifer to be encouraged to accept a referral to Anytown Advocacy Project	LD Nurse	Immediate – date of plan
Jennifer to positively access local community sexual health services.	GP to review current access arrangements	GP	Review 1 week
Jennifer is able effectively manage her finances to maintain an adequate diet	Continued encouragement to access budget management support and to follow an adequate diet plan	LD Nurse	Ongoing
Contingency Plan	Ensure Jennifer continues to be actively encouraged to access: an Independent Advocate; subject matter experts in sexual abuse support; accurate and up to date information regarding her future options		
Indicators / triggers for further action	Monitoring of Jennifer's engagement in support planning		
Contingency plan in the event of any further / on-going concerns	A review should be arranged when Jennifer's executive capacity assessment is confirmed; this will dictate future risk action planning and any other applicable legal implications		
Review date	2 weeks from the date of this Risk Action Plan		
Agreed by the person to be supported	Yes	No	
Signature of the person to be supported		Date:	