Multi-Agency Safeguarding Adults
Policy, Protocols and
Practitioner Guidance
for Kent and Medway

Adult Safeguarding Policy
Adult Safeguarding Protocols
Adult Safeguarding Practitioner Guidance
Appendices

Revised September 2017
a) Kent County Council Social Care Health and Wellbeing Directorate
b) Medway Children and Adults Directorate
c) Clinical Commissioning Groups and Health Trusts in Kent and Medway
d) Kent Police
September 2017

Dear Colleague

Re: Revised Kent & Medway Multi-agency Safeguarding Adults Policy, Protocols and Guidance

The Kent & Medway Multi-agency Safeguarding Adults Policy, Protocols and Guidance has been updated in accordance with the statutory safeguarding adults’ responsibilities, new legislation, lessons learnt from case reviews, audits and practice.

It will be the responsibility of Board Members, providers and partners to understand and implement their statutory responsibilities in line with the Care Act 2014. It is important to recognise amendments made and to refer to the latest version of this document which will be on the Kent.gov and Medway.gov websites.

Yours sincerely,

Deborah Stuart-Angus
Chair of the Kent and Medway Multi-Agency Safeguarding Adults Board
Foreword

'Taken as a whole, these provisions set out a new legal framework for adult safeguarding, based on local authorities' existing responsibilities and practice, and current statutory guidance....'¹

The Care Act 2014 replaced the No Secrets Guidance and sets responsibility for adult safeguarding in primary legislation, endorsing the principle of wellbeing, placing safeguarding adult's duties on a statutory basis. Thus the responsibilities for the Kent & Medway Safeguarding Adults Board now exist including safeguarding duties having legal effect on partners with clear statutory responsibility to ensure enquiries into abuse and neglect are made or caused to be made. Safeguarding Adults Boards are placed on a statutory footing, with a legal requirement for Safeguarding Adult Reviews to take place and a duty to cooperate is placed on and between the Board Members and relevant partners.

Section 46 of the Care Act repeals Section 47 of the National Assistance Act and Section 47 updates Section s46 of the National Assistance Act, regarding the duty to protect the adult's property if an adult at risk is admitted to hospital or a care home. It also re-enacts the Section 55 offence in the National Assistance Act. Schedule 2 of the Care Act sets out Statutory Board responsibilities and Care and Support and eligibility information can be found in the Statutory Regulations (attached in the Appendices to this document).

Statutory Guidance supports the Act and Section 14 clearly states that safeguarding is defined as protecting an adult's right to live in safety, free from abuse and neglect. There is a clear duty for Board Members to cooperate in order to prevent abuse and neglect, whilst strongly promoting an adult's well-being. It is part of the Section 42 responsibility to establish the outcomes that an adult at risk may require and it is important to obtain the views and wishes of the adult when deciding how, if and what action, should be taken. The Guidance also recognises that interpersonal relationships are complex and that an adult may experience ambivalence and be unclear and unrealistic about their personal circumstances.

The Act places a requirement (Section 42) on a Local Authority, to make or cause safeguarding enquiries, if there is concern that an adult with care and support needs (met or unmet) is experiencing, or is at risk of abuse and or neglect. This applies regardless of mental incapacity or capacity and setting, other than in a prison or approved premises, where different arrangements are in place. Where both care and support needs are not present but safeguarding concerns exist non-statutory enquiries can be carried out.

In line with "the making safeguarding personal" principles of the Act safeguarding duties need to establish the desired outcomes for the adult (or their representative). It will also be necessary to gather their wishes regarding actions that may need to be taken to stop or prevent the abuse or neglect and if so by whom. Where an adult has ‘substantial difficulty’ in being involved in safeguarding actions or processes, and where they do not have an appropriate representative, a duty exists to arrange for an independent advocate to represent and support the adult. This also applies if the adult is subject to a Safeguarding Adult Review (the latter replaced Serious Case Review).

This document then has been developed to meet and work within the safeguarding adult lawful requirements set out within the Care Act 2014; it’s supporting Statutory Guidance and the associated Schedules and Regulations. It should be noted that the Policy set out within this document will, where necessary and appropriate, take into account and pay due regard to, any discretionary powers set down within the Care Act 2014 where this will support effective safeguarding and decision making and in addition to the duties set out within the Statutory Regulations, the principle of well-being will be adhered to at all times.

This document is divided into three parts:

Part 1 - Policy
This Section identifies various aspects of abuse and defines the pivotal importance of safeguarding adults to the Kent & Medway Safeguarding Adults Board.

Part 2 - Protocols
This Section aims to clarify and support the roles and responsibilities of practitioners and managers across agencies in relation to their safeguarding duty.

¹ Statutory Guidance, Care Act 2014
Part 3 - Guidance
This Section provides information on prevention; lawful accountability and good practice when aiming to meet an adult at risk’s personal outcomes.

The Act defines that the Lead Agency for safeguarding adults and implementing a Section 42 Safeguarding Duty is the ‘social services’, which means that responsibility sits with the appropriate team in Kent County Council Social Services or Medway Council’s Children and Adults Directorate.

In relation to Kent and Medway NHS and Social Care (Partnership) Trust and the Acute Hospital Trusts, they may continue to co-ordinate responses to a concern, however in all cases and all situations, it will be the responsibility of the Lead Agency to decide that a Section 42 duty has been satisfied.

The following agencies are represented on the Safeguarding Adults Board and are responsible for ensuring that all agencies and services in Kent and Medway deploy their mutual statutory responsibilities:

- Kent County Council
- Medway Council
- Kent Police
- NHS Health Trusts in Kent and Medway
- NHS England
- Clinical Commissioning Groups
- Kent Surrey and Sussex Community Rehabilitation Company
- National Probation Service
- District Councils in Kent
- South East Coast Ambulance Trust
- Kent Integrated Care Alliance
- Kent Fire and Rescue Service
- Kent Prison Service
- Abbeyfield Kent

Consultation and review
The Multi-Agency Adult Policy, Protocols and Guidance for Kent and Medway will be reviewed and updated annually in April to take account of any issues identified. Everyone is invited to comment on them at any stage. Updates will be published on the Kent and Medway Council’s website’s on www.kent.gov.uk and www.medway.gov.uk. People may forward their views in writing or by telephone to the following addresses:

The Safeguarding Adults Policy and Standards Manager Kent County Council, Social Services Headquarters, 4th Floor, Invicta House, County Road, Maidstone, Kent ME14 1XX

Principal Officer for Safeguarding Adults Medway Council, Children and Adults Directorate, Level 4, Gun Wharf, Dock Road, Chatham, Kent, ME4 4TR

New versions will be published on the Kent and Medway Council’s website’s on www.kent.gov.uk and www.medway.gov.uk

Complaints
To make a complaint about adult safeguarding please contact the Adult Social Services Complaints Team at Kent County Council or the Social Care Complaints Manager, Medway Council at the above addresses.

Please note all complaints are logged and acknowledged but it may not be appropriate for the complaint to be investigated until an adult safeguarding enquiry has concluded, at which time Customer Care services will contact you.
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Policy Section
1. The Legal duty of promoting wellbeing

The Care Act sets down, that it is the general duty of a Local Authority to promote well-being in relation to how people are treated and the following must form part of that:

a) personal dignity and respect
b) physical and mental health and emotional well-being
c) protection from abuse and neglect
d) control by an adult over their day-to-day life (including care and support and how it is provided)
e) participation in work, education, training or recreation
f) social and economic well-being
g) domestic, family and personal relationships
h) suitability of living accommodation
i) the individual's contribution to society

And in exercising this function the Local Authority must have regard to:

a) the importance of beginning with the assumption that the adult is best-placed to judge their own well-being
b) the adult's views, wishes, feelings and beliefs
c) the importance of preventing or delaying the development of needs for care and or support and the importance of reducing needs that may already exist
d) the need to ensure that decisions about an adult are made having regard to all of their circumstances and are not only based on age, appearance, condition or behaviour which might lead others to make unjustified assumptions about the adult’s well-being
e) the importance of the adult participating as fully as possible in decisions and being provided with the information and support to enable this to happen
f) achieving a balance between the adult’s well-being and that of their representative, involved in care
g) the need to protect people from abuse and neglect
h) the need to ensure that any restriction on the adult’s rights or freedom is kept to the minimum

Promoting wellbeing does not mean simply looking at a need that corresponds to a particular service. At the heart of the assessment and planning process there must be a genuine conversation about people’s needs for care and support and how meeting these can help them achieve the outcomes most important to them. The Care Act stipulates that where someone is unable to fully participate in these conversations and has no one to help them, adult social care will arrange for an independent advocate. This duty also applies for adults who are subject to a safeguarding enquiry or Safeguarding Adults Review (SAR).
2. **The six principles of adult safeguarding**

The six key principles that underpin all adult safeguarding work are:

**Empowerment**

Personalisation and the presumption of person-led decisions and informed consent.

“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

**Prevention**

It is better to take action before harm occurs.

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

**Proportionality**

Proportionate and least intrusive response appropriate to the risk presented.

“I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed.”

**Protection**

Support and representation for those in greatest need.

“I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”

**Partnership**

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

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

**Accountability**

Accountability and transparency in delivering safeguarding.

“I understand the role of everyone involved in my life.”

By deploying these principles this multi-agency policy will achieve its aims.

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3. Multi-agency principles and values
   a) It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity.
   b) Priority should be given to the prevention of abuse by raising the awareness of adult safeguarding issues and by fostering a culture of good practice through support and care provision, commissioning, contracting and partnership working.
   c) Adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services. All agencies will respond to adult safeguarding concerns with prompt, timely and appropriate action in line with agreed protocols.
   d) The policy and protocols are applicable to all adult client groups whether living in a domestic setting, care home, social services or health setting or any community setting.
   e) The partners to this document have a lawful duty and expect their employees and their contracted agents, whether purchasers or providers, to conform to these policy principles and protocols for adult safeguarding.
   f) Adult safeguarding is a multi-agency responsibility and this policy and protocols have been produced on a multi-agency basis to ensure that agencies actively work together to prevent abuse and neglect and remain lawfully accountable.
   g) This document acknowledges the principles of intervention based on the concept of empowerment and participation of an adult or their representative if this is appropriate.
   h) The adult safeguarding policy and protocols must constitute an integral and lawful part of the philosophy and working practices of all Board members and their associated agencies and should directly and positively influence those and other affiliated agencies.
   i) Adult safeguarding policy and protocols aim to integrate strategies relevant to issues of adult safeguarding contained in current legislation.
   j) It is the responsibility of all agencies to take steps to ensure that adults are discharged from their care to a safe and appropriate setting.
   k) The need to provide support for the carers will be taken into account when planning services for adults and a carer’s assessment must be offered.
   l) The policy, protocols and guidance are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age, diversity or sexual orientation.
   m) The partners involved in developing this document are committed to supporting multi-agency training, education and information for everyone concerned, to create a zero tolerance climate where abuse is unacceptable.

4. The aims of adult safeguarding
   Safeguarding must aim to stop abuse or neglect wherever possible; prevent harm and reduce risk of it happening and enable adults at risk to have choice and control in how they live their lives. It must also:

   a) Promote an approach that concentrates on improving life for the adults concerned
   b) raise public awareness
   c) enable communities to help prevent, identify and respond to abuse and neglect
   d) provide accessible information about types of abuse, staying safe, raising concerns and addressing cause
   e) enable access to community resources; safe town centres and groups to reduce isolation
   f) ensure roles & responsibilities are clear
   g) set strong multi-agency partnerships with supportive learning
   h) break down cultures that are risk-averse or scapegoat or blame practitioners
i) clarify how responses to safeguarding concerns derived from poor quality care; inadequacy of service provision & patient safety, should be responded to
j) recognise importance of recording and sharing information to show patterns of abuse
k) provide information and support in accessible ways to help people understand different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult.

It must also:
l) promote an outcomes approach that results in the best experience possible for the adult
m) raise public awareness to build on prevention in identifying and responding to abuse and neglect.

In order to achieve this, we need to:
n) listen to what adults at risk are telling us
o) make safeguarding personal
p) make sure our roles and responsibilities are clearly laid out
q) build on our already strong multi-agency framework for safeguarding
r) make sure there is access to mainstream community safety measures for adults
s) clarify the interface between safeguarding and quality of service provision

5. Independent Advocacy

5.1 The Care Act 2014

Requires that the Local Authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has ‘substantial difficulty’ in being involved in the process and where there is no other ‘appropriate person’ to represent and facilitate their involvement.

Independent Mental Capacity Advocates (IMCAs) may be involved in adult safeguarding if the authority has exercised its discretionary power under the MCA and appointed an IMCA if protective measures are being proposed for a person who lacks capacity, at the time to make the relevant decisions or understand their consequences.

If a safeguarding enquiry needs to start urgently then it can begin before an advocate is appointed but one must be appointed as soon as possible. All agencies need to know how the services of an independent advocate can be accessed and what their role is.

This duty applies in all settings, including for people living in the community, care homes, and hospitals but excluded from prisons and approved premises where prison governors and National Offender Management Service (NOMS) are responsible for safeguarding adults in custody.

Where an individual is eligible for NHS Continuing Health Care, the relevant Clinical Commissioning Group (CCG) is responsible for care planning, commissioning health and care and support services, and for case management. But the Local Authority will continue to have a role in relation to safeguarding responsibilities, and therefore the duty to instruct an advocate, if they meet the eligibility criteria.

5.2 Role of Independent Advocates

The role of the independent advocate is to support and represent the person and to facilitate their involvement in the key processes and interactions with the Local Authority and other organisations as required for the safeguarding enquiry or SAR.
Advocates can assist a person to:

a) Decide what outcomes/changes they want;
b) Understand the behaviour of others that are abusive/neglectful;
c) Understand which actions of their own may expose them to avoidable abuse or neglect;
d) Understand what actions that they can take to safeguard themselves;
e) Understand what advice and help they can expect from others, including the criminal justice system;
f) Understand what parts of the process are completely or partially within their control;
g) Explain what help they want to avoid reoccurrence and also recover from the experience.

5.3 Advocacy for Carers

If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to whether the carer may need to have independent representation or advocacy.

6. Making Safeguarding Personal

The LGA and ADASS Making Safeguarding Personal development project was drawn up in response to feedback from people who were using safeguarding services. The feedback was that adult safeguarding work focused on process and procedure and those using such services wanted focus on resolution of their circumstances, with more engagement and control.

Key messages from the Making Safeguarding Personal development project have been:

a) if practitioners only focus on making people feel safe, they compromise other aspects of their wellbeing, such as feeling empowered and in control.
b) using an outcome focused approach and engaging with the person throughout the safeguarding process can be done and it leads to better outcomes for the person and does not cost anything.
c) using an asset based approach to identify a person’s strengths and networks can help them and their family to make difficult decisions and manage complex situations, preventing future referrals and potentially delaying long term care.
d) approaches adopted were family group conferencing, focusing on person centred, outcome focused approach empowering adult to draw on their strengths and personal networks

e) as social workers start to apply these principles to all complex cases and there is a gradual shift in culture
f) adults and their representatives can feel there is no retribution for the perpetrator and this highlights the need to support people in getting better access to justice and using restorative approaches

g) small changes can be made at relatively no cost to social work practice

h) further research and development is needed to fully explore approaches that help people to make difficult decisions in complex circumstances. See link below for further information:

Making Safeguarding Personal Executive Summary

In order to support the principles of Making Safeguarding Personal, it is the responsibility of the Local Authority to ensure that the adult/representative/advocate and/or the referrer, are kept informed throughout the progress of a safeguarding case and are made aware of any delays that may occur, providing this does not compromise police investigation or enquiries being carried out by others.
7. To whom does this Policy apply including Section 42 Duties

7.1 Safeguarding Concerns

A safeguarding concern is defined as the first contact between a person concerned about the abuse or neglect and the Local Authority or their representative.

7.2 Safeguarding Enquiry

This refers to any enquiries made or instigated by the Local Authority AFTER receiving a safeguarding concern. There are two types of safeguarding enquiries. If the adult fits the criteria outlined in Section 42 of the Care Act, then the Local Authority is required by law to conduct enquiries or ensure that enquiries are made. These will be referred to as ‘Statutory Safeguarding Enquiries’. Local Authorities will sometimes decide to make safeguarding enquiries for adults who do not fit the Section 42 criteria. These enquiries are not required by law and therefore will be referred to as ‘Non-Statutory Enquiries’.

7.3 Statutory Safeguarding Enquiry

S.42 of the Care Act 2014 sets out the statutory eligibility criteria:

Where a Local Authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident) and that adult has:

a) needs for care and support (whether or not the authority is meeting any of those needs)

b) is experiencing, or is at risk of, abuse or neglect, and

c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Then the Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case and, if so, what should happen and by whom. This then constitutes a statutory Section 42 enquiry.

The Care Act Regulations (eligibility criteria) define a care and support needs as arising … “from or are related to a physical or mental impairment or illness”

7.4 Non-Statutory Safeguarding Enquiry

These are safeguarding enquiries carried out on behalf of adults who do not fit the criteria outlined in Section 42 of the Care Act 2014. Local Authorities are not required by law to carry out enquiries for these individuals and do so at their own discretion.

The most likely circumstance in which the local authority may undertake a non-statutory enquiry is with respect to an individual who is providing care for someone with care and support needs (though not in a paid capacity or as part of a voluntary organisation).

The Care Act places a duty on local authorities to assess the support needs of carers and provide services where those support needs meet eligibility criteria. The Care Act Regulations (eligibility criteria) define a support needs as arising… “as a consequence of providing necessary care for an adult”
A non-statutory safeguarding enquiry may be instigated where an adult with support needs (as defined by the Care Act Regulations) is experiencing or at risk of abuse from the individual they care for and as a consequence of their caring role is unable to protect themselves from the abuse.

7.5 Who may be considered for statutory and/or non-statutory enquiries?

This may include people with learning disabilities, mental health issues, older people, Care Leavers (18+) and people with a physical disability or impairment. It may also include adult victims of abusive care practices; neglect and self-neglect; domestic abuse; historic child sexual exploitation (CSE); hate crime; female genital mutilation; forced marriage; modern slavery; human trafficking; honour based violence and anti-social abuse behaviour.

An adult’s need for additional support to protect themselves may be increased when complicated by additional factors, such as, physical frailty or chronic illness, sensory impairment, challenging behaviour, exploitation, drug or alcohol problems, social or emotional problems, poverty or homelessness and it is important to note that vulnerability can fluctuate.

Many adults may not realise that they are being abused and/ or exploited, particularly where there is an abuse of power, a dependency, a relationship or a reluctance to assert themselves for fear of making the situation worse. These issues are often seen in cases of Domestic Abuse.

For more information please see: The Care Act http://www.legislation.gov.uk/ukpga/2014/23

7.6 Who will lead?

The Local Authority is the lead agency for Section 42 Enquiries and police will lead criminal investigations, however the Local Authority will decide when a case can be closed to the Local Authority and if the Section 42 duty is satisfied.

7.7 Criminal offences

Many instances of abuse will constitute a criminal offence. Appropriate intervention must take into account that this may lead to criminal proceedings. Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating investigative action rests with the Police and decisions regarding prosecution are the responsibility of the Crown Prosecution Service. Therefore whenever complaints about alleged abuse suggest that a criminal offence has been committed, the police must be contacted. Consultation with the police is imperative to ensure police investigations are not hampered and evidence not contaminated. If an adult at risk reports a crime they should be advised that the police will be informed. If they are not prepared to support police action or believe that involving the police will put them at further risk, the police will be advised of this. The police will use the principles of safe enquiry which is core to all its work with victims in domestic abuse case work.

7.8 Early Sharing of Information

Early sharing of information is the key to providing effective help where there are emerging concerns. Statutory Guidance advises us that the fear of sharing information must not stand in the way of promoting and protecting the well-being of adults at risk of abuse and neglect. In relation to ensuring effective safeguarding, arrangements are in place that set out the processes and the principles for sharing information between each other, with other professionals and the Safeguarding Adults Board. A professional should never assume that someone else will pass on information which they think may be critical to the safety and well-being of an adult at risk of abuse or neglect. If a professional has concerns about an adult’s welfare in relation to abuse and/or neglect they should share the information with the
Local Authority. Communities can also help by being aware of abuse and neglect, how to respond and how to keep people safe. **If a criminal act is committed the Statutory Guidance advises that sharing of information does not rely on the consent of the victim.** Criminal investigation by the police takes priority over all other enquiries but not over the adult’s well-being and close co-operation and coordination among the relevant agencies is critical to ensure safety and well-being is promoted during the criminal investigation process.

7.9 Recognising abuse

'Research to date has found cases of abuse and neglect in all social and economic strata, in rural and urban settings, in all religious groups and in all races.'

It is important to consider the environment and context in which abuse is alleged or suspected because exploitation, deception, misuse of authority, intimidation or coercion may result in the adult being incapable of making his or her own decisions. Initial rejections of help should not always be taken as final. Provision of a safe place, should be considered to enable the adult to feel safe in order to be able to make a free choice about how to proceed. It is important to recognise adult abuse at an early stage and take effective action within the multi-agency framework to address the issues.

7.10 Adult to adult abuse

It is important to understand that an adult at risk may be abused by another adult. In some settings this behaviour may not have been considered to be abuse. Research has shown that where this kind of abuse is ignored or not addressed appropriately, the victims may suffer mental health problems, low self-esteem and may also become perpetrators of abuse against others. It is therefore necessary to address what may have become culturally acceptable behaviour as this could be an acceptance that adults abuse each other, or come from settings where behaviour and/or attitudes (which we now agree to be abusive) were accepted and condoned by staff and/or adults living in those establishments. When adults are subject to auspices of the Mental Health Act 1983 or the criminal justice system, they are still entitled to be both protected from abuse and prevented from abusing other adults at risk.

**Additional Guidance. When adult(s) with care and support needs or support needs alone abuse each other**

8. Types and Patterns of Abuse

Abuse and neglect can take many forms and every case should always be considered on its own merit with due consideration given to individual circumstances. The following categories of abuse are not mutually exclusive and an adult may be subject to more than one type of abuse at the same time, whatever the setting.

It is important to recognise that some adults may reveal abuse themselves by talking about or drawing attention to physical signs or displaying certain actions/gestures. This may be their only means of communication. It is important for carers to be alert to these signs and to consider what they might mean.

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3 Bennett.D.G: Shifting Emphasis from Abused to Abuser, May 1990
Abuse or neglect may be deliberate, or the result of negligence or ignorance. Unintentional abuse or neglect may occur owing to life pressures or as a result of challenging behaviour which is not being properly addressed. It is the intent of the abuse or neglect which is therefore likely to inform the type of response.

Abuse can happen anywhere: for example, in someone's home, in a public place, in hospital, in a care home or in a college. It can happen when someone lives alone or with others. It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse, the role of family members and paid staff or professionals.

Further information about indicators of abuse under each of these main headings can be found in the Guidance Section.

**Types of Abuse**

8.1 **Physical abuse**

a) hitting, slapping, scratching  
b) pushing or rough handling  
c) assault and battery  
d) restraining without justifiable reasons  
e) inappropriate and unauthorised use of medication  
f) using medication as a chemical form of restraint  
g) inappropriate sanctions including deprivation of food, clothing, warmth and health care needs  
h) female genital mutilation

8.2 **Sexual abuse**

a) sexual activity which an adult client cannot or has not consented to or has been pressured into  
b) sexual activity which takes place when the adult client is unaware of the consequences or risks involved  
c) rape or attempted rape  
d) sexual assault or harassment  
e) Non-contact abuse e.g. voyeurism, pornography

8.3 **Psychological abuse**

a) Emotional abuse.  
b) Verbal abuse.  
c) Humiliation and ridicule.  
d) Threats of punishment, abandonment, intimidation or exclusion from services.  
e) Isolation or withdrawal from services or supportive networks.  
f) Deliberate denial of religious or cultural needs  
g) Forced marriage  
h) Failure to provide access to appropriate social skills and educational development training  
i) Faith abuse

8.4 **Financial abuse**

a) having money misused or stolen  
b) having property stolen  
c) being defrauded
d) being put under pressure in relation to money or property

e) having money or property misused

f) finance or property mismanagement by a Registered Enduring Power of Attorney or Lasting Power of Attorney for Property & Affairs or a Deputy appointed by the Court of Protection.

8.5 **Neglect and acts of omission**

a) Ignoring medical or physical care needs

b) Failure to access care or equipment for functional independence

c) Failure to give prescribed medication

d) Failure to provide access to appropriate health, social care or educational services

e) Neglect of accommodation, heating, lighting etc.

f) Failure to give privacy and dignity

g) Professional neglect

h) Failure by a Registered Lasting Power of Attorney for Health and Welfare or a Deputy appointed by The Court of Protection to act in the **Best Interests** of the Donor of that attorneyship or deputyship, when the Donor has lost capacity to make the relevant decision(s) for themselves.

8.6 **Self-Neglect**

This should necessitate assessment by social and/or health care professionals which should be carried out within the guidance contained within the Mental Capacity Act 2005. For more information please see Social Care Institute for Excellence [Self Neglect Report - 46](#)

> “It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support. (From the statutory guidance, updated Dec 2016)

This is the link to Kent and Medway Multi-agency Policy and Procedures to Support People who Self-Neglect [Self-Neglect Policy and Procedure](#)

**Patterns of Abuse and the Circumstances in which they might take place:**

8.7 **Exploitation**

a) opportunistically or premeditated

b) unfairly manipulating someone (grooming) for profit or personal gain

c) modern slavery

d) human trafficking

e) radicalisation

f) cuckooing

g) mate crime

8.8 **Discrimination**

a) Discrimination demonstrated on any grounds including sex, race, colour, language, culture, religion, politics or sexual orientation

b) Discrimination that is based on a person's disability or age

c) Harassment and slurs which are degrading
d) **Hate crime**

### 8.9 Organisational abuse

Organisational abuse refers to abusive and poor care and or clinical practices that may develop when an adult is living or staying in a care home, or receiving respite or attending a day care establishment, or are receiving treatment or assessment in a Hospital or other NHS service or in relation to care provided in their own home - and they are potentially vulnerable to abuse and exploitation. This can be especially so when care standards and practices fall below an acceptable level as detailed in contractual specifications or fall below the Fundamental Standards for Quality and Care, as set out under the Care Act 2000.

### 8.10 Multiple forms of abuse

An individual or a group of individuals can carry out abuse or neglect. Patterns of harm may emerge and may include multiple forms of abuse, which can happen in an ongoing relationship, or in a service setting, or to several people at any one time. Patterns should be recorded and professionally shared, as repeated instances of poor care may for example, be an indication of organisational abuse. It is important to look beyond single incidents or breaches in standards, to underlying dynamics and patterns of harm. Any or all of these types of abuse may be perpetrated as the result of deliberate intent and targeting of adults at risk, negligence or ignorance. Examples are:

Serial abusing - in which the perpetrator(s) seek out and grooms an adult at risk.

This can be characterised by sexual abuse and or financial abuse:

a) long-term abuse - where the context may be an ongoing family relationship where domestic abuse may have become part of a relationship or part of generational behaviours

b) opportunistic abuse - such as theft occurring because the opportunity presents itself such as money or valuables unattended

### 8.11 Inappropriate Restraint

Department of Health Guidance: [Positive and Proactive Care](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300291/JRA_DoH_Guidance_on_RH_Summary_web_accessible.pdf) Reducing the Need for Restrictive Interventions, provides a framework to assist health and social care services to develop a culture where restrictive interventions are only ever used as a last resort and for the shortest possible time. It identifies key actions that will better meet people’s needs and enhance their quality of life, reducing the need for restrictive interventions and sets out mechanisms to ensure accountability for making these improvements, including effective governance, transparency and monitoring. Some key points from the guidance are:

a) staff must not deliberately restrain people in a way that impacts on their airway, breathing or circulation, such as face down restraint on any surface not just a floor

b) if restrictive intervention is used it must not include deliberate application of pain and must always represent the least restrictive option to meet the immediate need

c) staff must not use seclusion (this may differ if the person is subject to detention under Mental Health Act 1983)

d) People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support
e) Individualised support plans, incorporating planning for managing behaviour, must be implemented for people who use services and who are known to be at risk of being exposed to restrictive interventions

f) Providers must have clear local policy requirements and ensure these are available and accessible to users of services and carers

g) Post-incident reviews and debriefs must be planned so that lessons are learned when incidents occur where restrictive interventions have had to be used Section 6(4) of the Mental Capacity Act (MCA) 2005 states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something they are resisting, or restrict a person’s freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

h) the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and

i) the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

The final decision to restrain an individual rests with the responsible manager and it is essential that any instances of restraint are clearly recorded. The information must specify the following:

j) reason for restraint

k) nature of risk leading to restraint

l) method of restraint

m) who was involved in the restraint

n) date, time and duration of restraint

o) any injuries noted as a result of the restraint

It is essential that the person’s representative is kept informed of any such actions and if the agreed management procedures are ineffective, the responsible manager should immediately confirm the actions taken, (in writing), to the care manager/social worker/health professional and (where appropriate) seek their advice regarding future management of the adult’s behaviour.

If good principles of physical intervention are not in place and applied appropriately, any form of physical intervention may be considered to be abusive and it is essential that the following is in place:

p) an identified lead for increasing use of recovery-based approaches including (where appropriate) positive behavioural support planning and reducing restrictive interventions

q) a policy for managing challenging behaviour, which must be available and accessible to adults at risk, their representatives and professionals

r) a staff training programme which validates competence to carry out procedures

s) an agreed methodology of recording incidents

t) an internal audit programme to include reviews of the quality, design and application of behaviour support plans, or their equivalents.

8.12 Domestic abuse

The definition of domestic abuse applies to males and females and is referred to as:

‘a pattern of incidents of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.'
(Statutory Guidance Framework - Controlling or Coercive Behaviour in an Intimate or Family Relationship)

This can encompass but is not limited to the following types of abuse:

a) psychological
b) physical
c) sexual
d) financial
e) emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Domestic abuse is not a specific criminal offence in itself but can incorporate a range of incidents and criminal offences, victims can be from all Sections of society irrespective of race, culture, nationality, religion, sexuality, disability, age, class, educational level, gender or from any ethnic group, however national statistics show an extremely high prevalence of domestic abuse against women by men.

Kent Police will record all reports of domestic abuse and will investigate as necessary. Please see: Serious Crime Act 2015

Incidents reported by the police regarding an adult at risk may be also being addressed under these adult safeguarding procedures. The six key principles (The six principles of adult safeguarding) in safeguarding adults apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider Local Authority functions and the criminal justice system.

In Domestic Abuse situations the principle of safe enquiry is core to all work with victims. This should be undertaken sensitively to empower the adult to share their views and wishes. The adult must be provided with all relevant information and independent advocacy support where required to support them with making informed decisions. Where a criminal offence is suspected, the police must be informed even if consent has not been given. However, the views and wishes of the victim will be sought regarding any response by the police. If the crime impacts on other adults or children, the police will act accordingly.

Here is a link to the Joint Police Social Service and Health Protocol for Dealing with Cases of Domestic Violence where Adults are involved. This protocol deals with risk assessment and referral processes to the multi-agency Risk Assessment Conference (MARAC) to enable a streamlined and dovetailed approach.

Here is the guidance from the LGA/ADASS Adult Safeguarding and Domestic Abuse, A Guide for Practitioners and Managers
From 13\textsuperscript{th} April 2011 there has been a statutory requirement to consider carrying out a Domestic Homicide Review in all relevant cases. Kent and Medway have developed separate Domestic Homicide Review Protocols which support local practice. These have been written in line with the Home Office Guidance

For further information please see: http://www.domesticabuseservices.org.uk/

8.13 Hate Crime

Hate crimes and incidents can be against the person or property. Hate Crime hurts and it can be motivated by the offender’s hatred of people who are seen as being different. An adult or child may be a victim because of race, religion, disability, age, sexuality or gender.

True Vision has a website to enable those targeted to report hate crime as a result of their physical disability, sensory impairment, learning disability or mental health needs. (For Kent Police Hate Crime contacts please see Appendix 1).

8.14 Mate Crime

Mate Crime occurs when someone ‘makes friends’ with a person and goes on to abuse or exploit that relationship. The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a repeat and worsening abuse.

Mate crime can happen to anyone but children and adults with learning difficulties are especially vulnerable.

8.15 Modern Slavery or Human Trafficking

8.15.1 Introduction and definitions
According to the International Organization for Migration (IOM), millions of people, primarily women and children, are subjected to human trafficking and this is a violation of human rights and dignity. This is described by the UK National Crime Agency as:

\textit{movement of a person from one place to another into conditions of exploitation, using deception, coercion, the abuse of power or the abuse of someone’s vulnerability. It is possible to be a victim of trafficking even if your consent has been given to being moved. Although human trafficking often involves an international cross-border element, it is also possible to be a victim of human trafficking within your own country.}^5

There are three main elements:

\begin{itemize}
  \item[a)] The movement – recruitment, transportation, transfer, harbouring or receipt of people
  \item[b)] The control – threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or giving of payments or benefits to a person in control of the victim
  \item[c)] The purpose – exploitation of a person, which includes prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs.
\end{itemize}

\textsuperscript{5} http://www.nationalcrimeagency.gov.uk/crime-threats/human-trafficking
Children cannot give consent to being moved; therefore the coercion or deception elements do not have to be present. Countries throughout Europe translate and interpret the Palermo Protocol in different ways so the definition of what constitutes human trafficking can differ between nations.

The UK Human trafficking centre (UKHTC) plays a central role in the NCA’s fight against serious and organised crime. Find out more about the UK Human Trafficking Centre.

8.15.2 Reporting human trafficking
In the first instance the point of contact for all human trafficking crimes should be the local police force. If you have information about human trafficking or hold urgent information that requires an immediate response dial 999. If you hold information that could lead to the identification, discovery and recovery of victims in the UK, you can also contact the charity Crime stoppers anonymously on 0800 555 111.

National Referral Mechanism Guidance and links to Reporting Form
Kent and Medway Protocols for Adults who are at risk of Sexual Exploitation, Modern Slavery and Human Trafficking

8.16 Forced Marriage

You have the right to choose who you marry, when you marry or if you marry at all. Forced marriage is when physical (e.g. threats, violence or sexual violence), emotional and or psychological pressure (e.g. person is made to feel like they are bringing shame on the family) is brought to bear to make one person marry another.

8.16.1 Forced marriage offences
Forced marriage is illegal in England and Wales and this includes:
   i. taking someone overseas to force them to marry (whether or not the forced marriage takes place)
   ii. marrying someone who lacks the mental capacity to consent to the marriage (whether they’re pressured to or not)

Forcing someone to marry can result in a prison sentence.

8.16.2 Preventing or trying to stop a forced marriage
Contact the Forced Marriage Unit (FMU) if you are trying to stop a forced marriage or a person needs help leaving a marriage that they have been forced into. Trained professionals provide free advice on what to do next and can help with finding a safe place to stay or stopping a UK visa if a person has been forced to sponsor someone (contact details are in Appendix 1).

8.16.3 Forced marriage abroad
Contact the police and FMU if you think a person is about to be taken abroad or has been taken abroad to get married against their will. If they are already abroad, provide details regarding
   i. where the person has gone
   ii. when they were due back
   iii. when they were last heard of or from

The FMU will contact the relevant embassy. If they are a British national, the embassy will try to contact the person and help them get back to the UK if that’s what they want.

8.16.4 Forced marriage Protection Orders
The FMU can advise how to ask the court for a Forced Marriage Protection Order. Each order is unique, and is designed to protect according to individual circumstances e.g. the court may order someone to hand over your passport or reveal where you are. In an emergency, an order can be made to protect immediately. Disobeying a Forced Marriage Protection Order can result in a prison sentence.

8.16.5 Support for victims
Read the handbook about being a survivor of forced marriage containing further details of organisations that can give help and advice.

8.17 Female Genital Mutilation (FGM)

The World Health Organisation (2003) defines Female Genital Mutilation (FGM) as the partial or total removal of external female genitalia for non-medical reasons. FGM is also known as female circumcision, cutting or Sunna. Sometimes, religious, social or cultural reasons are put forward for this happening but it is abuse and a criminal offence, to a woman or child. The term covers all harmful procedures to the female genitalia for non-medical purposes. FGM ranges from pricking or cauterising the genital area, through partial or total removal of the clitoris, cutting the lips (the labia) and narrowing the vaginal opening. Changes to the FGM legislation now describes tattooing and genital piercing to the genitalia as a form of FGM.

The UK Government defines FGM as a crime, a form of child abuse, breach of human rights and a form of violence against women and girls. Key Amendments to the FGM legislation in Serious Crime Act 2015 included:

Extension of Extra-Territorial Jurisdiction
Section 70(1) of the Serious Crime Act 2015 ("the 2015 Act") amends section 4 of the 2003 Act so that the extra-territorial jurisdiction extends to prohibited acts done outside the UK by a UK national or a person who is resident in the UK.

Anonymity of Victims of FGM
Section 71 of the 2015 Act amends the 2003 Act to prohibit the publication of any information that would be likely to lead to the identification of a person against whom an FGM offence is alleged to have been committed. Anonymity will commence once an allegation has been made and will last for the duration of the victim’s lifetime.

Offence of Failing to Protect a Girl from Risk Of FGM
Section 72 of the 2015 Act inserts a new section 3A into the 2003 Act; this creates a new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 18, each person who is responsible for the girl at the time FGM occurred will be liable under this new offence. The maximum penalty for the new offence is seven years’ imprisonment or a fine, or both.

Female Genital Mutilation Protection Order (FGMPO)
Section 73 of the 2015 Act provides for FGMPOs for the purposes of protecting a girl against the commission of a genital mutilation offence or protecting a girl against whom such an offence has been committed. Breach of an FGMPO will be a criminal offence with a maximum penalty of five years’ imprisonment, or as a civil breach punishable by up to two years’ imprisonment.

Duty to Notify Police of Female Genital Mutilation
Section 74 inserts a new section 5B into the 2003 Act which creates a new mandatory reporting duty requiring specified regulated professionals in England and Wales to make a report to the police. The duty applies where, in the course of their professional duties, a professional discovers that FGM appears to have been carried out on a girl aged under 18
(at the time of the discovery). The following hyperlink provides guidance designated professional in relation to mandatory reporting.


The following hyperlink provides information on FGM fact sheet for agencies and service users.

More information can be found by contacting help@nspcc.org.uk or calling 0808 800 5000

8.18 Child Sexual Exploitation (CSE)

This is a form of child abuse which involves receiving something in exchange for sexual activity.

Local Safeguarding Children Boards (LSCBs) are responsible for ensuring that appropriate local procedures are in place and all frontline practitioners must be aware of the procedures and how they relate to their own area of responsibility. The Kent and Medway Safeguarding Children Procedures provide further information.

8.19 Online Safeguarding:

Online Safeguarding is not just an IT issue; it is about safeguarding young people and adults in the digital world as part of our safeguarding responsibilities. The focus should be on building resilience to online risk in order for people to feel safe and confident using online services. This often requires professionals, carers, advocates etc., to build their own understanding of today’s digital world.

The Kent Safeguarding Children’s Board have an Online Safeguarding page on their website which provides guidance to enable multi-agency staff to consider online safety within their safeguarding responsibilities and develop and implement a single and multi-agency approach to online safety. It also highlights very useful websites to help gain a greater understanding in this area of work. Further work is being carried out by the Kent and Medway Children and Adults Online Safeguarding Group to address the emerging issues raised around online safety which will produced in late 2017

9. Adults affected by Deprivation of Liberty Safeguards (DOLS)

9.1 Introduction

DOLS are set within the precepts of the Mental Capacity Act 2005 and they extend the provisions of that Act. The definition of what constitutes deprivation of liberty has been re-defined under what is known as the ‘acid test’ – set out in the Supreme Court Judgement,

* Safeguarding children and young people from sexual exploitation statutory guidance
19 March 2014 and so an adult who would normally engage in the full freedoms of a citizen, may only be deprived of their liberty when:

a) they are aged over 18  
b) they experience a mental disorder  
c) it is their best interests to protect them from harm  
d) it is a proportionate response to the likelihood and seriousness of the harm  
e) there is no less restrictive alternative  
f) they lack capacity to give consent to the arrangements made for their care or treatment in a care home, hospital or community setting under public or private arrangement  
g) detention under the Mental Health Act 1983 is not appropriate for the person at that time  

The ‘acid test’ is fulfilled if the following three aspects are present: the person is subject to continuous supervision and control and are they not free to leave i.e. staff would try to bring the person back and in all cases, the following are irrelevant to the application of the test: the person’s compliance or lack of objection; the relative normality of the placement and the reason or purpose for the placement having been made - Visit www.kent.gov.uk/mentalcapacityact or medway.gov.uk for the judgement and information on MCA and DOLS.

The spirit of Mental Capacity Act CA 2005 and DOLS should encourage a person centred view of the restrictions in place for an adult. The 5 principles of the Mental Capacity Act 2005 (MCA) should always be borne in mind as DOLS exist to safeguard individuals when a deprivation of liberty cannot be avoided. This must be part of a best interests care plan. Adults who are identified as being potentially deprived of their liberty must be considered on a case-by-case basis and all appropriate steps taken to remove the risk of a deprivation of liberty where possible, with a continuous emphasis on their empowerment and enablement.

Before considering deprivation of liberty, supporting documentation, including mental capacity assessments, risk assessments and best interest decisions, must be completed. Where a potential deprivation of liberty is identified, a full exploration of the alternative ways of providing the care and/or treatment should be undertaken, in order to identify any less restrictive ways of providing that care and/or treatment which will avoid a deprivation of liberty. Where the lack of capacity is confirmed and formally assessed, the acid test should be applied. If it is not possible to avoid deprivation of liberty, you may need to seek further advice.

9.2 Restraint/restriction of liberty

This is the use or threat of force to help carry out an act that the person resists and it may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

9.3 Practical steps to reduce the risk of deprivation of liberty occurring

Staff should minimise the restrictions imposed and ensure that decisions are taken with the involvement of the relevant person and their representative, family, friends and or carers.

a) make sure that all decisions are taken and reviewed in a structured way and reasons for decisions are recorded  
b) follow established good practice for care planning  
c) make a proper assessment of whether the adult lacks capacity to decide whether or not to accept the care or treatment proposed, in line with the principles of the Mental Capacity Act

7 P v Cheshire West and Chester Council and another P and Q v Surrey County Council
d) before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consider whether the person’s needs could be met in a less restrictive way

e) any restrictions placed on the person while in hospital, in a care home or in their own home, must be kept to the minimum necessary and should be in place for the shortest possible time

f) take proper steps to help the adult stay in contact with their representative, family, friends and or carers (if advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers)

g) review the care plan on an ongoing basis

h) consider contributions to care planning and review from advocates and representatives

9.4 Authorising a deprivation of liberty

The DOLS process for obtaining a standard authorisation or urgent authorisation can be used where adults lacking capacity are deprived of their liberty in a hospital or care home. The Court of Protection can also make an Order authorising a deprivation of liberty in domestic settings such as the adult’s own home and supported living arrangements. This route is also available for complex cases in hospital and/or care home settings.

9.5 The link between DOLS and safeguarding adults processes

Where a Best Interests Assessor (BIA) concludes that deprivation of liberty is not occurring, a DOLS authorisation would not be granted. In cases where authorisation is not granted because the best interest’s assessment fails for other reasons, e.g. the deprivation is not considered to be in the relevant person’s best interests, or mental capacity assessment fails because the person is assessed to have capacity, then it becomes a situation of unlawful deprivation of liberty and potential safeguarding concern.

When this happens, the relevant Supervisory Body (SB) authoriser is immediately alerted by the DOLS office so that they are aware of the seriousness of the unlawful situation. The DOLS office will also immediately inform the Managing Authority (MA) that DOLS authorisation is not granted and the relevant person is now being unlawfully deprived of their liberty. The responsibility then falls on the individual SB to contact the MA and agree to take things forward as appropriate, so that action is taken to end the unlawful deprivation of liberty as swiftly as possible and safeguarding alerts raised where appropriate.

9.6 Responsibilities of a registered Power of Attorney or Deputy

9.6.1 The Office of the Public Guardian
The Office of the Public Guardian (OPG) supports and promotes decision making for those who lack capacity, within the framework of the MCA (2005). Established in October 2007, the OPG supports the Public Guardian in registering and supervising Enduring Powers of Attorney (EPA) and Lasting Powers of Attorney (LPA), and supervising Court of Protection (CoP) appointed Deputies.

9.6.2 Powers of Attorney
People who lack mental capacity may require someone else to manage their financial, social and health affairs. The Mental Capacity Act 2005 made provision for people to choose someone to manage not only their finances and property should they lose capacity but also to make health and welfare decisions on their behalf. They will be able to do this through a Lasting Power of Attorney (LPA). Property and Affairs LPAs replaced Enduring Powers of Attorney (EPAs) in 2007. Please note that EPAs registered before 2007 are still valid (dependent on restrictions contained within the document). Practitioners must always ensure they receive valid documents and save a copy on file.
9.6.3 Enduring Power of Attorney
An Enduring Power of Attorney is a legal process in which a person (the Donor) hands over to someone else (the Attorney) the power to decide what is done with their financial affairs and property. They were replaced in October 2007 by Property and Affairs Lasting Powers of Attorney. A registered EPA only covers decisions relating to a Donor’s financial and property affairs, when they lose capacity.

9.6.4 Lasting Powers of Attorney (LPA)
An LPA is a legal process in which a person (the Donor) chooses someone else (the Attorney) that they trust to make decisions on their behalf at a time in the future when they either lack the mental capacity or no longer wish to make those decisions themselves. The Attorney is legally required to have regard to the Mental Capacity Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves. There are two types of LPA. The decisions could be about the Donor’s property and financial affairs or about their health and personal welfare, or both:

9.6.4.1 Property and Affairs LPA
A Property and Affairs LPA allows the Donor to appoint an Attorney to manage their finances and property whilst they still have capacity to make decisions for themselves. For example, it may be easier for them to give someone the power to carry out tasks such as paying their bills or collecting their benefits or other income. So a registered Property and Affairs LPA could act on behalf of the Donor in this way, if the Donor chooses so, before the Donor loses capacity. Alternatively, the Donor may include a restriction that the LPA can only be used at a time in the future when they lack the capacity to make decisions for themselves – for example, due to the onset of dementia in later life or as a result of a brain injury. A Property and Affairs LPA cannot make any Health or Personal Welfare decisions about the donor, unless they have been granted a Personal Welfare LPA.

9.6.4.2 Personal Welfare LPA
A Personal Welfare LPA allows the Donor to appoint an Attorney to make decisions on their behalf about their health and welfare. A registered Personal Welfare LPA can only be used in relation to the specific decisions for which the Donor has given authority for, when the Donor lacks the capacity to make these decisions for themselves. A Personal Welfare LPA cannot make any Property and Affairs decisions about the donor, unless they have been granted a Property and Affairs LPA.

9.6.5 Court of Protection appointed Deputies
The Court of Protection makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity. The Deputy order sets out the specific powers in relation to the person who lacks capacity. They will depend on the needs of the person and are ultimately the Court’s decision. The powers may apply to any aspect of the person’s life, including their finances, personal welfare and consenting to medical treatment and social care interventions.

9.6.6 Private Solicitors
In some cases family and friends of the Service User may have arranged the LPA/EPA via a private Solicitor. If this is the case then the family member or friend will need to contact the Solicitor to arrange for the correct documents to be released and maintained on record. Being provided with the name of a Solicitor is not enough to determine whether an LPA/EPA has been awarded, the Practitioner will need to see and keep a copy of the original LPA/EPA in the Service User’s case file.

9.6.7 Reporting concerns about Attorneys and Deputies
Adult Safeguarding Policy

Concerns about the actions of an Attorney acting under a registered Enduring or Lasting Power of Attorney, or a Deputy appointed by the Court of Protection, can be discussed with the Compliance and Regulation Unit of the Office of the Public Guardian.

If it is believed that a Crime has been, or is being committed, you must also contact the Police especially if urgent protective actions are required.

For reporting a concern to the Office of the Public Guardian

https://www.gov.uk/report-concern-about-attorney-deputy

Further information on Next of Kin Decision Making can be found at:


10. Priority for raising concerns and making decisions

All agencies in Kent and Medway are committed to ensuring the safety and care of adults and children and all staff and volunteers have a professional and moral duty to immediately report any witnessed or suspected abuse to their line manager. (It is important to ensure that health and social care professionals in practice placements receive support from their college/ university and placement supervisors if they have concerns).

If there is sufficient cause for concern, the line manager should ensure that the information is referred immediately to adult social care within the Local Authority. If the concern has arisen in an Acute Trust, the Local Authority still need to know as they will retain oversight of the case, should a statutory Section 42 enquiry be launched, however a hospital safeguarding co co ordinator or safeguarding lead, will be involved (Protocols, Section 13).

Every reported case must be assessed by adult social care as a matter of urgency to determine an appropriate course of action. This will involve gathering information and initial consultations and is likely to take the form of making or causing non statutory enquiries to be made so that a decision can be reached to launch a statutory Section 42 Enquiry.

Statutory enquiries should ideally be completed within 6 months and a post abuse care plan should identify any relevant monitoring and review arrangements.

If concerns are raised out of hours, the Out of Hours Team will take any immediate protective action and pass the concern to the appropriate team.

Further Information
Guidance and flowcharts for raising a concern can be found in the Guidance Section 8 and 9.

The relevant forms are:

Kent Social Services KASAF document

Medway Council SAF document

Useful addresses are in Appendix 1

11. The function of initial consultation and planning
Adult safeguarding is a complex and multi-layered process. Wherever abuse is reported it is essential to undertake an evaluation of the information received, talk to the adult at risk, establish their desired outcomes, gather information to establish the facts and record the information.

Safeguarding consultation will take into account a range of factors to determine next steps which include:

a) There will be consideration as to whether consent has been given or not
b) A decision regarding the case reaches the criteria for a Statutory s42 enquiry
c) reliability/credibility of the information received need for any emergency or other protective action
d) possibility that the alleged abuse is a criminal offence
e) impact of the alleged abuse on the adult(s)
f) capacity of the adult(s) for self determination
g) vulnerability of the adult(s)
h) extent of the abuse to this or other adults or children
i) length of time it has been occurring
j) risk of repeated or escalating acts involving this or other adults or children
k) information about the alleged perpetrator(s)
12. **The function of a Section 42 Enquiry**

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13. **Allegations Management**

Under the Care Act 2014 and Children Act 2004 everyone within Adult Services has responsibility to carry out their normal functions having regard to the need to safeguard and promote the welfare of adults at risk, children, and young people and for ensuring their well-being whilst protecting them from harm.

The allegation management process relates to addressing concerns that come to the attention of the authority that may call into question a person’s suitability, in a paid or unpaid capacity, to work with adults or children. Where there is no ongoing safeguarding enquiry, the [Allegation Management Referral Form](#) should be completed and sent to the Central Referral Unit (CRU) for Kent or the Access and Information Service for Medway, where it will be recorded and passed to the appropriate Local Authority Designated Officer (LADO) for adult or children’s services, who will be responsible for addressing any reported concerns raised. **However, if a crime is believed to have been committed, the Police must be contacted immediately.**

Information regarding individuals who may pose a risk to adults or children can be received through a number of sources. The following are some examples:

- Police referral
- Information from a member of the public
- Referral from children’s services
Adult Safeguarding Policy

- Referral from health colleagues
- Information resulting from a safeguarding enquiry

Guidance from the Care Act 2014: 14.123 - Allegations against people in positions of trust
Examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who has:
  - behaved in a way that has harmed, or may have harmed an adult or child
  - possibly committed a criminal offence against, or related to, an adult or child
  - behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs

See also employer responsibilities

14. Escalating Concerns

14.1 Generally there is a good working relationship between agencies and services, but occasionally situations arise when workers within one agency feel that the actions, inaction or decisions of another agency do not adequately safeguard an adult at risk.

Disagreements are most likely to arise around:
  a) Levels of risk and response
  b) Roles and responsibilities
  c) Decision Making
  d) Communication

Effective safeguarding adults work depends on an open approach and honest relationships between agencies and services. All practitioners have a duty to act assertively and proactively to ensure that an adult’s welfare is the focus of safeguarding activity. All practitioners must challenge the practice of other practitioners where they are concerned that this practice is placing an adult(s) at risk of harm.

14.2 When escalation may be considered
Where a practitioner disagrees with a decision or response from any agency or service regarding a safeguarding or welfare concern they must firstly consult with their line manager to clarify thinking and the desired outcome. Initial attempts should be made to resolve the matter practitioner to practitioner.

If the practitioners are unable to resolve differences through discussion and/or meeting within a time scale, which is acceptable to both of them, their disagreement must be addressed by more experienced / more senior staff using the formal Escalation Policy (see link below).

Kent-and-Medway-Multi-Agency-Escalation-Policy-for-Adult-Safeguarding
Protocols Section
ADULT SAFEGUARDING PROTOCOLS

Introduction

The focus of safeguarding should always consider an adult’s recovery and what they want to happen and any work must be evidenced and recorded through the Multi-agency alert and monitoring procedures. These protocols lead you through reporting concerns; establishing the adult’s desired outcomes; making informal enquiries; gathering and sharing information; decision making about moving to a statutory Section 42 enquiry; contributing if necessary to a case conference; safeguarding plans, monitoring, review and utilisation of other means to protect an adult, such as referral to alternative services; self-help and circles of support. These protocols should be read in conjunction with:

- the previous Section on Policy
- Care Act 2014, Statutory Care and Support Guidance
- Statutory Code of Practice (Mental Capacity Act 2005)
- Statutory Code of Practice DOLS (2008)
- NHS Serious Incident Framework (2013)

1. Who is responsible for ensuring adult safeguarding concerns are addressed?

Everyone has a responsibility to ensure that a concern about the alleged abuse of adults is addressed. The lead responsibility for managing adult safeguarding lies with the Local Authority and the Care Act 2014 places a duty to co-operate on The Kent & Medway Safeguarding Adults Board members. The government also requires other organisations to work in partnership with the Board. Every reported incident of abuse, or suspected abuse, must be taken seriously and addressed with appropriate urgency and an adult safeguarding alert form must be completed.

1.1 Possible responses

There may be a number of possible responses when an adult safeguarding concern is discussed with the Local Authority (see Guidance section 23) at any stage in the process from initial consultation to raising a statutory Section 42 response, it may be determined that:

a) It is not adult abuse or it is discounted following evaluation/assessment or Information received
b) There is evidence of abuse and it appears more appropriate to address the problem in a less formal way e.g. through the provision of support services for a stressed carer
c) It is not adult abuse but a care management assessment is instigated
d) It is abuse but the victim is not in need of care and support and a referral to a more appropriate service may be suggested e.g. housing services
e) It appears to be abuse, the alleged victim is an adult at risk and a statutory Section 42 enquiry is raised
f) Where the alleged victim does not appear to have care and support needs but the safeguarding issues need to be addressed, a non-statutory enquiry must be considered
g) The concerns relate to general poor standards of care in a regulated setting and referral to CQC (regulatory authority) is more appropriate. The information may also be passed to the Local Authority Contracts Team and the Commissioners of the service.
2. **What do the Protocols cover?**

The adult safeguarding protocols set out a framework with documentation to assist in all stages of the process. When there are issues or concerns regarding abuse or suspected abuse of an adult, in any setting, they should be referred to the Local Authority where the alleged abuse took place. Officers will then ensure that all the relevant information available at this early stage is acted upon and recorded. Please see useful contact addresses in Appendix 1.

Some issues of concern may be very complex, involving multi levels of risk and several or many adults and several agencies. Concerns of such a nature will invoke a statutory Section 42 enquiry.

Where a safeguarding alert is received and the adult appears to have care and support needs which prevent him/her from protecting his/herself from the abuse, a Section 42 enquiry will be required.

A non-statutory enquiry may be instigated in some instances where the statutory criteria (above) are not met, for example where a carer is experiencing abuse from the adult they care for and because of their caring role is not able to protect his or herself from the abuse.

In both scenarios it is important for the adult or their representative to be contacted to establish what they want to happen.

At any stage in either a statutory Section 42 enquiry or a non-statutory enquiry, the designated senior officer can decide that issues have been sufficiently resolved. This would require sign off by a Senior Manager and the decision will be communicated to the adult; to the referrer and to the people who have a 'need to know' the outcome of the concern. Adult safeguarding cases can progress through all or some of the following stages:

- **a)** Raising the concern
- **b)** Consultation with the adult and relevant agencies – informal enquiries
- **c)** Decision as to whether to proceed to Section 42 enquiry – statutory enquiry
- **d)** Planning action
- **e)** Making or causing further formal enquiries, assessing the impact of the abuse and working for recovery
- **f)** Case Conferencing
- **g)** Post abuse care planning
- **h)** Monitoring/Reviewing

This document seeks to help you to appreciate issues that may occur.
3. **Lead Responsibility**

The Local Authority is the lead agency for initiating a Section 42 enquiry. A Designated Senior Officer (DSO) is responsible for the management of individual adult safeguarding cases within the local authority. The DSO may be:

a) the safeguarding adults co-ordinator, a service manager, team manager, a senior practitioner or in very serious cases an Assistant Director in Kent County Council Social Care Health and Well Being Directorate

b) Head of Service, Operations Managers or senior social workers/ senior social care officers in Medway Adults and Children’s Directorate

The ultimate responsibility for statutory decision making in adult safeguarding cases remains with the Assistant Director for Kent and the Assistant Director for Children and Adults for Medway.

The DSO may delegate the task of making or causing enquiries, to an experienced practitioner who has received an appropriate level of training and has relevant experience and knowledge, from whichever agency they work and they will then report back to the DSO. This practitioner will be referred to as the Inquiries Officer (IO). Where the nominated IO is not a representative of Local Authority, the coordination of the Enquiry will be the responsibility of the DSO. The DSO or the IO will work with those charged with carrying out aspects of the Enquiry to coordinate the work to meet the terms of reference agreed.

It is important that the practitioner carrying out the enquiry should be independent of the decision making within the safeguarding concerns, although the evidence they provide will support effective decision making.

While a DSO takes overall managerial responsibility and always retains oversight of the case. Signing off a Section 42 duty will rest with a senior manager as agreed by the authorities. The IO is responsible for specific issues identified within the agreed enquiry terms of reference.

In Kent when safeguarding adult concerns are raised in respect of a young adult who is being supported by the ‘Leaving Care Team’ the lead responsibility for managing the safeguarding case rests with the relevant adult social care team. The Leaving Care Team will assist with carrying out the enquiries necessary to address the concerns. They will be supported by the DSO for the case and/or the safeguarding adults’ coordinator.

4. **Raising a Concern**

4.1 **Who should report concerns?**

Anyone may report concerns regarding actual, alleged or suspected abuse or neglect directly to the local authority. Reports can be made by phone; e-mail or in writing. Service providers should also use appropriate reporting documents for Kent and Medway. All organisational procedures should reflect statutory duties set out within the Care Act 2014 which sets out the duty to co-operate and to report safeguarding concerns. In regulated services such as care homes or domiciliary care services, the Care Standards Act (2000) places the requirement to report to the Care Quality Commission regarding death, illness or other serious events occurring within the service and includes:
Adult Safeguarding Protocols

a) any serious injury to any person receiving services from the organisation
b) any event which affects the well-being or safety of any service user
c) any allegation of abuse of an adult at risk by the registered person or any person who works for the organisation.

Internal procedures will usually expect that if staff have concerns, then they should report these to a senior manager. All staff should also be made aware that they can approach the regulatory bodies, the local authority or the police, independently, to discuss any worries they have about abusive acts or services and that they should do so if:

d) they have concerns that their manager or proprietor may be implicated
e) they have grounds for thinking that the manager or proprietor will not take the matter seriously and/or act appropriately to protect service users.
f) they fear intimidation and/or have immediate concerns for their own or for a service user’s safety.

This is known as ‘whistleblowing’ and information should be readily made available about how staff can access support and protect their own interests.

Anonymous reports will also be taken into account and treated seriously, however anonymity can be respected but is not always guaranteed, particularly if information becomes part of any subsequent legal proceedings. In addition, The Data Protection Act (1998) removes blanket confidentiality from third party information.

4.2 Acting in an emergency

In a situation where there is immediate risk of harm or need for treatment, all staff in all agencies are authorised to call the police and/or ambulance service without referring to a senior manager, if not doing so would cause unnecessary delay in protecting the adult or others from crime or injury. In fact not making urgent contact may later be construed as negligent or failing in duty of care. Staff need to be made aware of this and should be aware they would not be subject to any consequent sanctions or to disciplinary action, unless there was malicious intent.

4.3 Responsibility to respond

In any potential adult safeguarding situation within the boundaries of Kent County Council or Medway Council it is normally the responsibility of the particular local authority in which the adult is resident, to make any necessary enquiries and plan any consequent action. It is however, the responsibility of the placing authority to engage with the safeguarding process and assess the adult’s needs in relation to the allegations made, responding appropriately to any recommendations and outcomes that have been achieved as a result of having made enquiries.

If alleged abuse or neglect occurs whilst an adult in out of area respite or temporarily staying in another Local Authority area, it will be appropriate for the temporary host authority to take lead the response to make any necessary enquiries, if the alleged abuse took place in that area. This is because:

a) there could be implications for the safety and welfare of other service users
b) police in the host authority would also lead on any criminal investigations

Hospital care management teams should support adult safeguarding processes if an adult is hospitalised but lead responsibility will always rest with a host local authority. A host local authority can delegate the requirement for informal or statutory enquiries (Section 42) to be made but the managerial oversight of satisfying (and signing off) the Section 42 duty, rests with the host Local Authority. Effective liaison and collaboration between authorities is essential to ensure that lead responsibilities are understood.
New safeguarding concerns therefore, will be passed to the relevant team and if required specialist support from other teams will be agreed. This will apply where the impact of the autistic spectrum condition or sensory impairment effecting the adult (or alleged perpetrator) directly contributes to the safeguarding concern in question or the additional support of deaf services is indicated.

4.4 Referral process

Contact should be made with the appropriate office of the local authority in line with Section 4.3 above. Referrals may be made by telephone and must be backed up in writing by professionals or made in writing in the first instance. You will need to provide as much information as you can about the extent and nature of the alleged abuse or neglect and the context in which you believe that it has occurred. In order for either statutory or non-statutory enquiries to be made regarding alleged adult safeguarding concerns, adults will need to be identified. More general issues relating to standards of care provided by a regulated service should be reported to the regulatory authority.

4.5 Pre-referral consultation process

If you are uncertain whether or not to refer a matter to the local authority, you can consult with professionals, who are there to help. This consultation may be anonymous with regard to the identity of the caller and any other people involved.

For Kent phone 03000 41 61 61, for Medway phone 01634 334466 and state that you want to consult about an adult safeguarding concern.

If it becomes clear during the consultation with the local authority, that an identifiable adult(s) with care and support needs have been abused or is at significant risk of abuse or neglect, the local authority has a duty to cause or make enquiries.

If during the consultation with the local authority it becomes apparent that the adult(s) has either care or support needs, and has been abused or is at risk of abuse or neglect, then non-statutory enquiries should be undertaken.

The qualified member of staff receiving the information will assist with this by reference to the factors outlined in Protocols Section 4.7.

It is essential that following consultation, clarity exists regarding the Local Authority decision to make enquiries or not.

4.6 Recording outcomes of a consultation

The information provided to the local authority will be recorded in the duty recording system together with a note of any advice given along with the recommendation(s) for any further actions and or referrals that may be necessary.

Staff from other organisations should ensure that accurate records are made of the identified concerns and of all consultations made, recording details of the people consulted, decisions made and recommendations given.

4.7 Local Authorities response to an allegation of abuse or neglect

The qualified staff member from the local authority receiving the information will need to determine from the information whether enquiries need to be made or should be caused to be made. Receiving officers will consider the information within the context of the situation that has led to the consultation/referral, assessing presenting information (which is frequently not clear at this stage). Officers may:
a) provide information, advice and signposting
b) or take any necessary actions, which may include making enquiries or causing others to do so
c) and, or make a referral to more appropriate services e.g. Trading Standards, police

The adult’s needs and the appropriateness of intervention should be assessed in light of the alleged scenario that has led to contact with any statutory agency or voluntary sector service. These may include: Housing, Community Wardens, Medway Council Community Safety Officers, Domestic Abuse Support Services, Environmental Health or Trading Standards. Situations or incidents may include exploitation; physical, financial, psychological, or sexual abuse or sexual exploitation; discriminatory or organisational abuse; neglect and or self-neglect; domestic violence; hate crime; mate crime; anti-social behaviour; modern slavery, human trafficking, female genital mutilation or forced marriage.

In all cases the receiving officer will engage with referrers or consulters to determine whether the concerns raised constitute the need to make a statutory or non-statutory enquiry.

Where a Local Authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident) and that adult has:

d) needs for care and support (met or unmet by the Local Authority)
e) is experiencing, or is at risk of, abuse or neglect, and
f) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Then the Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken and, if so, what should happen and by whom. This then constitutes a statutory Section 42 enquiry.

Other factors to be considered include:

g) extent of the abusive act(s)
h) impact of the abuse on the adult
i) whether abuse was a one-off event or part of a long-standing relationship or pattern
j) impact on others including children
k) intent of the alleged perpetrator
l) illegality of the alleged perpetrator’s action(s)
m) risk of abuse being repeated

4.7.1 Decision to proceed

Initial non statutory enquiries can be made which will inform the officer’s decision whether or not to move to a statutory Section 42 Enquiry. All decision making will be based on lawful fulfilment and risk and may include emergency protective action. A full record must be made of actions taken and information gathered.

The allocation of the role of Designated Senior Officer (DSO) will be made following discussion between the officer receiving the information and the line manager.

4.7.2 Decision not to proceed

If a decision is made at that point not to proceed in line with the adult safeguarding policy and protocols, the professional referrer will be advised and the rationale for the decision must be documented. If there is any disagreement with this decision that cannot be resolved between the local authority decision maker and the professional referrer, the Escalation Policy (Kent-and-Medway-Multi-Agency-Escalation-Policy-for-Adult-Safeguarding) should be followed. If the referrer is a member of the public or a family
member, they should be advised to use the Complaints Procedure for the relevant local authority.

The Local Authority however must provide information and advice, including where appropriate financial information about care and support, and signposting to mainstream or universal services.

It may be that the issue is not adult abuse and an adult may benefit from community care assessment or if a carer is present, then a carer’s assessment must be offered. The response may be that non-statutory enquiries may be needed to be carried out on behalf of adults who do not fulfil the criteria outlined above (Protocol 4.7) and such enquiries would relate to an adult who:

i. is believed to be experiencing, or is at risk of, abuse or neglect
ii. does not have care AND support needs (but might just have support needs) and non-statutory may occur at the authority’s discretion.

In all cases, except where it is immediately clear that the allegations do not constitute adult abuse, the concerns will be recorded within Framework Adult Safeguarding Alert Episode (Medway Council) and in Kent the Kent Adult Safeguarding Alert form will be completed and information recorded on SWIFT.

In both cases throughout this document, where appropriate, both forms relating to concerns have been referred to as the Alert form. Information as presented will be discussed with the local authority line manager and a preliminary decision taken regarding necessary actions.

4.8 What if the adult does not want any action taken?

The purpose of adult safeguarding is to secure or return the adult’s autonomy and recovery, as far as possible. If the adult has capacity and they are not being unduly pressurised or intimidated they may not wish for any intervention. Whilst acknowledging this, the adult will be informed that the professional may have a duty to share that information. In order to be sure that the adult(s) are deciding for themselves, you must talk to the adult. It may be necessary to consider how and where this discussion takes place to enable the adult to safely consider and report their desired outcomes and wishes.

It will be important to obtain the views and wishes of the adult. If the adult lacks capacity to make decisions with regard to the safeguarding concerns, the views of their representative/advocate must be considered. However, if a crime has been committed the police will be informed (see Care Act 2014 statutory guidance 14.75).

If the abuse does not appear to constitute a criminal act but other adults or children are or may be at risk, the concerns must be reported to the Local Authority who will decide how the matters are to be addressed, e.g. through a statutory or non-statutory enquiry.

If the suspected crime has occurred within an intimate or family relationship please see guidance below:

statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

4.9 What if the abuse has occurred in a care service?

The following Section outlines what may be appropriately dealt by an organisation; what needs to be referred to the local authority for consideration regarding Section 42 enquiries
and what should immediately be reported to the police. (For incidents occurring in a service provided by an Acute Hospital Trust (Protocols Section 13))

4.9.1 Level 1 Concern
If there has been an apparently minor incident or a disagreement for example involving one service user and another and this has occurred between adults who have the same power as the other, then some adult safeguarding concerns may be dealt with by the provider organisation (this excludes bullying, or any act which may be considered abusive). In order for this type of decision to be made, the concern must be raised by the Provider to the local authority and must also be reported to the regulatory authority.

Following consultation with the local authority, it may be agreed that a ‘Level 1 response’ is appropriate (see Guidance section 22 - Framework for Responding to Adult Safeguarding Concerns). As part of a Section 42 Enquiry the Level 1 ‘process;’ can be challenged by the local authority at any time if outcomes are deemed to be substandard. The Level 1 Service Provider Report Form should be emailed to the provider by the DSO and in turn the provider should complete and return the report to the DSO in the agreed timescale.

A Level 1 response to a concern falls within the Local Authority’s s42 responsibility by ‘causing’ an enquiry to be made. If it is agreed, following consultation with the local authority, that a Level 1 response is appropriate, a provider will be asked to establish the adult’s desired wishes, as far as possible and then make a written assessment of the alleged incident and the presenting circumstances. Provider records and their submitted written report must take account of the terms of reference for the enquiry provided by the DSO for the case and will normally record:

a) what outcomes the adults involved, wanted (where possible)
b) what actions were taken to make them safe and by whom
c) what the overall outcomes to the enquiry are - for example, staff disciplinary procedures; training requirements; staff supervision and or an assessment of the organisation’s supervision of the care and supervision needs, of the adults concerned
d) a risk assessment for the adults and involved and how this will be managed and monitored
e) any risk to others and how this will be managed and monitored
f) revised care planning for adults involved
g) any additional protective responses necessary for all adults involved

Records should be available to the Regulatory Authority and must be shared with social services. Outcomes and process can at any time be challenged by the local authority as only they can sign the case off as and when the Section 42 duty has been satisfied.

Where the safeguarding concern fulfils Section 42 criteria a statutory enquiry will be launched and input from the provider may be requested. If it is possible that the abuse may constitute a criminal offence, the local authority will contact the police. If the provider raises the concern they should also inform the regulatory authority, the adults funding authority and the commissioners of the service. If the local authority becomes aware of adult safeguarding issues before the service provider, they will inform all of the aforesaid and if it is likely that a criminal offence may have been committed, the police will be contacted.

5. What happens if adults with care and support needs abuse each other?

Abuse by one adult at risk by another within a service setting should be addressed as an adult safeguarding issue. The trigger for reporting concerns is the abusive act itself and not the degree of responsibility or intent of the person carrying out that act.
Organisations that aim to provide support to service users who have challenging behaviour need to have an understanding of the history and needs of the user to ensure that they are able to both protect them from abuse and prevent them from abusing other adults within the service. The organisation must carry out a pre-placement assessment to ensure that they are able to meet the needs of the service user and to develop a care plan and risk assessment to meet those needs e.g. lessons learned from Winterbourne View and Mid Staffordshire Hospital.

It is important therefore to adopt a culture of zero tolerance of abuse. An acceptance by the service of low level abuse and or bullying from whatever source, will ultimately, if allowed to continue, lead to a culture that is damaging to all those who receive and participate in that service.

It is important that all instances of abuse are recognised and addressed in the most appropriate manner and that records of what has been witnessed or reported are factual and do not attempt to minimise adult abuse and/or criminal actions. Examples of good recording may include objective information about: What was witnessed? What were you told? Who was involved? When and where did this happen?

Additional guidance can be found at the link below

6. Sharing Confidential Information

Whether or not planning a response to an adult safeguarding concern is through informal consultation or a formal meeting, you are likely to be sharing information that would normally be considered confidential.

Each agency holds information, which in the normal course of events, is regarded as confidential and will have their own safeguards and procedures for sharing this with other related agencies. The Care Act has set out the legal duty to co-operate amongst agencies where there is a duty to safeguard. Other laws also apply to information sharing, dependent on circumstances and the Data Protection Act (1998) is vital in protecting people’s information and in Section 29 sub Section (1) it sets out the parameters for sharing information in relation to preventing a crime.

Under Section 115 Crime and Disorder Act (1998) a worker has the power (not a duty) to share information if s/he thinks a crime has been, or could be committed in the future. In addition, the Public Interest Disclosure Act (1998), section 43b provides protection for the worker sharing information with the police about a suspected crime.

All Agencies who have signed up to the Kent and Medway Safeguarding Adults Policy, Protocols and Practice Guidance are required to report to the police where they suspect a crime has been committed. The views and wishes of the adult at risk will be considered with regard to any further action that may be taken.

This information may be shared with personnel from:

- Local Authority
- Health Trusts
- Police
- Probation

If representatives from other non-statutory agencies are present, for example in a planning meeting, then a Chair may ask them to leave whilst confidential information is
appropriately shared. The minutes will be shared by confidential email. Alternatively, it can frequently make sense to hold a meeting in parts, if confidential information can only be shared with some, as opposed to all, invitees. This methodology also protects information from being circulated inappropriately as those who attended the particular part of the meeting are the only people who are able to access the minutes to that part.

The Public Interest Disclosure Act (1998) also sets out the parameters for sharing information when it is in the public interest to do so, such as whistleblowing about a crime, abuse and/or neglect.

6.1 Making decisions about sharing confidential information
Concern about abuse or neglect of an adult provides sufficient grounds to warrant sharing information on a 'need to know' basis and/or 'in the public interest' and unnecessary delays in sharing that information should be avoided. Whenever possible an adult must be consulted about information being shared on their behalf. Where they have capacity and they are not being pressured or intimidated, their agreement should be sought and their refusal respected. However if a crime has been committed the police will be informed. The level of risk to the adult or to other adults or children will inform any actions taken by the police.

The principles that should govern the sharing of information include:

a) confidentiality must not be confused with secrecy
b) information will only be shared on a 'need to know basis' when it is in the best interests of the adult
c) informed consent should be obtained but if it is not possible and others are at risk, it may be necessary to override the requirement
d) it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse or neglect, particularly in situations where others may be at risk.

Statements of confidentiality and equal opportunities should be read out at the beginning of all adult safeguarding meetings and both should be placed at the top of the attendance sheet for meetings and on the first page of the minutes (Guidance Section 17).

7. Gathering initial information

Once the adult safeguarding concern has been received, the Designated Senior Officer (DSO) will initiate enquiries to try and establish the adult's wishes and desired outcomes. The DSO will also decide if an independent advocate should be appointed for the adult, if they are likely to have ‘substantial difficulty’ in engaging with the safeguarding process and they lack a suitable representative. The DSO will speak to different agencies and individuals, to try and establish the facts and to assess risk. Initial enquiries will have the following purpose:

a) to establish the desired outcomes for the adult or their representative
b) to establish if an advocate is needed
c) to pool information
d) to evaluate the information
e) to decide about the appropriate level of intervention and what will best aid the adult to recovery
f) to co-ordinate input into any assessment that may be deemed appropriate
g) to clarify the nature of the enquiry i.e. statutory or non-statutory

These enquiries may be made by phone and must be documented. Where the issues are complex and/or more than one agency is involved, a formal planning meeting of all
Appropriate and relevant agencies and service representatives is recommended to ensure that all the issues are fully explored. These enquiries form part of the initial planning stage and should be initiated as a matter of urgency within 48 hours after the concern has been received, unless exceedingly high risk has been identified.

The Designated Senior Officer (DSO) must arrange:

- To allocate an appropriately trained and experienced person to become involved in the case and to take any actions that may be required (Inquiries Officer/IO). The DSO will need to consider the communication, language, cultural, religious and gender factors when allocating the case and if any conflict may arise if the client's care/case manager, community or district nurse is appointed as the IO. Allocated IOs may be appointed from social services, NHS or the Police in a crime investigation only. In less serious cases a service provider (Level 1 response) may be appropriate.

- Checks with the other agencies as to whether the adult at risk or alleged adult deemed responsible, or setting, is known and under what circumstances they have been involved. Examples of who may be contacted are: general practitioner, police and accident & emergency departments, Safeguarding nurse or nurse manager, regulatory authority or contract service. Additionally, information may be obtained from the probation service and other voluntary or statutory organisations that may be providing services to the adult or his or her family or carer.

The following checks will carried out by the local authority to determine if:

a) the adult has care and support needs under the Eligibility Regulations set out within the Care Act 2014
b) If the Eligibility Regulations (Care Act 2014) fail to offer protection, whether the discretionary powers within the Care Act will be used to enable the adult to be protected, if their wellbeing is affected by the alleged abuse or neglect
c) the outcomes the adult wants have been established and recorded
d) if the adult may find the process difficult and they have no appropriate representative and they may benefit from an advocate
e) there is any medical evidence about the alleged abuse or neglect and its impact
f) any disclosure or witness reports have been completed, prior to local authority or police involvement
g) there are any issues related to potential discrimination
h) there is any documentary evidence in accident/ incident reports; daily logs or rotas
i) there are any records referring to consent or capacity to consent
j) consent has been over-ruled in the interests of this enquiry or that appertaining to any other adult or child.
k) regulatory authorities have been informed (where a care home or domiciliary service is involved).
l) the contracts service has been informed if an organisation with a KCC/Medway contract is involved
m) the line manager and Human Resource department have been contacted if person deemed responsible is an employee, volunteers, is contracted or has any association with the local authority or agency concerned
n) other localities or authorities have been informed of the issues where the adult(s) or the alleged perpetrator(s) are funded by them
o) family or carers have been informed of the issues (only where it is appropriate to do so).

After gathering initial information and discussing the situation with the adult and or their representative, it may be possible to move to developing a safeguarding plan. This will depend on there being enough information on which to base this decision, and risk has
been reduced, removed or managed. In this case the DSO will ensure that a post abuse plan is drawn up to safeguard the adult(s), in consultation with them and their representative. The DSO will also ensure that an appropriate action plan is completed in relation to the person and/or service held responsible. A plan should specify a time for review and any indicators or circumstances that may trigger further action and appropriate feedback should be given to the referrer.

If the issues do not appear to constitute abuse and other processes are indicated then a Senior Manager should sign off the case and specify what other actions are required. The referrer must be advised of this decision. If they disagree with this, they should be advised to put their concerns in writing to the manager concerned. This will then be registered as a formal complaint. If a staff member of the local authority disagrees with the decision taken by the senior manager they may refer their concerns to the chair or the deputy chair of the Kent and Medway Adult Safeguarding Board.

8. Risk/Protection

Assessment and risk management are essential aspects of the adult safeguarding process and need to be considered at every stage. In addition to assessing the risk identified at the initial stage when the concern was raised, all participating agencies and services will need to take into account the possible risks to other adults and/or children.

The views of the adult should be sought at the earliest opportunity in keeping with making safe enquiry if they are not known at the time of the alert. If the adult lacks or is believed to lack the mental capacity, to make decisions with regard to keeping themselves safe, the involvement of representatives; relatives or advocates to support the client through the safeguarding processes is vital.

If there is a possibility that a criminal offence has been committed the police should be involved at the earliest possible stage and they will take responsibility for ensuring the preservation of evidence.

The level of risk has to be weighed up in deciding whether to take any emergency action to protect the adult(s) or children and a risk may exist that any such action may alert the alleged perpetrator resulting in evidence being removed or altered. This must be taken into account when considering how to manage the holistic situation. If the matters involve a regulated care service and it is believed that no criminal offences have been committed, the DSO will need to consider the most appropriate way of securing any documentary evidence in discussion with the Care Quality Commission.

If emergency action has been taken, a planning process should be co-ordinated, within 48 hours of the alert being received, involving all appropriate agencies, departments and service providers. Where more than one agency is involved, a planning meeting is recommended to enable full discussion of actions taken and allow for future planning.

In the event of an unexpected or unexplained death of an adult where adult safeguarding concerns already exist or are raised around the time of death, the police should be informed of the death as a matter of urgency. The police will take responsibility for any criminal investigations and will liaise with the Coroner. Provider services must inform the local authority within 24 hours, if an adult who is the subject of existing safeguarding concerns dies.

When concerns relate to an organisational setting following discussions with other agencies during the evaluation of information and initial planning stage, the Designated Senior Officer will be responsible for ensuring that the proprietor or registered manager
Adult Safeguarding Protocols

are advised of the adult safeguarding issues unless it is believed that they may be personally implicated in the allegations made.

As a matter of principle, contact with the proprietor or registered manager of any care service should be undertaken as soon as it is practicable. This is important to enable them to take appropriate steps to protect adults or children who may be at risk and to enable them to address their employment responsibilities.

8.1 What if the risks involve a care service?

‘The primary focus of adult safeguarding under the Care Act is NOT about the quality of health and care services; providers have the primary responsibility for this, with commissioners providing external challenge and review and CQC ensuring that the fundamental standards are met and taking enforcement action as necessary. That is not to say there is not a role for the Local Authority or social workers where care services are poor, particularly in supporting the adult(s), families and reviewing care plans’. (DoH Implementation of the Care Act Letter 20141107 v2)

Where there appears, to be significant risks to an adult, consideration must be given to informing relevant interested parties of the concerns and possible risk factors. This may include commissioning authorities outside Kent or Medway.

This may be achieved by the use of the flag system. If the organisation does not have a contract with any agency in Kent or Medway a level of risk should be agreed and commissioning authorities informed of the risk level. Decisions about risk and communication should be made in consultation with the Head of Service/Service Manager/Assistant Director and the relevant Commissioning Manager. Within Medway Council any decision to suspend placements within a care service will be made within the Council’s specific Embargo Policy.

Any agreement reached must be recorded in the records of the planning process or in the adult safeguarding paperwork at any stage in the safeguarding process.

Levels of risk should be classified in the following way:

**Risk level 1** - An adult safeguarding case is being assessed, there is an Enquiry being pursued, but there is currently no evidence that other service users are at risk. This risk level will only be used when initial abuse concerns are reported in relation to one service user. (for further information contact identified manager).

**Risk level 2** - An adult safeguarding case is being assessed, there is an Enquiry being pursued and it is possible that other adults may be at risk of significant harm due to abuse, or poor practice. Some or all adults are being assessed in relation to these concerns. (For further information contact the identified manager).

**Risk level 3** - An adult safeguarding case is being assessed, there is an Enquiry being pursued, and there is evidence of significant risk to other adults due to abuse or poor practice. No new placements should be made until the issues have been resolved. (For more details contact the identified manager).

**Public facing information** (Kent County Council)

A Traffic Light system will be applied to all services.

This information, under duty of candour, will be made visible to the General Public and health and social care organisations via the Kent online Care Directory.
### Colour | Definition
--- | ---
Green (Level 1) | Contractor is operating within the acceptable levels of Performance and Quality.
Amber (Level 2) | The Contractor has been issued a Restriction Notice and is in the process of corrective action.
Red (Level 3) | The Contractor is under a Suspension Notice. KCC is not currently placing new people within this service.

Where the risk is assessed at levels 2 and 3 (Restriction or Suspension) consideration should be given to advising the families/carers of other residents that an Enquiry is being undertaken. If other commissioning authorities have not already been informed, they should now be contacted and they will be responsible for informing the families/carers of their clients about the Enquiry.

If the service provider has not already been involved within the adult safeguarding process they must be advised by either the DSO or the commissioning manager, of any decisions taken during the adult safeguarding process which affect them or their service (for services within Medway, where risk level 3 has been agreed, communication with the provider will be in line with the Embargo Policy). They will need to consider the appropriateness of admitting any additional residents to the facility when an adult safeguarding risk level 2 or 3 has been agreed and an Enquiry is in progress (see [Safeguarding Checklists for Practitioners in Kent.pdf](#) – Section 5).

As the Enquiry moves towards completion, actions taken by the service in order to address the concerns will result in ongoing review of the service provision and improvements are likely to result in a lowering the initial level of assessed risk. This will mean that the risk level will be reduced from 3 to 2. Subsequently the risk level will be removed when all of the concerns have been addressed and the service has been reviewed as able to provide care in accordance with standards expected.

Additional processes may be used to address quality in care concerns and/or contract compliance issues which may also use a similar flagging system to indicate levels of concern. If the quality of care in a service is believed to be poor and may risk harm to the users of services unless actions are taken contact should be made with the lead commissioning authority.

### 8.2 What protective actions may be considered?

If at any stage in the adult safeguarding process it becomes evident that another adult or child may be exposed to significant risk, immediate protective measures must be considered and where appropriate actioned.

Protective actions can include:

- a) informing Children’s Services of the concerns for the child/children
- b) consideration by the employer of using staff disciplinary procedure and adult safeguarding policy for the protection of the adult(s) and the alleged perpetrator
c) moving the adult(s) to a place of safety and care (e.g. to an appropriate family member willing and able to provide care, residential home, hospital etc.)

d) moving the alleged perpetrator to another placement and/or providing additional support

e) appointment of an independent legal advocate for the adult especially where their interests may run counter to those of the various agencies/authorities’ legal departments.

f) If not already completed, contact the police

Please note that this list is not exhaustive

9. Responsibilities

9.1 Generic responsibilities

The following points may assist you to consider actions that may need to be taken to support the multi-agency adult safeguarding protocols:

a) everyone has a duty to report any allegations or suspicions of abuse or potential abuse of an adult at risk either to their immediate line manager or to discuss their initial concerns with social services, the regulatory authorities or the police

b) this includes not only abuse identified within a service but also abuse carried out by anyone else

c) health and social care professionals may identify adult safeguarding concerns during the normal course of their work which should be reported through the adult safeguarding processes. Staff should support the adult safeguarding processes by attending relevant planning meetings, case conferences and supporting any post abuse work allocated to them

d) if you are employed in a caring capacity and have reason to believe that your line manager is colluding in the abuse you may report your concerns directly to the local authority, to the regulatory authorities or to the police. You may prefer to follow the whistleblowing procedures in your own agency. The person receiving the information under the whistleblowing procedures must take responsibility for ensuring that the issues are addressed appropriately (Guidance Section 8). If they decide that an adult safeguarding referral should be made to the local authority, they may decide to withhold the name of the member of staff who originally identified the abuse.

e) if the person deemed responsible is also a service user then a member of staff will need to be allocated to attend to their needs and ensure that they do not pose a risk to other adults at risk.

f) in the event that Police have been called, care must be taken to preserve evidence, especially in cases involving physical or sexual abuse, (Guidance Section 14).

g) no staff within the service should alert or confront the alleged abuser if to do so would place anyone at risk of harm or risk contamination of evidence.

h) a factual detailed record of the adult safeguarding concern should be made as soon as possible (Guidance Section 3). Care must be taken to ensure that the record is kept in a secure place to ensure that the person deemed responsible does not have access to it. This could compromise any Enquiry.

i) if the person deemed responsible is a member of staff or a volunteer, consideration must immediately be given to protecting the adult at risk and children from the possibility of further abuse until the enquiries have been made. If you are the manager you are advised to use your internal staff disciplinary procedures to safeguard the interests of both the adult(s) and the staff member(s) concerned. Discuss your actions with the regulatory authorities.
成人保护协议

j) 如果成人保护转介涉及刑事犯罪，不得试图由服务方询问成人或弱势证人。这将在法定调查和评估涉及的议题作为成人保护规划过程的一部分进行。服务提供商应参与规划和调查，除非有非常明确的理由怀疑其参与会损害调查的任何阶段。

k) 预期管理方和为成人提供服务的员工将全面配合任何成人保护调查，并遵守在事后行动计划中做出的任何建议。

l) 服务提供商须在可能的24小时内，向地方政府通知处于现有保护担忧下的成人死亡。

9.2 负责人（DSO）职责

作为DSO，你负责实施第42条职责，负责处理案件的协调和管理，并主持可能需要的会议。在涉及复杂护理的框架内，DSO将高度参与协调调查的各个部分。因此，建议考虑为案件会议和任何建立会议指定一个不同的主席（这可能是来自其他位置或团队的高级管理人员）。

你应该将负责进行调查和评估的职责分配给适当受过培训和经验丰富的员工，他们将向你报告。这个人将被称为主调查员（IO）。你需要提供支持、监督和建议给IO，并确保他们有必要的资源来履行自己的职责（这包括时间、行政支持和另一个与你分享采访任务的人）。

作为DSO管理案件的你负责：

a) 确认有一份已完成的警报表，且在Medway成人保护方面，此案件将被记录在Frameworki Adult Safe Guarding Concern in Kent的Kent Adult Safeguarding Alert Form和在SWIFT上。

b) 确保在初步调查期间成人安全。

c) 使用初步调查来决定成人是否仍处于继续遭受伤害的危险中。这些初步检查与其他机构和部门也将需要确定是否还有其他成人或儿童可能处于风险。重要的是，与护理经理、社会工作者、医疗工作人员或监管人员的接触或访问将不会泄露任何被认为是严重负责的可能人员，除非这是不可避免的。

d) 决定调查的性质。

e) 咨询警方是否对有犯罪行为的嫌疑感到怀疑，因为任何延迟都可能导致证据被污染。因此，警方可能希望参与任何紧急行动，以保存法医证据或文件。

f) 在成人案件死亡和已存在或最近提出保护担忧的情况下，确保向验尸官办公室通报保护担忧。验尸官将安排必要的调查。

g) 如果指控一名为成人提供持续护理或支持的工作人员，应采取措施减少该工作人员对其他人的进一步风险。你应该尽快通知服务的经理，以便他们采取适当的行动来保护其他人。
adults in their service. If it is possible that they are implicated in the abuse issues, protective actions will need to take this into account.

h) arranging an appropriate planning process within 48 hours or as soon as practicably possible. The planning process will need to involve all relevant professionals, agencies, services and departments and any other person who has information essential to the case. This should take the form of a formal planning meeting if emergency action has been taken or where the factors in Section 9.1 are present.

i) a formal planning meeting will allow a full discussion of actions already taken and allow for future planning. Where the allegations involve a staff member from any organisation or agency providing services, a senior representative of the service should be invited to the meeting unless they are personally implicated in the abuse concerns. If, in exceptional circumstances, the service provider has not already been made aware of the concerns, you will need to ensure that a decision is taken, during the meeting, about informing the service provider of the issues that need to be assessed.

j) liaising with the commissioning service, where appropriate, regarding the status of the contract and deciding with them whether any action is needed in relation to the contract, either before or after the investigation has taken place (Protocols Section 9.4).

k) ensuring that, where appropriate, placing authorities are informed of safeguarding concerns in a care setting which might affect their clients. This will enable them to be involved in meetings and assessments as necessary.

l) ensuring that a complete record of all contacts, meetings, phone calls, interviews and decisions are kept securely on the client's file.

m) ensuring that there is a record of the decisions taken as a result of a formal planning meeting and/or recording the outcome of initial post alert consultations.

n) ensuring that any Enquiry is carried out and assessments are fully recorded and that there is a written summary of the findings on which to base decisions.

o) chairing the case conference and ensuring that full support is available for adults at risk who may attend. The DSO should have appropriate training and support to undertake the role (see Guidance Section 20).

p) ensuring that appropriate pre-conference support has been provided to the adult and/or his/her representatives in the case conference. You have the authority, in consultation with the adult and other representatives, to restrict or exclude attendance of people at the conference if they are likely to prevent a full and proper discussion. This should be clearly recorded in case conference notes.

q) ensuring that decisions taken, at a case conference or other review meetings, are minuted including decisions concerning:

- the adult at risk or child
- the person responsible;
- the service setting/agency

r) As chair of the planning meeting or case conference you should take responsibility for ensuring that the employer(s) has made appropriate referrals to the Disclosure and Barring Service (DBS) in appropriate cases. Where the employer(s) do not agree with this, the Local Authority can use a discretionary power under the Safeguarding Vulnerable Groups Act 2006 to make the referral to the DBS where they consider that the person deemed responsible may have placed an adult or child at risk.

s) If the employer is reluctant or refuses to make the referral, this should be reported to relevant regulatory body, who will take responsibility for following this up with the employer. This should be recorded.

t) ensuring that action points from meetings are circulated within 2 working days and minutes to be circulated in 10 working days unless exceptional circumstances make this impossible.

u) ensuring that the outcomes of the case are conveyed to relevant parties.
9.3 Inquiries Officer (IO) responsibilities

The role of the IO is central to the safeguarding process. The IO will need to have an understanding of the multi-agency safeguarding adult policy and protocols and be appropriately trained and experienced to undertake the task role. Where an IO is not a representative of social services, the DSO will take responsibility for managing the Section 42 Enquiry; adding information to the database maintaining records of contacts and having managerial oversight. The responsibilities of the IO are:

a) To complete the initial risk assessment and evaluation (KASAF stage 2 in Kent) following discussion with the DSO or other senior.
b) Ensure any immediate actions are undertaken to safeguard the adult at risk
c) In conjunction with the DSO, to formulate an action plan and terms of reference for the enquiry:
   • Include the adults views and wishes regarding outcomes
   • Consider how to best ensure the adults participation in the SG process and any issues which could lead to discriminatory practice (advocacy and family involvement, culture, language, gender, sexuality, disability)
   • Identify the agencies and organisations that can contribute to the enquiry and safeguarding actions
   • To record all contacts, enquiries, recommendations and outcomes on the IO report template and contact sheets. (Refer to “Safeguarding Adults Checklists for Practitioners” S. 6 for further guidance).

9.4 Commissioning Responsibilities

Commissioning processes should aim to ensure good standards within service settings and contract monitoring should identify deviations from agreed standards and contractual specifications. For example this can be particularly helpful if poor practice, negligence, accidental or deliberate actions have caused, or are likely to cause, an adult to experience harm within that service.

Commissioning requirements expect service providers to have their own adult safeguarding procedures in place to deal with issues of concern regarding abuse or suspected abuse.

These procedures do not replace the Kent and Medway Multi-agency Protocols but should act to complement and support them. The following should be adhered to:

a) any concerns about the abuse of adults or possible abuse noticed or reported should be reported to the appropriate Local Authority.
b) action may need to be taken prior to a planning meeting, to reduce risk, particularly if staffs are implicated in concerns. This will need discussion with both DSO and commissioner to determine who will advise the registered manager of the service.
c) as part of the planning process, consideration must be given to the concerns and the level of risk within the service and the provider must be informed in writing of any issues that affect their contract, if that contract is with a local authority all commissioners should support the adult safeguarding process by attending any relevant planning meetings and carrying out agreed actions
d) if it is necessary to obtain details of other adults using the service to advise their representatives and or funding authorities of concerns, the DSO will obtain the information from the provider and give this information to the commissioners
e) commissioning staff should support any actions agreed in the post abuse care plan and they may be asked to evidence that any agreed changes to management; staffing or service standards have been requested of the provider.
f) close liaison should be maintained between commissioners and the DSO with regard to any service contract changes that may be necessary, throughout the process.
9.5 Employer responsibilities

As an employer you should ensure that:

- **a)** the service has an adult safeguarding procedure which dovetails with this document
- **b)** all service users are safeguarded from abuse
- **c)** all allegations and incidents of abuse are followed up promptly with recorded actions
- **d)** you effectively utilise your own internal procedures
- **e)** appropriate measures are in place pending outcomes to Enquiries e.g. performance management and disciplinary procedures
- **f)** you understand your reporting duties (Protocols Section 4)
- **g)** all matters which have bearing on safety and wellbeing of an adult(s) in your care must be reported to regulatory authorities and service commissioners
- **h)** internal processes do not contaminate any evidence which may be gathered as part of a police investigation or Local Authority Enquiry.
- **i)** any actions you take must make safeguarding paramount whilst balancing this with best practice in employment legislation and the Human Rights Act 1998
- **j)** you must act in accordance with the Safeguarding Vulnerable Groups Act 2006 and you must refer employees/ volunteers involved in regulated activities with adults at risk (according to the definitions within the Act) to the Disclosure and Barring Service (DBS), for consideration for inclusion on the Barred List, should they pose or have posed a risk to adults who are vulnerable or children (Guidance Section 19).
- **k)** allegations raised against a staff member outside of the Safeguarding criteria, are referred through the Allegations Management referral process where it will be recorded and passed to the appropriate Local Authority Designated Officer (LADO) for adult or children’s services, who will be responsible for addressing any reported concerns raised. However, if a crime is believed to have been committed, the Police must be contacted immediately. If the outcome of the referral to the Local Authority Designated Officer (LADO) substantiates the allegations, then the employer will be advised that they have a duty to make a referral to the Disclosure and Barring Service and should also consider if a referral to any Professional Regulatory Body is required. See Allegations Management

Normally you can expect to be involved in the adult safeguarding planning processes unless there are concerns that you or your agency is implicated in any way which may impede an Enquiry by the local authority.

10. Planning an Enquiry

10.1 Decision Making

The local authority are the lead agency for all Section 42 Enquiries and a legal duty exists to establish the outcomes of the work of an Enquiry to assess if safeguarding practice has been effective and if the adult’s outcomes have been met. This has to be completed before a case is closed to decide if the Section 42 duty has been satisfied.

If the adult at risk who has care and support needs is likely to have difficulty in engaging with the safeguarding process and they do not have an appropriate representative, then an independent advocate must be appointed to support them.

The designated senior officer will need to decide if a formal planning/strategy meeting is required. They should take account of the following:

1. That they have sufficient information via consultations with various people/agencies to proceed directly to an enquiry. If this is the case they will plan how this is to be
They will establish the terms of reference for the enquiry; who will be involved in this work and who will be responsible for each aspect. This must take into account the desired outcome/s of the adult at risk. A timescale will be agreed for the completion of the work and the results to be reported back to the DSO. It will be DSO’s responsibility to determine the need for a case conference or an alternate way to feedback information about the outcomes to other key participants. These may include the adult or their representative, the person believed to have been responsible for the abuse/neglect, the referrer, carers and service providers.

2. That they can move straight to risk assessment, care/action plan because there is enough information at this stage on which to base a decision. In this case the DSO will ensure that a post abuse care plan is drawn up to safeguard any adults at risk, in consultation with them and their carers where appropriate. They will also ensure that an appropriate action plan is completed in relation to the person and/or service held responsible. The plans should specify a time for review and any indicators or circumstances that should trigger further action. Appropriate feedback should be given to the referrer at this stage.

3. Where the enquiry is complicated and requires a number of actions that may be taken by others to support the outcome, it may be appropriate for a round table discussion or formal planning meeting. Action should never be put on hold because of the logistics of arranging meetings. Proportionality should be the guiding principle. A formal multi-agency planning meeting will be managed and recorded in the same way as a formal case conference, see Guidance section 20.

4. If the adult at risk wishes to participate in meetings with relevant partners, such a meeting should be convened. However actions should not be ‘on hold’ until meetings can be arranged. If the adult at risk does not have the capacity to attend, a representative or an advocate should represent their views.

In complex cases there may be a need for more than one meeting during the enquiry process.

<table>
<thead>
<tr>
<th>If a DSO thinks a Section 42 Enquiry should go ahead then the Enquiry MUST address the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The adult’s expressed outcomes</strong></td>
</tr>
<tr>
<td><strong>Assess the level of risk of abuse or neglect and risk of repeated acts</strong></td>
</tr>
<tr>
<td><strong>Assess risk to children and others</strong></td>
</tr>
<tr>
<td><strong>Empower people and make safeguarding personal and person centred</strong></td>
</tr>
<tr>
<td><strong>Take account of human rights of all adults at risk and carers</strong></td>
</tr>
<tr>
<td><strong>Decide on care and support needs</strong></td>
</tr>
<tr>
<td><strong>Assess what outcomes the adult(s) wants e.g. restricted contact with perpetrator/criminal justice/access to community</strong></td>
</tr>
<tr>
<td><strong>Timescales for reporting and actions</strong></td>
</tr>
</tbody>
</table>
10.2 Involving adults in safeguarding meetings

Effective involvement of adults at risk and/or their representatives in safeguarding meetings requires professionals to be creative and think in a person centred way. This may include consideration of:

- The best way to involve the adult at risk
- The best venue for the person
- The length of any meeting
- The best time
- The agenda
- Any preparation time the adult at risk may need
- Who is best to coordinate or chair
- The agreement by all parties to equality and non-discriminatory practice
- The strengths of the adult at risk
- The adult at risks personal support networks

10.3 Complex multi-agency planning

If a criminal act is suspected, the police must be informed. The Local Authority retains the Section 42 duty. (It is important to ensure that the safety of the adult(s) is not delayed by police activity). Police action may be supported by care/case management, health or regulatory staff. Liaison regarding case progress will be carried out by the DSO or the Inquiries Officer (IO) and agreement regarding actions of others, during or pending any police investigation, will need to be in place.

Where the allegations involve a staff member from a provider service, a Senior Manager from that organisation should be invited to the meeting, or to part of the meeting. Exceptions may exist where they personally may be implicated in the alleged abuse or where there are good grounds to believe that their presence may impede the sharing of information and/or the progress of the Enquiry. Alternative arrangements to ensure the agency is represented should be made.

See also 10.6

10.4 Strands of an Enquiry

An Enquiry will have five main strands, they include:

a) to establish the adult’s (or their representative’s) desired outcomes
b) to establish matters of fact about one or more incident(s) in which abuse or neglect is alleged or concerns have been raised.
c) to assess the support and protection needs of any adult(s) still at risk.
d) to meet the adult's desired outcomes, where possible, aid their recovery, reduce risk and improve prevention
e) to review the management of the any service which has increased risk and any improvements required or sanctions to be recommended.

10.5 Responsibilities and accountabilities

The lead agency and must be clear in planning the Enquiry roles, responsibilities and timeframes. Interviews with vulnerable victims or witnesses must be documented and be carried out with the support of appropriate staff.
a) if the police are not involved the local authority will take responsibility for establishing the facts as far as possible and for taking appropriate action to protect the adult(s)
b) if the police are involved they are responsible for any criminal investigation including evidence gathering and the use of visually recorded evidence should a case go to court.
c) where police have initially taken the lead for an investigation and subsequently determined that there will be no further police action and a Section 42 duty exists, the local authority will establish the desired outcomes for the adult at risk and may or may not choose to continue making enquiries until they establish that the Section 42 has been satisfied and outcomes have been achieved
d) where the alleged abuse or neglect has taken place in a regulated service and formal statements are required under the Health and Social Care Act 2008, the Regulator is responsible for ensuring actions are taken in compliance with the requirements within the Act. (This work may be carried out in parallel with other investigatory activities).
e) where the alleged abuse or neglect has taken place in a non-regulated but commissioned service e.g. adult fostering, day care or work opportunity service, appropriate professionals, which may include the manager of the service, may be asked to contribute to the Enquiry.
f) S.10 of the Care Act 2014 states that carers must be offered an assessment of their need. This applies to carers who are adults and provide care, or intend to provide care, to another adult with care needs. It does not apply if the care is provided in a paid capacity or through voluntary work (s.10 [3] & S10[9])
g) where there are large scale concerns parallel assessments or reviews of the needs of other adults are very likely to be necessary, with possible input from the CCG; primary and or continuing health care.
h) staff who are involved in an Enquiry should seek support from their own professional bodies, unions or legal services.

Where any individual has potentially committed a criminal act they may be investigated by the police with a view to prosecution and this may take place in parallel with, and not instead of, any regulatory and/or disciplinary action by the employer and/or regulating body.

The DSO role involves co-ordinating the sharing of information for these different arenas, planning any agreed joint interviews to avoid repeated and distressing rehearsal of the facts, and drawing up a timetable, which acknowledges the different timeframes involved in taking these disparate forms of action.

Following the allocation of the case by the DSO, the Inquiries Officer (IO) should start the statutory enquiry process within 48 hours, in conjunction with the other professionals. A timetable should be drawn up indicating the order in which tasks will be undertaken.

10.6 Interviewing adult at risk and witnesses

The adult should not be interviewed in the presence of the alleged adult deemed responsible. An adult may be accompanied by the most appropriate person from the following list at the discretion of the police (if there is a criminal investigation) or at the discretion of the local authority as part of the Section 42 Enquiry (please see protocols for involving people with hearing impairment in Guidance Section 9):

a) a personal representative
b) an interpreter
c) a BSL or Makaton interpreter
d) an independent advocate or representative
e) an IMCA
f) an IDVA

g) an IMHA

h) an Appropriate Adult

i) an Intermediary

Any interviews with significant witnesses and/or the complainants should ideally be carried out by two people. Joint interviews and joint visits are preferable to prevent the adult having to repeat their story. In criminal cases, one interviewer must be a police officer. Examination of documentary evidence such as files, accident and incident reports, daily logs, accounts, medical records and staff rotas may prove vital to the Enquiry.

10.7 Compiling a report

At the end of the Enquiry, the Inquiries Officer (IO) will compile a concise report and summarise the information gathered and the facts that have been established. Those involved may be asked to contribute to one or more Sections of the report drawing on their personal or professional knowledge, judgement and/or on specific inquiries carried out as part of the investigation. There is an expectation for the enquiry and the report to be completed within 4 weeks of the Terms of Reference for the enquiry having been agreed with the IO. If this time scale is likely to be exceeded due to the complexity of the case the DSO must be kept informed and will advise relevant others of the expected delay.

The report should cover the following points:

a) details of the initial concern, the impact on the adult and risks identified

b) an outline of any previous concerns

c) details of the adult or their representative’s preferred outcomes

d) the adult’s capacity to make decisions regarding the safeguarding Enquiry and an assessment as to why

e) an outline of the adult’s situation, their network and social supports

f) any issues of discrimination

g) information about the alleged person(s) deemed responsible

h) brief account of the enquiry process, input from other agencies and cross referencing any associated agency reports.

i) an evaluation of information gathered and the facts that can be established

j) an assessment of how serious the abuse or neglect has been; how risk has been mitigated and managed and how recovery of the adult has been promoted

k) recommendations about future action to support the person via their own networks and/or manage any ongoing risk

l) conclusions about culpability and responsibility for the abuse, neglect or harm

m) other actions to be taken.

n) recommendations about when and in what circumstances the case should be revisited

o) recommendations for a safeguarding plan, monitoring and review

The completed report should then be passed to the DSO for decision making. The report will be available to inform the case conference and marked ‘Confidential’. If a case conference is not held the information, the outcome and the recommendations for future care planning and monitoring will be shared with people on a ‘need to know’ basis. In cases where the employer is considering disciplinary action or referral to DBS, the DSO will make a copy of the report, or a summary, available to the employer.

10.8 Duty of Candour.
The Government created Statutory Regulations relating to Duty of Candour in response to The Francis Report on incidents that took place at Mid Staffordshire Hospitals NHS Foundation Trust. Candour means frankness, openness and honesty. The aim of the regulation is to ensure that providers of health and social care are open and honest with service users when things go wrong with their care and treatment.

To meet the requirements of the regulation, a provider has to:
• Make sure it has an open and honest culture across and at all levels within its organisation.
• Tell service users in a timely manner when particular incidents have occurred.
• Provide in writing a factual account of the incident and an explanation about the enquiries and investigations that organisation will carry out.
• Offer an apology in writing.
• Provide reasonable support to the person after the incident

11. Case Conference

11.1 Case Conference Decision

Most Enquiries, involving agencies in addition to social services, should lead to a formal case conference at which decisions will be taken. A decision not to proceed to a case conference will be made by the DSO and the reasons for not proceeding clearly recorded and shared with key people in other agencies. If anyone has any concerns about a case being brought prematurely to a close they should share their views by phone or in writing to the DSO concerned, who should review his/her decision in discussion with the Senior Manager.

Cases in which a conference is not warranted might include low level cases that concern only one agency, or in which actions to be taken are straightforward and non-contentious. A case conference checklist is available in Safeguarding Checklists for Practitioners.pdf – Section 6.

Where a case conference is not held, a post abuse care plan should exist which sets out how the person can stay safe through prevention and community engagement. The plan should also set out provision for monitoring, review and feedback to agencies that have been involved. Feedback will be given to the referrer which may not necessarily contain details of actions taken. A post abuse checklist is available in Safeguarding Checklists for Practitioners.pdf - Section 7.

11.2 Conducting a case conference

If a case conference is to be convened, arrangements should be made as soon as possible after receiving the report of the Enquiry. This should normally be within 60 days of the receipt of the initial concern and will probably have been agreed as part of the planning process. If the case conference has to be delayed beyond a period of 60 days, this should be agreed by the DSO and reasons for extending the Enquiry should be clearly recorded.

11.3 Case conference purpose

The aim of the case conference is to share the outcome of the Enquiry and any consequent assessment(s) and to make recommendations regarding the ongoing care and protection of the adult(s), action(s) in relation to the perpetrator(s), in collaboration with other relevant people and agencies.

The case conference should provide a forum for:
Adult Safeguarding Protocols

a) establishing and recording the facts; discussion and joint decision making about findings and the circumstances surrounding the alleged abuse
b) deciding if the adult’s outcomes have been met
c) agreeing measures to be taken to assure the future protection of the adult, prevention and risk management.
d) identifying and supporting sanctions or other interventions to be taken in relation to the person deemed responsible
e) specifying actions to be recommended in relation to the service or provider agency
f) ensuring that full consideration is given to the possibility that other adults may be at risk and agreeing action to reduce or eliminate that risk
g) agreeing appropriate feedback to the adult at risk, agencies and services on a 'need to know basis', including the referrer.
h) ensuring that, where ongoing concerns exist appropriate monitoring and governance arrangements are established.

If there is any disagreement with the recommendations and outcomes of the case conference, these should be formally expressed and recorded in the minutes. Should an appeal regarding this need to be made then at the earliest opportunity, the Chair must refer the matter to a senior manager. If an agreement still cannot be reached, then the escalation process should be used. Escalation Policy for Adult Safeguarding - Resolving Practitioner Differences

11.4 Invitees to a case conference

It may be necessary to address the different elements of the case in separate Sections of the meeting and to vary those attending for different agenda items. Minutes of the conference should only be distributed to the participants who attended a particular part of the case conference. The following people may be invited to attend all or part of the meeting:

a) The adult must be invited, however, if they are unable or unwilling to take part, their nominated representative or advocate, if they have one, should be invited to attend appropriate parts of the conference. Every effort should be made to empower the adult to play as active a part in the meeting as possible.
b) It may not be practical for all adults to attend, say for example in the case of a case conference which has a focus on a provider service. Where an individual has been identified as a vulnerable victim, the DSO or IO must inform the adult about the meeting and if they are unable or unwilling to take part, their representative, or advocate should be informed. The Chair of the meeting must gain agreement about how each adult or their representative receives feedback, for example via letter, relative feedback or a resident’s meeting.
c) A family member, carer, or friend.
d) The DSO, at their discretion, will invite all relevant professionals.
e) The person who was alleged to be responsible for the abuse/neglect should only be invited to the case conference in exceptional circumstances.

If the setting or provider agency is deemed responsible for the abuse occurring, an establishment case conference about the service and its management should be held separately after the client focused case conference. The DSO/senior manager should formally advise the management of the service concerned, at least 48 hours prior to the meeting about the issues likely to be raised.

Regulatory bodies and commissioning staff should take a more prominent role in this meeting.
11.5 Case conference preparation

Where an adult or witness is invited to attend all or part of the case conference they should be fully briefed by the chair regarding the arrangements for the meeting and the issues that may well be discussed.

Anyone invited to be part of a case conference should check with the DSO about the role expected of him or her in the conference. They might seek advice about any documents, which may be required during the conference. If this is confidential material from the adult's file, their permission should be sought, or alternatively seek authorisation from a service manager about releasing this information in the context of this Enquiry. If there is a need to summarise, select specific points that have a bearing on the issues arising, for example the adult's capacity or ability to protect themselves. Any special reports should be concise and to the point.

Careful planning is required in instances where organisational abuse is an issue and more than one adult or their representative is involved in the meeting. It is important to ensure that confidentiality is maintained and information is shared strictly on a need to know basis.

Read papers in advance of the conference, if they have been made available. Make sure that where these are marked 'highly confidential' appropriate provisions are made for transporting them to, and keeping them after, the conference.

The Chair should ensure that reports provided to representatives to assist in the decision making are collected at the end of meeting.

11.6 Chairing a case conference

The DSO will usually chair the case conference and minutes will be taken. At the meeting the chair will:

a) ensure appropriate support is provided to the adult and/or their representative
b) present a brief background of the case and explain purpose of the conference: this should be followed by a statement of facts and details by the IO from their report
c) establish if the adult’s (or their representative’s) outcomes have been achieved
d) facilitate a free and full discussion of the facts to establish the status of the concerns
e) formulate a clear safeguarding protection plan if appropriate and clarify future deployment of prevention, risk management and recovery of the adult
f) facilitate discussion regarding any risk to others and formulate a plan to reduce or remove the risk, in liaison with other agencies
g) facilitate the development of a post abuse care plan which documents any actions and assesses ongoing risk and measures to be taken to prevent further abuse.
h) set out plans for additional services or therapeutic interventions and/or changes in service provision or daily routines.
i) identify specific indicators that should trigger a review
j) provide a reminder of crucial times/events such as inquests, court cases, and release from custody and/or disciplinary hearings that might lead to further precautions becoming necessary.
k) set out a timetable for review and monitoring arrangements to ensure that the care plan is effectively implemented specifying by whom each task is to be carried out, within what time-scale and who is accountable.
l) in a separate Section of the meeting, agree what action(s) will be recommended to be taken in relation to the person(s) deemed responsible for the abuse and the setting. The Chair should check that all necessary and relevant referrals have been made to professional and regulatory bodies.
m) summarise the whole discussion and outcome of the conference and arrange a date for reviewing the arrangements made to protect and support the parties involved.

n) confirm relevant feedback arrangements to appropriate people including the referrer.

In complex cases where the risk of ongoing abuse remains a significant factor, the nature and frequency of review meetings will vary in each case. They should be arranged within six months or earlier if the situation changes and/or the risks have increased. Care should be taken to monitor the implications of outstanding issues and processes such as bail hearings, court cases, action under the Safeguarding Vulnerable Groups Act 2006 including Disclosure & Barring, disciplinary hearings, tribunals or action by professional bodies, parole and release dates after prison sentences.

The minutes of the conference should be succinct and contain only essential facts, decisions, recommendations and an outline of the post abuse care plan for those concerned. Any decision regarding the sharing of information outside the conference should be recorded in detail. Minutes will be circulated to participants marked 'Highly Confidential'. Written reports provided by agencies will not be circulated with the minutes, unless this has been agreed at the meeting. They will be retained securely in the client’s file.

In cases where there is disciplinary action or a referral made to the disclosure and barring service, the DSO will make a copy of the minutes, or a summary report, available to the employer.

11.7 An establishment case conference

If the investigation has revealed problems related to the general standards of care and/or abusive practices within a service, an establishment case conference may be held. This is likely to be led by the senior manager but there is an expectation that managers from contract services and regulatory authorities play a significant role within the meeting. Outcomes of this conference may result in ongoing auditing, monitoring, enforcement notices or cancellation of the existing registration and the contract. Consideration will be given to the support required to remedy any identified problem areas. Effective communication and collaboration between the relevant agencies is essential.
12. Adult Safeguarding Consultation Protocol between Police and Local Authorities

Adult Safeguarding Concern Form
Completed

Stage 1
- Evaluation of information
- Are there any criminal issues?

Stage 2
Consultation with other agencies and services

Yes

Send the alert form to the Police via secure email, and follow up with an urgent phone discussion about how to proceed.
Police will attend the Planning meeting(s), or engage in a strategy discussion.

Possibility

Safeguarding Process continues without Police involvement

No

Should concerns emerge that a crime may have taken place, contact police immediately

GUIDANCE NOTES ON CONSULTATION
AS is a multi-agency responsibility and the local authority leads Section 42 responsibilities which places a legal duty on them to safeguard and act in the ‘Best Interests’ of an adult at risk. To do this consultation should be carried out with any agency/service who may have information regarding the adult, the alleged abuser(s) and where it took place.
Outcome of consultations must be recorded.

Contact must include the police if there is suspicion that a crime has taken place. In discussion with the police explain the Adult Safeguarding concerns and share additional information on a need to know basis. Seek their views.
Information held by other agencies should assist in the evaluation of the concerns reported and in planning appropriate responses.

LAWFUL PRACTICE PRINCIPLES
The local authority is the lead agency and the preferred outcomes of the adult must be established. However if a crime is believed to have taken place this must be reported to the police. An adult at risk who is believed to have capacity, and is not being intimidated or pressurised and understands the risks and possible consequences, may decide that they do not want to support a criminal investigation. The decision whether to pursue an investigation sits with the police. It is important to ensure that the decision taken by the adult(s) at risk has been taken with a full understanding of all the issues and possible consequences.

IF IN ANY DOUBT THAT THE CONCERNS CONSTITUTE A CRIME CONSULT THE POLICE.
13. **Guidance Notes for Adult Safeguarding between the Local Authorities in Kent and Medway and Acute Hospital Trusts**

In line with the Care Quality Commission, the Care Act Statutory Guidance and this policy and its protocols, an allegation of abuse or neglect occurring within the services provided by an Acute Hospital Trust must be reported to the local authority to enable them to decide if a Statutory Section 42 duty to make Enquiries exists.

The Local Authority statutory adult safeguarding duties mean that they are responsible for making Enquiries although they may require others to undertake them. The local authority retain the responsibility for ensuring that the enquiry is referred to the Designated Adult Safeguarding Manager (DASM) at the hospital and that it is acted upon.

The local authority manager / DSO is responsible for considering the information available and for agreeing that the statutory duty is met and must contact the DASM to determine the most appropriate course of action. However if there is any possibility that a crime may have been committed, or other agencies are involved the DASM should consider holding a multi-agency planning/strategy meeting to ensure that roles and responsibilities are clearly defined and delegated. Local Authority representatives may be asked to provide support to the patient and or their family during the enquiry process.

Where it is determined by the local authority from the information available that there is a duty for Section 42 enquiries to be made they can request that the enquiries are made by the Trust. This means that the patient's (or their representative where mental capacity is in question) preferred outcomes should be established and the Trust should make enquiries to determine the details regarding: what happened, when, where, how, why the abuse or neglect occurred. They will co-ordinate these actions within agreed timescales, aiming to meet the patient's desired outcomes. This will involve oversight from the local authority that will be responsible for determining if the Section 42 duties have been met. They will challenge the Trust, if they believe that the Section 42 duties to carry out the enquiry have not been met.

The Trust may at any time request advice and guidance from the local authority and request that the local authority commissions an independent advocate to support the patient if required.

If a carer is involved in the case, the Trust must advise the local authority so that a carer’s assessment can be offered.

When the enquiries have been completed the hospital DASM should complete the monitoring information on the alert/referral form. They should also complete a closure/form summarising the outcome of the enquiry and any actions agreed. The form(s) together with copies of any evidence gathered must be passed to the local authority manager for the locality/area where the alleged abuse occurred. This manager will be responsible for countersigning the closure form and ensuring that the information is fully entered on the SWIFT/FRAmework.

14. **Causative Factors of Pressure Ulcers**

The purpose of this protocol is to support multi-agency decision making when considering whether or not to raise a safeguarding concern for an adult presenting with one or more pressure ulcers. The main issue to consider before raising the concern is: “was the pressure ulcer most likely to have been preventable?” As well as this framework, each
provider must have their own procedures for incident and pressure ulcer reporting to fulfil statutory reporting requirements.

**Process**

This is described in ‘Thresholds for Managing Concerns about Pressure Ulcers’ and contributory factors are described in ‘Pressure Ulcer Threshold Guidance’ *(next pages)*. The identified factors which determine events (Tier 1) leading up to the pressure ulcer development must be recorded to provide information for the safeguarding process. For more information please use the following link:


To use the Protocols please consult with your line manager and if the concern is community based (including residential and domiciliary care) if a nurse is not involved, please refer to the adult’s GP for support.
15.1 Thresholds for Managing Concerns about Pressure Ulcers

Thresholds for Managing Concerns About Pressure Ulcers

- KCC Adult Social Care Contact details
  - For a telephone consultation: 0300 333 5547
  - Send referral to: CentralDutyTeam@kentgcsx.gov.uk
  - Or fax referral to: 01732 221946
- Medway Adult Social Care Contact Details
  - For a telephone consultation: 9-5pm (01634) 334466
  - Out of hours service: 0845 626677
  - Fax: During working hours (01634) 334504 or out of hours service: (01233) 845596
  - Secure Email: During working hours: ss.access3 info@medway.gov.uk
  - Before sending any referrals by Fax or Email please telephone first to advise and confirm correct details.

Where concerns relate to NHS acute trust setting inform the Hospital Safeguarding Lead

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**Yes** - KASAF raised – provide info re:
- What harm or abuse has been caused?
- Who caused the harm or abuse?
- Where did the harm or abuse take place?
- Have you discussed concerns with other staff/care providers?
- What outcome do you want for the patient from social services?
- What outcome does the patient want?

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**Yes** – Record potential contributory factors:
- Lack of risk and/or assessments
- Lack of robust care plan, review and evaluation
- Lack of compliance with MCA legislation
- Lack of appropriate equipment
- Failure to access specialist advice e.g. TVN
- Care provider fails to identify and respond to deterioration in general condition
- Failure to act by others
- An omission to act
- Failure to recognise limitation of care provision
- Failure to act in expectations of role
- Failure to follow policy
- Patient concordance with assessed treatment plan
- Are others at risk of harm?

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Threshold Guidance sheet for examples of concern

Source Acknowledgement: Newcastle Safeguarding Adults Board – Safeguarding Threshold Guidance

March 2015

# Pressure Ulcer Threshold Guidance

Each Provider must have their own procedures for incident and pressure ulcer reporting, which fulfill all local and statutory reporting requirements whilst providing the framework for reporting pressure ulcers as an adult protection alert in line with the Multi-agency protocol.

The examples below provide a limited illustration of managing concerns about pressure ulcers and indicate the possible range of severity.

## Lower Level Pressure Ulcer Concern
(Remember the cumulative effect of low level concerns may lead to harm)

- Isolated missed home care visit - no harm occurs
- Minor events that still meet criteria for ‘incident reporting’
- Patient not concordant with assessed care plan
- Informal carer requiring additional support to meet adult at risk needs
- MCA has been considered in least restrictive approach to manage pressure area care
- Patient’s co-morbidities are such that PU development would have been likely
- Patient was receiving planned and well provided end of life care

## Significant

- Concern remains / Serious concerns confirmed
- KASAF completed
- Provider Incident investigation prompted

## Very Significant Harm

- Inexplicable Pressure Ulcer development and deterioration within a care setting or where the person is supported with personal care by paid worker.
- Clear plan in place which introduces controls to reduce risk.
- Multi-agency case conference called where required to meet needs of service user
- Service user is aware of the risks of non concordance with care plan and this is clearly recorded.

## Critical

- KASAF + Urgent statutory Police and/or Social Services action
- Investigation
- Multi-agency contribution to Investigation / SAR/DHR

- Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
- Failures in recording severe deterioration of pressure ulcer for further health opinion.
- Coroner reports cause of death attributable to pressure ulcer
- Mental Capacity Act not observed in supporting best interests as related to health care
- Failure to arrange access to life saving services or medical care
- Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
- Widespread, consistent ill treatment
- Professionals involved fail to follow their code of conduct

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Information from Safeguarding Adults; The Role of Health Service Practitioners (Department of Health 2011) (page 51) may help in decision making process.

March 2015
15. Medication Errors

15.1 Introduction

The purpose of this protocol is to support a consistency in relation to medication errors and safeguarding adult concerns and it can be used by in primary and secondary care settings including:

a) intermediate care
b) nursing and residential care homes
c) community based services e.g. domiciliary care services, district nursing, pharmacies
d) General Practice, including dispensing GPs
e) hospital wards / departments (including Community Hospitals, Acute Health Services and Mental Health Services)
f) Shared Lives Schemes

15.2 What is a medication error?

A medication error is defined as an error in the process of prescribing, dispensing, preparing, administering, monitoring, storing and providing medicines advice, regardless of whether any harm occurred. Errors may result in an incident, an adverse event or a 'near miss' and have a variety of causes such as lack of knowledge; failure to follow systems and protocols; inadequate level of staff competency; lack of training; poor communication; poor written or verbal instructions (for further information please refer to the following Threshold Guidance for Assessing and Reporting Medication Errors).

The Care Quality Commission (CQC) sets out Fundamental Standards for quality and safety for regulating health and social care providers and Outcome 9 looks specifically at the standards for the management of medicines. Providers must have clear procedures in place regarding the prescribing, dispensing, administration, storage and documentation of medicines, which includes arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses relating to medicines.

These arrangements should encourage local (and where applicable), national reporting, learning, promoting an honest, open and fair culture of safety. They must also ensure that staffs have the requisite level of training and competency regarding medicines

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9 Link to NICE Guidance for care homes [http://www.nice.org.uk/guidance/sc/SC1.jsp]

10 CQC Guidance, July 2013
management. In addition, registered doctors, nurses, pharmacists or allied health professionals have a duty to work within their professional code of practice and competency level.

15.3 When would a medication error be considered as a safeguarding concern?

Incidents should be assessed on an individual basis taking into account the needs, wishes and health of the adult concerned, in addition to a discussion with a line manager; safeguarding lead, pharmacist; pharmacy advisory service and where indicated with social services. The following examples show medication errors which are appropriate for making a safeguarding referral (not an exhaustive list). Any medication error which:

a) leads to harm or death
b) requires medical intervention to assess the adult for actual or potential harm e.g. GP consultation or attendance at A&E
c) was deemed to be a deliberate act
d) was administered covertly without appropriate application of the MCA and best interest processes
e) is part of a pattern or culture e.g. same drug, same carer or same adult, considering frequency and duration of incidents
f) involved the administration of a controlled drug
g) involves more than one adult e.g. missed drug rounds
h) involves medication often associated with misuse or abuse e.g. benzodiazepines or opioids.
i) results in failure to apply the MCA statutory principles/best interest which result in people failing to receive essential medication.

The safety and well-being of all adults at risk is paramount and continual errors, even without harm, are a key indicator to prompt the review of systems regarding medicines management; staff compliance and training needs. The NHS are required to report and investigates medication errors as per specific organisational policy or procedure. Since July 2013, non-NHS providers are required to notify CQC about medication errors that cause:

j) a death
k) serious harm
l) abuse or a safeguarding concern
m) an incident reported to or investigated by the police

Organisations should seek advice from local health and safety advisors; pharmacies; or governance departments regarding the need to inform others such as:

n) Health and Safety Executive (HSE)
o) National Patient Safety Authority (NPSA)
p) Medicines and Healthcare Regulatory Authority (MHRA)
q) Registrants Professional Body e.g. NMC, GMC, AHP
Threshold Guidance for Assessing and Reporting Medication Errors

Kent Adult Social Care Contact details:
For a telephone consultation
9-5pm: 03000 41 91 81
Out of hours: 03000 41 91 91
Secure Email: CentralDutyTeam@kentcsx.gov.uk
Secure Fax: 03000 41 91 91

Medway Adult Social Care Contact Details
For a telephone consultation
9-5pm: 01634 334456
Out of hours: 03000 41 91 91
Secure Email: ss.accessandinfo@medway.gov.uk.cismed.net
Out of Hours: CentralDutyTeam@kentcsx.gov.uk

CQC Contact details:
Tel: 9-5pm: 03000 616161
Fax: 03000 616171
HSCA_notifications@cqc.org.uk

Where concerns relate to a NHS Provider inform the relevant Safeguarding Lead

Refer to Threshold Guidance sheet for examples of Tier categories.
# Threshold Guidance for Assessing and Reporting Medication Errors

All agencies must have robust procedures in place to provide assurance in relation to the prescribing, dispensing, administration, storage and documentation of medicines and must ensure their staff have the requisite level of training and competency regarding medicines management. (Registered practitioners have a duty to work within their sphere of practice and competency level)

<table>
<thead>
<tr>
<th>Lower Level Harm (Tiers 1-2)</th>
<th>Harmful (Tiers 3-4)</th>
<th>Significant Harm (Tiers 3-4)</th>
<th>Critical Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow organisations incident reporting procedure</strong>&lt;br&gt;<strong>Consider impact of recurrent minor incidents/errors</strong>&lt;br&gt;<strong>Consider impact of recurrent quality in care/practice/training concerns</strong>&lt;br&gt;<strong>Discuss with Line Manager/GP/Doctor/Pharmacist</strong>&lt;br&gt;<strong>Discuss with Local Safeguarding Lead or Local Authority (KCC/Medway)</strong>&lt;br&gt;<strong>Consider adult at risk’ views and wishes</strong>&lt;br&gt;<strong>Consider need for safeguarding referral and document rationale</strong></td>
<td><strong>Complete Safeguarding referral with rationale included</strong>&lt;br&gt;<strong>Consider actual harm or the risk of significant harm to the adult</strong>&lt;br&gt;<strong>Consider if error has occurred on more than one occasion</strong>&lt;br&gt;<strong>Could be a one off event but criminal/ legal issue would necessitate the referral even where there is no harm to the adult</strong>&lt;br&gt;<strong>Follow local incident reporting procedure/investigation</strong>&lt;br&gt;<strong>Consider need to initiate SI/RCA investigation process</strong>&lt;br&gt;<strong>CQC notification</strong></td>
<td>These incidents/concerns should be addressed under multiagency safeguarding protocols for Kent and Medway.</td>
<td>These incidents/concerns should be addressed under multiagency safeguarding protocols for Kent and Medway.</td>
</tr>
<tr>
<td><strong>Missed medication/ administration error on one occasion—no harm or distress experienced by adult at risk</strong>&lt;br&gt;<strong>Delay in administration of medication, but no significant harm or distress experienced by adult at risk</strong>&lt;br&gt;<strong>Sufficient organisational measures in place i.e. gaps in provision and/or uptake of training, supervision, audit</strong></td>
<td><strong>Missed drug round/ recurrent episodes of missed medication or error/s</strong>&lt;br&gt;<strong>Medication administration error involving controlled drug occurs</strong>&lt;br&gt;<strong>Use of medication that is not consistent with the adult at risk’s needs or expressed wishes</strong>&lt;br&gt;<strong>Pain inadequately addressed causing deterioration in physical or mental health</strong>&lt;br&gt;<strong>Unsafe practice or systems for the prescribing, dispensing, storage or documentation of medicines</strong>&lt;br&gt;<strong>Referrer or adult at risk and/or representative expresses concern not resolved</strong></td>
<td><strong>MCA not considered when adult at risk</strong>&lt;br&gt;<strong>Choose not to take medication</strong>&lt;br&gt;<strong>Unsafe practice regarding the administration of medicines</strong>&lt;br&gt;<strong>Deliberate maladministration of medications</strong>&lt;br&gt;<strong>Covert administration of medication without proper medical authorisation or consent from adult or MCA not followed</strong>&lt;br&gt;<strong>Adverse side effects experienced as a result of the maladministration of medication</strong>&lt;br&gt;<strong>Inappropriate sedation of patient</strong>&lt;br&gt;<strong>Medication error involves medication often associated with drug misuse or abuse e.g. benzodiazepines, opioids</strong>&lt;br&gt;<strong>Medication incident involving potential diversion of controlled drugs</strong>&lt;br&gt;<strong>Actual harm or risk of significant harm to one or more adult at risk</strong></td>
<td><strong>Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death of adult’s</strong>&lt;br&gt;<strong>Adult at risk and/or their representative have identified serious concern and Tier 4 response is their desired outcome</strong>&lt;br&gt;<strong>Urgent remedial action required and implemented through safeguarding adults or quality improvement strategies</strong>&lt;br&gt;<strong>Actual harm or risk of significant harm to one or more adult at risk</strong>&lt;br&gt;<strong>Serious harm or death of adult at risk</strong></td>
</tr>
<tr>
<td><strong>No harm to adult at risk</strong>&lt;br&gt;<strong>Recurring missed medication or administration errors</strong>&lt;br&gt;<strong>Medications not available when adult at risk is transferred or discharged from care environment</strong>&lt;br&gt;<strong>Insufficient organisational measures in place to provide assurance</strong>&lt;br&gt;<strong>Complaint from adult at risk and/or representative but, following investigation, they are satisfied with agency actions/response</strong></td>
<td></td>
<td></td>
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</tbody>
</table>

Source Acknowledgement: Newcastle Safeguarding Adults Board – Safeguarding Threshold Guidance
Guidance Section
ADULT SAFEGUARDING GUIDANCE

1. Preventative Strategies

It is important to remember that the ultimate intention of adult safeguarding is to prevent abuse or neglect; encourage early detection; aid recovery and to promote the well-being of the adult. Consideration of the following factors will positively contribute to prevention:

1.1 How adults minimise risk of abuse

a) Understanding what constitutes abuse and advice on self-protection and sources of support
b) how to get help, e.g. support groups and self-advocacy schemes where adults can discuss issues of concern and rally mutual support
c) making sure they are part of any decisions which affect their lives
d) staying healthy, aware and involved
e) If a personal assistant is employed directly by the adult, they need to be aware that the responsibility for monitoring care standards rests with them as an employer

1.2 How staff and carers can minimise risk

a) understanding what constitutes abuse
b) acknowledging that 'it could happen here'
c) having open and honest discussions about care practise and concerns
d) being aware of the issues of vulnerability and exploitation
e) investing in personal development, training and skills development
f) supporting a learning culture and feedback to each other (and in teams)
g) being prepared to question or challenge care practices that could be abusive

1.3 How services can minimise risk of abuse

a) having a Safeguarding Adults Policy
b) having a Whistle Blowing Policy
c) maintaining safe and effective employment and recruitment practices
d) assuring pre-placement assessments are carried out to identify that a service can meet an adult’s needs
e) producing personalised plans and risk assessments to identify how the service will meet identified needs
f) making sure plans and risk assessments are agreed and signed up to by all relevant parties
g) ensuring staffing levels and competence can meet the needs of adults at risk
h) encouraging good communication between staff, managers, families and adults at risk
i) recording and responding to complaints and positively deploying the learning from them, in line with Duty of Candour responsibilities.
j) ensuring staff and volunteers receive training about how to effectively safeguard and prevent abuse
k) support training initiatives about all areas of care, support and community engagement
l) having efficient reporting and recording systems in place
m) having a clear escalation policy
n) having clear and easily accessible policies which promote good practice,  

See also Care Act 2014 Part One, Section One “Promoting Individual well-being”
2. Possible signs of Abuse

In addition to adults directly disclosing abuse, this Section provides further information to assist in the identification of adult abuse and should be read in conjunction with Policy Section 8: Types and Patterns of Abuse. Indicators are the main signs and symptoms which may suggest that some form of abuse is or may have taken place, but caution must be exercised in relation to establishing adult abuse due to the presence of one or more of these indicators - without further detailed assessment and enquiry.

2.1 Pre-disposing factors which may lead to adult abuse

The following factors may be relevant to any adult at risk whether living in their own home, a care or nursing home or are receiving care, support or services in hospital or any community setting:

a) an unequal power relationship (physical, emotional or financial) between abused and the abuser or living with people where there is a form of dependence
b) an adult with learning disabilities, mental health problems, or chronic progressive, disabling illness that can create caring needs which exceed the carer’s ability to meet them
c) a personal or family history of violence; alcoholism, substance misuse or mental
Adult Safeguarding Guidance

illness
d) emotional and social isolation of a carer and or a lack of support
e) minimal/no communication between an adult and carer
f) difficulties that can lead to substandard living conditions

The following Section describes indicators of abuse and albeit not exhaustive, it may help in deciding next steps.

2.2 Physical abuse

Physical abuse is usually associated with assault and injury, and should be reported to social services (also some injuries may have innocent explanations and can result owing to certain medical conditions). Discretion and sensitivity should always be used and if there is suspicion that an adult at risk has been intentionally injured or as a result of carelessness or neglect, police and the local authority should be informed.

This is likely to require a S42 Enquiry and or a criminal investigation.

Serious attention should be given to any marks or injuries such as skin imprints; burns; bites or use of a weapon. Descriptions of colour, size, depth and shape will be important, as will any relevant clinical assessment. Information will need to be recorded and stored appropriately and body maps can help. Individuals who make allegations should be listened to and taken seriously and the adult’s explanation is crucial. This can be assisted with a simple open question e.g. ‘What happened here?’ and by the person not being near any inappropriate influences.

Where communication is not possible, enquiries with others will need to be made, to try establish a cause. Consideration needs also to be given to:

a) history of unexplained falls or minor injuries especially at different stages of healing
b) unexplained bruising in well-protected body areas e.g. inner thighs, upper arms etc.
c) burns e.g. by cigarettes; rope etc.
d) history of frequent changing of GP or reluctance for visiting a GP or seeking help
e) accumulation of prescribed medicine which is not administered
f) malnutrition, ulcers, pressure sores and being left in wet clothing or beds

2.3 Sexual exploitation and abuse

Sexual exploitation abuse often manifests in unusual behaviours, however it is important to note that no specific behaviour or behaviours are definitive of this taking place. All alleged sexual abuse or exploitation must be reported to the local authority and the police who will advise on next steps. This should be done immediately but within 24 hours given the need to protect potential forensic evidence.

Consideration must be given to the adult’s mental capacity, their best interests and if there are others (including children) who may be at risk and:

a) disclosure
b) unexplained changes in demeanour and behaviour
c) tendency to withdraw and spend time in isolation
d) expression of explicit sexual behaviour and/or language which is out of character
e) irregular and or disturbed sleep pattern
f) bruising or bleeding in the rectal or genital areas
g) torn or stained underclothing
h) sexually transmitted disease or pregnancy
i) coerced, trafficked or manipulated to participate in sexual activity or porn
j) alcohol or drug induced behaviours which result in sexual activity
k) grooming activities towards adults at risk
l) being controlled and unable to please their partner
m) unfulfilled promises that abuse will stop

2.4 Ill-treatment or wilful neglect

The Mental Capacity Act 2005 introduces two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decision.

The offences may apply to:

a) anyone caring for a person who lacks capacity - formally or informally, paid or not
b) a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA)
c) a Deputy appointed for the adult by the Court of Protection

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties can range from a fine to a custodial sentence of up to five years or both.

Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:

a) have deliberately ill-treated the person, or
b) be reckless in the way they were treating the person resulting in the person’s ill treatment

The meaning of ‘wilful neglect’ varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act that they knew they had a duty to do. Wilful bullying or behaviour likely to engender fear however, may amount to ill-treatment. Carers of adults at risk who wilfully fail to provide adequate food, clothing, medical aid or accommodation for them may be guilty of this offence. Signs may be failing to thrive, poor personal hygiene; hunger; thirst; dehydration; fear; unremoved hazards and social isolation.

The most serious offences may come about in circumstances of neglect and the local authority should always be informed as it is likely that a Section 42 Enquiry will commence. Police will always be informed as part of such an Enquiry and may carry out a criminal investigation.

2.5 Organisational abuse

The types of abuse described in Policy Section 8 of the Policy and the indicators of abuse outlined above apply to services provided by commissioned and non-commissioned services, including those from Kent County Council, Medway Council, private, health or voluntary organisations. It is important to consider the cumulative impact of inadequate standards which can result in abuse or neglect. These may have arisen from inadequate standards in relation to clinical governance, leadership or training.

Indicators of neglect in such circumstances may be:

a) inadequate clothing; food; fluids; heating; lighting or call bell access
b) inadequate assessment and recording about adult’s needs
c) inadequate personal, physical condition e.g. pressure sores
d) unkempt and unwashed; frequently in night clothes during the day
e) failing to clinically assess or give prescribed medication or obtain appropriate medical assistance
f) unexplained or continued weight loss
g) failure to acknowledge privacy and dignity.

h) reluctant contact with professionals or visitors

i) unable to access spectacles, hearing aids etc. causing sensory deprivation

j) fearful

k) loss of or low self esteem

l) depression

m) unexplained changes in behaviour

2.6 Psychological abuse

It is impossible to experience abuse by any of these descriptors and not feel a psychological impact. Some signs of this may be:

a) loss of appetite or overeating

b) anxiety, depression, confusion or resignation

c) social withdrawal and isolation

d) inability to sleep and or long periods in bed

e) depression

f) reluctance to engage with services or help

g) self-harm

h) inability to remove one’s self from the abuser

i) observed changes in relationship behaviour

j) drug and alcohol abuse

k) frequent medical visits for non-specific ailments

Psychological abuse can amount to ill-treatment under The Mental Capacity Act 2005. Emotional abuse can amount to criminal assault.

2.7 Financial and material abuse

Financial and material assets are for the benefit of that person and use of these by others (without expressed permission) may constitute financial abuse: e.g. theft or misappropriation can be regarded as a criminal act.

If an adult requires assistance to manage their financial affairs, they will benefit from early advice, for example, during assessment and or review, where their suggestibility to undue risk and influence should be considered and where advocacy or deputyship may help in relation to their mental capacity and best interests. If an adult is able to make informed decisions and can handle their own financial affairs they should always be encouraged and supported to do so. Indicators of financial abuse may be:

a) theft, fraud, deception

b) pressure on a person regarding their will, property ownership or inheritance

c) misuse or misappropriation of benefits

d) inability to pay basic bills

e) withdrawal of large sums of money without reasonable explanation

f) disappearance of personal possessions

g) substandard living conditions compared to the adult’s accustomed lifestyle

h) Intense interest in adult’s financial affairs or assets, without appropriate legal authority.

i) Reluctance or unwillingness by a person with a registered enduring or lasting power of attorney (for property and finances or a Deputy appointed by the Court of Protection to pay accounts or to provide the adult with personal monies to meet their essential day to day needs.

For more information please see the Financial Abuse Toolkit
2.8 Discrimination

There are different types of unlawful discrimination:

- **Direct discrimination** - where someone is treated less favourably than another person because of a protected characteristic
- **Associative discrimination** - this is direct discrimination against someone because they are associated with another person who possesses a protected characteristic
- **Discrimination by perception** - this is direct discrimination against someone because others think that they possess a particular protected characteristic. They do not necessarily have to possess the characteristic, just be perceived to.
- **Indirect discrimination** - this can occur when you have a rule or policy that applies to everyone but disadvantages a person with a particular protected characteristic
- **Harassment** - this is behaviour that is deemed offensive by the recipient. Employees can now complain of the behaviour they find offensive even if it is not directed at them.
- **Victimisation** - this occurs when someone is treated badly because they have made or supported a complaint or grievance under this legislation.

The **Equality Act 2010 states it is unlawful to treat anyone** unfairly because of following **protected characteristics**:

- Age
- Disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion, faith or belief
- sex
- sexual orientation

A person is protected from discrimination when they are:

- at work
- in education
- a consumer
- using public services
- buying or renting property
- a member or guest of a private club or association

A person is also protected from discrimination if:

- they are associated with a person who has a protected characteristic, e.g. a family member or friend
- they have complained about discrimination or supported someone else’s claim

Helping those with a ‘protected’ characteristic is called ‘positive action’ and this is legal if the person:

- is at a disadvantage
- has particular needs
- is under-represented in an activity or type of work
It can however be lawful to have specific rules or arrangements in place, as long as they can be justified. If discrimination has or may have taken place the following routes can assist:

- using an organisation’s complaint process
- the use of mediation’ or ‘alternative dispute resolution’
- making an application to a tribunal

If a person is the subject of discrimination there may be signs of:

- prejudicial decision making
- being treated differently or unfairly or rudely
- a lack of access to jobs; housing; services; education and opportunities
- withdrawal, isolation, fearfulness and anxiety
- being inappropriately excluded
- acute embarrassment
- depression and loss of self esteem
- resistance or refusal to access services that are required to meet need
- expressions of anger and or frustration
- change in character and/or behaviour

The [Equality Advisory Support Service](#) can also provide for help advice.

### 2.9 Modern Slavery or Human Trafficking

The main elements of human trafficking are:

**The movement** – recruitment, transportation, transfer, harbouring or receipt of people.

**The control** – threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control of the victim.

**The purpose** – exploitation of a person, which includes prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs.

See following links for: [Human Trafficking and Modern Slavery](#) and [National-Referral-Mechanism-Guidance](#)

Children cannot give consent to being moved; therefore the coercion or deception elements do not have to be present. Countries throughout Europe translate and interpret the Palermo Protocol in different ways so the definition of what constitutes human trafficking can differ between nations.

**Reporting Human Trafficking**

In the first instance the point of contact for all human trafficking crimes should be the local police force. If you have identified an adult at immediate risk, dial 999. If you hold information that could lead to the identification, discovery and recovery of victims in the UK, you can also contact the charity Crime stoppers anonymously on 0800 555 111 or dial 101.

### 2.10 Forced Marriage

You have the right to choose who you marry, when you marry or if you marry at all. Forced marriage is when physical (e.g. threats, violence or sexual violence), emotional and/or psychological pressure (e.g. person is made to feel like they are bringing shame on the family) is brought to bear to make one person marry another. See link below for further information:

[Statutory_Guidance_publication – Forced Marriage](#)
2.10.1 Forced marriage offences
Forced marriage is illegal in England and Wales and this includes:

i. taking someone overseas to force them to marry (whether or not the forced marriage takes place)
ii. marrying someone who lacks the mental capacity to consent to the marriage (whether they’re pressured to or not)

2.10.2 Preventing or trying to stop a forced marriage
Contact the police and Forced Marriage Unit (FMU) if you are trying to stop a forced marriage or a person needs help leaving a marriage that they have been forced into. Trained professionals provide free advice on what to do next and can help with finding a safe place to stay or stopping a UK visa if a person has been forced to sponsor someone (contact details are in Appendix 1).

2.10.3 Forced marriage abroad
Contact the FMU if you think a person is about to be taken abroad or has been taken abroad to get married against their will. If they are already abroad, provide details regarding

   i. where the person has gone
   ii. when they were due back
   iii. when they were last heard of or from

The FMU will contact the relevant embassy. If they are a British national, the embassy will try to contact the person and help them get back to the UK if that’s what they want.

2.10.4 Forced marriage Protection Orders
The FMU can advise how to ask the court for a Forced Marriage Protection Order. Each order is unique, and is designed to protect according to individual circumstances e.g. the court may order someone to hand over your passport or reveal where you are. In an emergency, an order can be made to protect immediately. Disobeying a Forced Marriage Protection Order can result in a prison sentence.

2.10.5 Support for victims
Read the handbook about being a survivor of forced marriage containing further details of organisations that can give help and advice.

2.11 Female Genital Mutilation (FGM) see Policy Section 8.17

FGM is a hidden crime and it is therefore difficult to assess the scope of this. The NSPCC estimates that 23,000 girls under 15 could be at risk of FGM in England and Wales and nearly 60,000 women could be living with the consequences of FGM. More information can be found by contacting help@nspcc.org.uk or calling 0808 800 5000

Link to the Mandatory Reporting of Female Genital Mutilation – Procedural Information from the Home Office and Department for Education

Offences
The Female Genital Mutilation Act 2003\(^\text{12}\) states that a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl or woman’s

labia majora, labia minora or clitoris, but no offence is committed by an approved person who performs a surgical operation, necessary for physical or mental health, or surgical operation on a girl or woman in any stage of labour, or has just given birth.

A person is also guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris. Penalties are up to 14 years in prison or a fine or both.

2.12 Patterns of abuse/abusing

This varies and has a range of different dynamics which can include:

a) serial abusing – where the perpetrator seeks out and 'grooms' adults at risk. This can incorporate sexual abuse and financial abuse
b) long term abuse - in the context of an ongoing family relationship such as domestic abuse between spouses or generations
c) opportunistic abuse – where theft may occur because the opportunity has presented itself
d) situational abuse – where pressures have built up and challenges present
e) neglect - because those around him or her are not able to be responsible for the adult's care may be because the carer needs assistance or may have their own health or other problems
f) organisational abuse – where poor care standards, lack of positive response to complex needs, rigid routines, inadequate staffing and insufficient knowledge can cause harm to adults at risk
g) unacceptable ‘treatments' or programmes which include sanctions or punishment such as withholding of food and drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication
h) failure of agencies to ensure staff receive appropriate guidance on anti-racist and anti-discriminatory practice
i) failure to access key services such as health care, dentistry, prostheses
j) misappropriation or misuse of adult's monies, fraud or intimidation in connection with wills property or other assets.

3. Responding to Initial Disclosures of Adult Abuse

Although staff are encouraged to be alert to the signs and signals which may indicate that someone is being abused, many incidents will only come to light because the person discloses this themselves. Bear in mind that a disclosure may take place many years after a traumatic event or when someone is afraid and this should not cast doubt on the person's truthfulness. The person to whom a disclosure is made may not necessarily be the person to take an investigation forward. So if you are told about abuse, your must respond sensitively and professionally and pass the information on to your line manager/senior manager as soon as possible but within 24 hours - unless you suspect that they themselves may be implicated. If this is the case, or you are concerned about their response, you should report your concerns directly to the local authority, or to the police or to The Care Quality Commission if it is a regulated service.

If someone discloses abuse to you, you should:
a) stay calm and try not to show shock or disbelief
b) listen carefully to what they are saying
c) be sympathetic ('I am sorry that this has happened to you')
d) be aware of the possibility that medical evidence might be needed
Tell the person that:
e) they did the right thing to tell you
f) you are treating the information seriously
g) the alleged abuse was not their fault
h) you have to inform the appropriate person
i) you/the service will take steps to protect and support them

You must:
j) use open questions, such as: 'Can you tell me what happened / Can you tell me what was said/ Can you describe that to me?'
k) report to your line/senior manager and to local authority, or police (or CQC in a regulated setting) as soon as possible and within 24 hours, ensuring any immediate risk is responded to
l) As soon as possible, record factually what was said, use exact wording and phrases, not your opinion
m) describe the circumstances in which the disclosure came about
n) note the setting and anyone else who was there at the time
o) Be aware that your report may be required later as part of a legal action or disciplinary procedure

You must not:
a) press the person for more details
b) interrupt when a person is freely recalling significant events; (e.g. don't say 'Hold on we'll come back to that later') as they may not say it again
c) ask leading questions that could be interpreted as putting words or suggestions forward (for example ‘Did you mean….?’)
d) promise to keep secrets because this information cannot be kept a secret but can be managed confidentially
e) make promises you cannot keep (such as: ‘This will never happen to you again’)
f) contact or confront an alleged abuser
g) start an investigation on your own
h) be judgmental (for example ‘Why didn’t you run away?’)
i) pass on the information to anyone other than those with a legitimate 'need to know,' such as your line manager or other appropriate person

4. The Line Manager’s responsibility when initially advised of a disclosure

If you think, from the information you have received, that that an allegation of abuse exists, you must contact the local authority to discuss and report the concerns, or the police or the regulator (CQC). You must try to be careful and not compromise any possible criminal, or Section 42 Enquiry.

You should also be aware of over questioning an alleged victim, which is why you should ring the local authority for advice. Keeping accurate records is essential.

5. Guidelines to report Adult Safeguarding concerns to the Local Authorities in Kent and Medway

a) To consult or make a referral
These guidelines are designed to assist anyone who has a concern about an adult at risk who is or may be a victim of abuse. Adult Safeguarding is now a statutory responsibility and if you are not sure if your concerns constitute adult abuse, than you must contact the local authority for consultation and advice. Raising a concern begins the process of gathering information to decide if it is appropriate to deal with this as a statutory Section
42 adult safeguarding enquiry or not. For a consultation or to raise an alert about concerns, contact either:

Kent Social Services: 03000 41 61 61 (08.30 – 17.00 hours)
Medway Social Services: 01634 334466 (08.30 – 17.00 hours)
Out of Hours Service (Kent and Medway): 03000 41 91 91

b) **Information for statutory, private and voluntary organisations**
All agencies/services involved in the care of adults at risk in Kent and/or Medway should have their own adult safeguarding policy and procedures, consistent with the Multi-agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway. In all cases, the referrer should be prepared to provide information to support the adult safeguarding statutory process. If all information is not available, the referral should not be delayed. If the person(s) at risk is funded by another Local Authority, then that authority must also be informed.

To make a safeguarding referral to Kent Safeguarding Alert Form: [KASAF document](#)
for older version on word [Kent-adult-safeguarding-alert-form.doc](#)

To make a safeguarding referral to Medway [SAF document](#)

Word version of SAF available at [Medway.gov.uk](http://Medway.gov.uk) (end of the page)
6. **Flowchart for Abuse Witnessed or Suspected that has occurred in Kent or Medway**

An alert begins a process of gathering facts, assessment of the concern and adult’s needs; and a risk assessment to decide if a statutory or non-statutory enquiry should take place and within any organisation, an employee or volunteer must alert their line manager or designated officer to any safeguarding adult concerns or allegations:

- **You are alerted by a member of staff or become aware that abuse or neglect has occurred or is suspected**

1. **Where possible, ensure the immediate safety and welfare of the adult at risk (and of any other adult or child at risk)**

2. **Is urgent medical or police attention required? Call 999**

3. **Does a crime need to be reported? Be aware of the possible need to preserve forensic evidence. Call 101 (non-emergencies). If life is in danger or crime is in progress call 999**

4. **Decide on whether to raise an adult safeguarding concern by gathering only initial information. If you are not sure whether to raise an alert, CONSULT with Kent County Council/Medway Council Adult Social Care Team (see contact details).**

   Notify the person you are considering raising a safeguarding concern and discuss Making Safeguarding Personal objectives (see here). If the person does not consent to the information being shared, are there justifiable reasons to act contrary to their best wishes? Such as risks to others/ the concern relates to conduct of an employee/ volunteer/ mental capacity of person to decide/ inability to consent due to undue influence or intimidation/ possibility of serious harm occurring?

5. **Decide on whether to raise a concern, gathering only essential information necessary to report to Kent Adult Services, using the KASAF**

   If you are having trouble using the form above, please use this version: [Kent-adult-safeguarding-alert-form.doc](#) or call for a Consultation on 03000 41 61 61 between 8.30 and 5 pm or out of hours on 03000 41 91 91

   Report concerns by sending Medway Council a completed a SAF document

6. **Document the incident and any actions or decisions in your records**

7. **Inform the relevant Regulatory Body and Commissioners if relevant**

8. **Inform line manager of actions**

9. **Where possible ensure person who raised concern is offered support**
### Contact details for Kent’s Central Duty Team:

Contact details for Kent’s Central Duty Team:

- **CentralDutyTeam@kent.gcsx.gov.uk** (Secure e-mail*)
- **Central.duty@kent.gov.uk** (Standard e-mail)
- Phone: **03000 41 61 61**

### Contact details for Medway Council Adult Social Care

- **During working hours:** T: 01634 334466 or Fax: (01634) 334504
- **Secure Email:** ss.accessandinfo@medway.gov.uk.cjsm.net
- **Out of hour’s service:** T: 03000 41 91 91

### 7. Adult Safeguarding Guidance for Providers

If an adult safeguarding concern is raised regarding your organisation/service, this is what you can expect to happen:

| 1. | Adult safeguarding concern raised about an adult at risk who is receiving care |
| 2. | Consultation will take place to gather information and to enable a decision to be made regarding need for a statutory or non-statutory enquiry to take place and if an advocate is needed for the adult. A planning meeting may be held. |
| 3. | If it is decided that a planning meeting will go ahead, relevant multi-agency professionals will be invited. The referrer and/or service provider may be invited to all or part of a planning meeting. You will be advised of what you need to bring to the meeting. If the decision regarding a statutory enquiry has not yet been made it can be made at this point and the level of perceived risk is agreed |
| 4. | The service provider will be advised of relevant agreed actions |
| 5. | **Risk Assessment**
Risks identified and actions detailed. Risks can reduce or increase and information about risk will be shared with other appropriate agencies such as regulators, registration authorities and commissioners. Service may be flagged via the local authority or NHS contracts databases and the provider will be notified. |
| 6. | **Statutory Enquiry**
If a criminal investigation is likely the police will lead the Enquiry, however the local authority retains the overarching responsibility for co-ordinating the Enquiry and deciding if the Section 42 duties have been met. To contribute to a Statutory Enquiry assessments may be conducted by the appropriate agencies, for example: the local authority social care services; health, contracts or regulators. These enquiries may run concurrently. It will be important to address the scope of alleged abuse and impact on all service users. Employers should be aware of their responsibilities under employment law but should avoid compromising a criminal investigation or a Statutory Enquiry. An emergency safeguarding support plan may need to be put into place for a) the adult and b) the service. |
| 7. | **Adult safeguarding review meeting(s) and/or establishment case conference**
Registered manager and other provider service managers may be invited to part of the meeting Feedback of the outcome of the Enquiry, risk reviewed and further action decided
Post abuse care plan agreed, involving service improvement planning where necessary
A separate meeting may also address needs of any person with care and support needs who have been responsible for the abuse |
| 8. | **Decision**
Decision taken regarding the outcome of the case, (have the desired outcomes of the adult been met) and its status (open/closed) and all relevant people advised of the outcome of the Enquiry when it has concluded |
| 9. | **Monitoring and review of service improvement plan by identified personnel** |
8. **Whistleblowing (Public Interest Disclosure Act 1998)**

Whistleblowing is the term given to a situation where a member of staff or a volunteer reports a concern about something that is happening in their workplace. This may be with regard to fraud, health and safety issues, abuse or the standard of care provided to an adult at risk or child. The wrong doing a whistle blower discloses must be in the public interest. A whistle blower is protected by law, they should not be treated unfairly or lose their job if they blow the whistle. See [Gov.uk Whistleblowing for employees](http://www.gov.uk).

a) The concern may be reported to the line manager within the organisation or it may be reported to a more senior manager or to an external body.
b) Some organisations have a whistleblowing procedure with a designated officer to deal with workplace concerns
c) It can be very difficult for a person who acts as a whistleblower with respect to their relationships with other members of staff and their employers. They may be very fearful for their future employment prospects.
d) A member of staff may report concerns about abuse or suspected abuse of an adult directly to the duty officer at the office of social services nearest to the home of the adult.
e) The person ‘blowing the whistle’ may be reluctant to give their name or they may ask that they remain anonymous. Their wishes will be recorded and respected as part of the referral process. Whilst respecting their right to confidentiality, they cannot however be given an absolute undertaking that they will not be identified at a later date, especially if any legal action is indicated.
f) In the case of a crime being reported, the referrer will be informed that the matter will be reported to the police.
g) If the person ‘blowing the whistle’ chooses to go through an intermediary, that person has a duty to report the abuse of an adult at risk to the duty officer of the local authority, or to the police if they consider that a criminal offence may have been committed.

The **Whistleblowing Helpline** **08000 724 725** offers free advice for the NHS and Social Care.

Click [here](http://www.gov.uk) for the publication ‘raising concerns at work: Whistleblowing Guidance for Workers and Employers in Health and Social Care.

Key sections in the guidance include:

• The importance of whistleblowing as an early warning system of problems, which research shows is often ignored
• An outline of the legislation – the Public Interest Disclosure Act 1998
• A flowchart of the whistleblowing process (on page 14)
• Top tips for workers who wish to raise concerns, and sources of advice and support for them
• Top tips for operational managers to respond positively when staff raise concerns
• At corporate level, the Guidance sets national standards for whistleblowing policies for employers, together with a summary of their responsibilities
• Case studies of good practice, Frequently Asked Questions, and further information and links

There is also a helpful website called public concern at work: [http://www.pcau.org.uk/](http://www.pcau.org.uk/).
9. Concerns for d/Deaf and Deafblind people

9.1 Introduction

The aim of this guidance is to ensure that all agencies and their staff understand how to obtain appropriate expertise and communication support services for d/Deaf and Deafblind adults, when concerns about abuse are raised.

People who consider themselves members of a cultural and linguistic minority group and who use British Sign Language (BSL) as their first and preferred language are usually described as Deaf (with a capital D). All other deaf people (i.e. people who are hard of hearing. Partially deaf or deafened) are usually described as deaf (with a small d). Therefore the term d/Deaf is used to describe both/all types of deafness and all communication methods.

Deafblindness is a combination of sight and hearing loss that affects a person’s ability to: communicate; access all kinds of information and get around. Deafblindness is not just a deaf person who cannot see, or a blind person who cannot hear, as the two impairments together increase the effect of each other.

If the d/Deaf or Deafblind adult is involved in a safeguarding concern, the support of Sensory Services must be requested.

In KCC if the adult has a social worker/ care manager then a referral can be made directly to them. Sensory Services will allocate a DSO, decide on advocacy and manage the case if the primary support need is related to Deaf or deafblind. However if the primary support need is not Deaf or deafblind, Sensory Services will co-work alongside the appropriate Adult Social Care Team.

In Medway a referral should be made to the Deaf services Team, the team will co-work alongside the Adult Social Care Team offering specialist advice and expertise and assessment.

This will clarify the type of communication support required and who should provide it and may include the use of Deaf Relay Interpreters where necessary.

The lead team are responsible for arranging appropriate interpreters for statutory and non-statutory enquiries, through accessing the “Sign Language Interpreting for Deaf and Deafblind People” contract that is managed by Sensory Services. Sensory Services staff should not be asked to act as interpreters.

Prior to any formal interview with a d/Deaf or Deafblind person, there will be a need to clarify the roles of the respective practitioners/carers and Sensory Services staff will ensure that the communication needs of the d/Deaf and Deafblind user(s) are appropriately addressed.

9.2 Relay Interpreters

The term Relay Interpreting is used when more than one interpreter is needed to assist communication. This is used when Deaf or Deafblind person does not understand the literal interpretation (by a BSL interpreter) or the interpreter has difficulty understanding the voice or the signing of the Deaf or Deafblind person. A second (usually Deaf)
interpreter will further modify the conversation to suit the understanding of the Deaf or Deafblind person.

When Relay Interpreting is used, the duration of the meeting/appointment will be significantly increased and it is possible that some information may be lost. Both the interpreter and the other professionals have to be alert and sensitive to help the relay person rephrase questions using simple, more common concepts if the adult user does not seem to understand.

9.3 Criminal enquiries

Kent Police have direct access to communication support provision (including sign language) via the “Sign Language Interpreting for Deaf and Deafblind People” contract that is managed by KCC. Special provision is made in the contract to make certain that appropriately qualified and vetted interpreters/communication professionals are available, which may include specialist Deaf Intermediaries. When arranging communication support Kent Police the d/Deaf or Deafblind person’s preferred communication method is considered and their cognitive ability. When language needs to be further modified to suit a Deaf adult’s understanding, sometimes a Deaf Relay Interpreter may also be required (possibly alongside a BSL interpreter). Police are responsible for arranging and paying for appropriate interpreters and if additional interpreters are required for court proceedings and/or for defence purposes the responsibility for obtaining and paying for these interpreters’ lies with the court or the defence respectively.

An Early Special Measures meeting between the Police and the CPS may be required to ensure that appropriate steps are taken to maximise the adult ability to provide evidence.

9.4 Types of communication support for d/Deaf and Deafblind people

The following types of communication support can be arranged for assisting d/Deaf and Deafblind adults:

a) British Sign Language (BSL)
b) Irish Sign Language (ISL)
c) Sign Supported English (SSE)
d) Deafblind Manual (visual-frame)
e) Deafblind Manual (hands-on)
f) Deaf Relay
g) Speech-to-text reporting (STTR)
h) Lip speaking
i) Note taking.

Contact details can be found in Appendix 1 and more information is available for KCC staff on KNet: http://knet/ourcouncil/Pages/Deaf-and-deaf-blind-interpreting.aspx

10. Safeguarding responsibilities and autistic spectrum conditions

The Autistic Spectrum Conditions Team (ASC) operates in Kent only. It has limited resources countywide and is able to provide Designated Senior Officer (DSO) role for ‘open’ cases to the team. The team’s current operational guidance states that the ASC Team’s workers would not take DSO responsibility for a case not previously known to the authority and such cases would go direct to Adults Team. The Team may however
assume or support the role of the Enquiries Officer, should a Statutory Section 42 Enquiry have to be made, and where the protective factors relate to an autistic condition. This would be agreed between the Area and the ASC Team Manager.

11. **Adults with Cognitive and Communication Difficulties (was 12)**

Good communication takes time, particularly when safeguarding enquiries involve an adult where there may be language difficulties, or some degree of cognitive impairment. In these circumstances, it is important that professionals are sensitive to the potentially coercive effects of pressurised decision-making, including discussion of concerns about harm or abuse that broach sensitive subjects:

The basic principle is that all individuals should be offered information and support in a manner appropriate to their understanding and needs:

a) adults should be supported to explore choices about their safety and wellbeing. This includes adults who may lack capacity, have cognitive and communication difficulties however assessed have some ability to participate in decision-making.

b) be honest and sensitive. Thought should be given to timing of discussions and to the use of communication aids where appropriate

c) consider the use of pictures, or, where English is not a first language, translators.

d) consideration should also be given to the use of fact sheets and other written communication supports.

e) adults should be encouraged to participate as far as possible in any safeguard decision-making involving them.

f) the adult may want those close to them to be involved in communication and decision-making if appropriate.

g) professionals must avoid the use of communication styles that inadvertently imply that the adult lacks autonomy, dignity or competence.

h) good practice is about more than conveying information; it is also about establishing positive safeguarding professional relationships during planned interviews including any therapeutic and support services.

i) time should be taken to identify the adult’s underlying values and beliefs that may have a bearing on decisions that need to be made during the safeguarding enquiry process.

j) where the criteria in the Mental Capacity Act are not met, consideration should be given to involving an advocate, such as an Independent Mental Capacity Advocate (IMCA) who can promote the best interests of the adult, they can also help facilitate good communication.

12. **Mental Capacity and Safeguarding Adult Consent**

In every situation it will be assumed that an adult can make their own decisions unless it is proved that they are unable to do so. There will be a presumption against lack of capacity.

When Safeguarding Adults procedures are being considered, the consent of the adult believed to be at risk should always be sought. Consent should be obtained as early as possible and if appropriate by the alerting local authority or agency so that the concerns can be progressed to ensure the safety of the adult at risk.
This does not necessarily mean that the word ‘Safeguarding’ has to be used but the issue should be discussed with the adult using appropriate terminology such as ‘in order to make sure you are safe, we wish to share information with other people and possibly hold a meeting to discuss our concerns’ or similar words. A signature is not necessarily required, but the person’s consent should be clearly recorded in the case file.

Ensuring that an Informed Decision is made although undue pressure should not be exerted on the adult at risk to change their mind:

a. The issue should be discussed fully and the adult should be given all the relevant information available in order to make an informed decision, including who will be involved and the various possible outcomes which might result from their decision.

b. They should be reassured that their case would be dealt with sensitively and professionally under Safeguarding procedures and any specific concerns that they raise should be addressed.

Exceptions
There are four potential exceptions to the consent general rule:

1. If other people appear to be at risk of harm (adults or children)
2. If there is a ‘legal restriction’ or an overriding public interest
3. If the adult is exposed to life threatening risk and they are unreasonably withholding their consent
4. If the adult has impaired capacity or decision making in relation to the safeguarding issues and the withholding of consent.

A ‘legal restriction’ in this context means that there may be exceptional circumstances where a service user makes a decision or intends to act in a way that is unlawful or where their care needs to be addressed under the Mental Health Act 1983.

An ‘overriding public interest’ refers to a situation where it is essential to share information in order to prevent a crime or to protect others from harm (e.g., ‘Hate Crime’—a statutory responsibility to report). This is supported by the Crime and Disorder Act 1998.

12.1 Withheld consent

In all cases where an adult at risk is withholding consent and there are concerns about their welfare, a senior manager’s opinion should be sought on the best way to proceed. This may include taking legal advice where consent has been withheld.

12.2 People Who Lack Mental Capacity

If the adult at risk appears to lack mental capacity or to have impaired mental capacity in relation to the issue of consent, the local authority must assess the person’s mental capacity using the 2 stage test as defined in the Mental Capacity Act 2005.

12.3 Best Interests Decisions

If the person is assessed as lacking mental capacity, then the decision as to whether to invoke the Safeguarding procedures must be made by the local authority in the adult’s Best Interests in terms of the Mental Capacity Act 2005. Please note that the reasons for making this decision should be fully documented.

In the event that another person has legal decision making powers in relation to welfare decisions (i.e., under a Lasting Power of Attorney or has been given the status of Welfare Deputy by the Court of Protection), then they will normally be the person to make the Best Interests decision. However, if there are concerns that the person with such powers may be involved in the suspected abuse, legal advice should be sought at an early stage.
12.4 People with Mental Capacity

If the adult at risk is considered to have mental capacity in relation to a decision about giving or withholding consent, he/she has the right to withhold consent to the use of Safeguarding Adults procedures – except in very specific circumstances as outlined Exceptions above.

12.5 Mitigating Risk

Where abuse is suspected and although the adult has been given all the information and reassurances, the adult at risk has withheld their consent to the implementation of Safeguarding Adults procedures, all other alternatives for minimising risk should be considered in discussion with the adult at risk (eg changes to the care package, additional monitoring etc).

12.6 Consent Withdrawn at a Later Stage

It is important to note that initial consent can be withdrawn at any time and that the adult at risk should be made aware of this. In the event that consent is given initially but later withdrawn, exactly the same guidance applied as described earlier in this section.

12.7 Recording

It is essential that all discussions involving consent to the use of Safeguarding Adults Procedures and all decisions are clearly recorded in the case file. The person concerned should be kept up to date about the process and any decisions to be taken as a result of it. Where the adult at risk indicates that they have concerns as the procedure progresses, these should be recorded along with the outcome of a further discussion to confirm that the adult continues to consent to the process.

12.8 The principle of best interests, lawful accountability and duty of care

The Mental Capacity Act 2005 Code of Practice gives guidance to people who:

- work with people who can’t make decisions for themselves
- care for people who can’t make decisions for themselves

It explains what you must do when you act or make decisions on behalf of people who can’t act or make those decisions for themselves.

12.9 Consent to medical examination in the context of a possible criminal offence

A medical examination may be considered for two reasons:
a) medical treatment may be required
b) the examination may provide evidence that could be used in a prosecution

When urgent medical attention is required following a physical or sexual assault this will normally take priority over any other actions. If the adult is considered to have mental capacity, their consent should be obtained before a medical examination for forensic purposes is carried out. If there is any possibility that forensic evidence could be established, the adult’s permission should be sought regarding police involvement. If it is considered that the adult does not have mental capacity at the time, a decision must be made which reflects the best interests of the person and the wider public.
12.9.1 Practice matters

a) Where a medical examination is indicated the issues should be explained in a way that gives the adult the best opportunity for understanding it.

b) Communication issues must be considered where English is not the adult's first language or where physical or sensory impairment or learning disabilities make communication difficult.

c) If there are concerns about the mental capacity of an adult or an alleged perpetrator, and there are safeguarding concerns, and the person may struggle with being subject of this enquiry then a suitable advocate should be appointed and an assessment of mental capacity should be carried out as part of a safeguarding enquiry.

d) Unless there is evidence of a recent mental capacity assessment a referral should be made to the appropriate professional. The assessment can then be used to inform the post abuse safeguarding or service improvement plan.

e) If police need to carry out an interview with an adult at risk or a vulnerable witness, then the process should be managed under Achieving Best Evidence principles.

f) It will be necessary to ensure that the adult is offered an independent advocate if they may struggle with managing being subject of a safeguarding enquiry. They may also need legal and or financial advice.

g) Where it is established that an adult has mental capacity to make informed decisions and they choose to place themselves at further risk of abuse, they should be made aware of the possible outcomes of their decision.

h) They should be offered a range of options that they may wish to pursue either now or in the future. They should always be left with information, advice and guidance that would allow them to access help and advice in the future.

13. Managing Allegations Against Staff

a) Organisations providing health and/or social care services to adults at risk must have their own staff disciplinary procedures.

b) If a manager in such an organisation is aware that a member of staff is abusing or suspected of abusing an adult, they should use their internal staff disciplinary procedures to mitigate against further risk.

c) If it appears that a criminal offence has been committed then the police must be informed as a matter of urgency.

d) The employer must report their adult safeguarding concerns to the local authority and advise what actions they have taken to protect adults or children from the risk of abuse.

e) If it appears that a safeguarding enquiry is necessary then police or the local authority should co-ordinate the response.

f) The employer should ensure that they comply with employment legislation at all times.

g) The employer may await the outcome of any external investigation/enquiry before taking any disciplinary action. They may also however carry out their own internal inquiry into the issues raised provided this does not interfere with any criminal investigation.

h) Managers of a service that is registered under the Health and Social Care Act 2008 must inform the appropriate office of the Regulatory Authority.
14. Working with the Police

14.1 Early Involvement

Police investigations should proceed as a part of a Section 42 Enquiry and their early involvement may have benefits such as:

a) ensuring any possible evidence is not lost or contaminated
b) assisting them to establish if a criminal act has been committed
c) in investigating and interviewing
d) in preventing duplication of interviews

A higher standard of proof is required in criminal proceedings i.e. where the test is ‘beyond reasonable doubt, compared to disciplinary, regulatory proceedings to statutory enquiries where outcomes are based on the ‘balance of probability and the most serious offences can often emerge from uncertain and unclear circumstances. Sometimes gathering reliable evidence can require swift unannounced action. Safeguarding options can increase in proportion to the availability of reliable evidence and information.

Inappropriately alerting dangerous carers can leave vulnerable people unprotected and at risk. Professionals have to consider seeking consent for certain actions and information sharing and should be aware of the Data Protection Act and crime prevention exemptions (Section 29 (1)). They also must consider the rights of individuals under the Human Rights Act such as the right to live free from torture and degradation. Professionals should have access to the multi-agency adult safeguarding policy, protocols and practitioner guidance for Kent and Medway.

14.2 Consent of the adult

Staff should obtain the consent of an individual before calling the police unless to do so would endanger any person, interfere with the effective investigation of crime or result in the interference with or loss or destruction of any evidence. Staff should consider this in the light of the seriousness of any situation and with regards to the capacity of the individual concerned.

14.3 Calling the police in an emergency

When dealing with an incident that involves the abuse of an adult at risk or a child, staff should call the police (dial 999) immediately if:

a) there is serious risk of significant harm occurring
b) there is likely to be evidence that needs to be preserved (in which case police will arrange this)
c) it is believed that a recent sexual or physical assault has taken place
d) someone has been injured as a result of an assault
e) an allegation is made regarding an incident of theft (call 101)
f) the alleged perpetrator needs to be removed or is thought to be near the premises and provides a risk
g) there is reason to believe that a crime is in progress

If you are unsure what to do, call the police who will decide if a crime has been committed and what intervention is appropriate.
14.4 Preserving evidence

When dealing with any allegation of abuse, due regard should be given as to whether the police should be involved and whether it is necessary to preserve evidence relating to the incident. The following should also be considered:

a) the wellbeing of the victim must be your first priority
b) to enable the police to investigate effectively it is crucial that evidence is preserved. If in doubt consult the police on the telephone prior to their arrival

c) what is done or not done, in the time prior to police arriving on the scene, may make all the difference to their investigation

d) when dealing with allegations of abuse or other irregularities, documentation should not be removed or altered in any way

14.5 Practical guidelines

The following points may help you preserve evidence:

a) The welfare and safety of the individual is the primary consideration. Where possible secure the area concerned until the police arrive. This is not always possible as the victim(s) may require treatment.

b) Where someone is injured it will be necessary to determine the extent of the injury, provide first aid and transfer the injured person to hospital. Staff should preserve as much of the area as possible without disturbing anything in it.

c) ensure that the victim and the alleged perpetrator do not come into contact with each other once the allegation has been made. This should prevent any cross contamination of evidence.

d) remember that the welfare of the alleged victim is paramount and you will not be held accountable if you inadvertently destroy or invalidate evidence.

b) do not wash anything or in any way remove blood, fibres etc.

h) preserve the clothing and footwear of the victim. Handle them as little as possible.

i) note in writing the state of the clothing of both the alleged victim and the the person alleged to be responsible for harm. Note injuries in writing. Make full written notes on the conditions and attitudes of the people involved in the incident. This should be done as soon as practicably possible.

j) note and preserve any obvious evidence such as footprints or fingerprints or any other evidence, which may have been left behind by the suspect.

k) preserve any CCTV footage if security cameras are present.

14.6 Cross contamination in sexual abuse

Whenever two objects meet there is an exchange of material from each to the other: in other words every contact leaves a trace. The following should be considered in cases of sexual abuse:

a) in serious cases, an examination of the victim by an appropriately trained forensic medical examiner will need to take place, if permission is granted

b) an examination of the person alleged to be responsible for the harm should also be carried out after arrest.

c) try not to have any person in physical contact with both the victim or the alleged perpetrator as cross-contamination can destroy evidence
d) preserve bedding where appropriate and any items that might contain evidence e.g. used condoms

e) in any instance where a victim is seriously injured and is taken to hospital, the police should ask for a sample of blood to be taken before any transfusion is given, as a transfusion will invalidate evidence in relation to blood

f) health care staff should endeavour to work in conjunction with the police at the scene and to co-operate with the investigating officer during the subsequent investigation.

g) if an allegation of sexual abuse is disclosed days after the alleged offence, it may still be possible to collect forensic evidence. Do not assume that it is too late. Let the police decide.

15. Trading Standards and Safeguarding of Adults

National Trading Standards is responsible for gathering important intelligence from around the country to combat rogue traders and tackle a number of priorities. These priorities currently include mass marketing and internet scams, illegal money lending and other enforcement issues that go beyond local authority boundaries.

Professionals should report a company to Trading Standards if they suspect an adult is at risk, for example:

- a. they misled an adult at risk into buying their products or services
- b. they sold an adult at risk unsafe or dangerous items
- c. they didn’t carry out the work properly, for example, their work left an adult at risk’s home in a dangerous state
- d. they sold an adult at risk fake or counterfeit items
- e. they pressured an adult at risk to buy something they report didn’t want to buy
- f. they sold an adult at risk a car that wasn’t ‘roadworthy’ (it would cause danger if it was on the road)

The adult at risk or the supporting professional can the use an online form or write to the consumer helpline – ensuring to mention that they are reporting a trader to Trading Standards.

Information on KCC Trading Standards is available here. Information on Medway Trading Standards is available here.

15.1 Rogue Traders

Rogue traders target residents at risk and carry out little or no work, charging exorbitant sums of money. They will usually offer roofing, driveway or gardening services at a reduced price, but work is often unnecessary or badly done and the trader later increases the price.

15.2 Distraction Burglars

Distraction burglars can be any of age and appearance, male or female. They aim to trick or worry person into leaving their house or into letting them in, by making up stories. They or an accomplice will then enter the property in order to either carry out the burglary or assess security measures within the property in order to return later.

15.3 Internet Scams
Some websites can look like they're part of an official government service or that they provide more help than they actually do. This can mean the person pay for services that they could get cheaper or for free if they used the official government service. Examples include:

a. ordering new passports
b. booking driving tests

Trading Standards advice:

a. Don't give out private information - such as bank details or passwords,
b. Reply to text messages, download attachments or click on any links in emails if not sure they're genuine

15.4 Loan Sharks

Loan Sharks are illegal moneylenders who often charge very high interest rates. They may use threats and violence to frighten people who can't pay back their loan. Illegal money lending is a criminal offence and often sees unlicensed lenders target vulnerable people. People may have been dealt with by a loan shark if they have ever:

a. been offered a cash loan without any paperwork
b. been threatened because they couldn't pay
c. had their bank card taken away from them, other than by the bank itself.

National Trading Standards has set up Illegal Money Lending Teams in England and Wales investigate and prosecute illegal money lenders. The teams are made up of specialist investigators and victim support officers from various backgrounds including trading standards, local authority safeguarding colleagues, policing and debt advice.

16. Financial abuse. The Role of Assessment, Commissioning and Inspection

16.1 Roles and responsibilities

Effective prevention and detection of financial abuse is the responsibility of all parts of the health and social system. All staff, whether they are assessors, commissioners, regulators or providers, has a part to play. Effective co-ordination and communication between each of these elements is essential to ensure that adults at risk are as well protected as possible.

16.2 Assessors

Adults with Care & Support Needs, as set out in the Care Act 2014 may, or may not, have mental capacity and their condition may be stable, improving or deteriorating. Depending on the person's capacity various options for managing a person's money or property exist. The assessor should ensure that responsibility for this function is addressed at the care planning stage.

The functions may be fulfilled by relatives, professionals, or statutory agencies and consideration of who should undertake this role should be part of the risk and wider assessment process. If an applicant for care has substantial financial assets, they or their representative should be advised to seek guidance from a professional advisor who is covered by the financial services authority. Where legal provisions are already in place the assessor must see and take a copy of evidence of Enduring/Lasting Power of Attorney/Deputyship/DWP Appointee during the assessment.

16.3 Giving Financial Advice
In discharging a duty in the Care Act about providing information and advice the Local Authority must ensure that information and advice is provided on:

a) how to access independent financial advice on matters relating to care and support
b) the extent of an adult’s responsibilities to pay for it
c) their rights to statutory financial and other support, locally and nationally

The Care Act Statutory Guidance\(^\text{13}\) clearly states that financial information and advice is fundamental to enabling people to make well-informed choices about how they pay for their care. This is deemed integral to the adult in their consideration of how they may be able to pay care costs, either now or in the future. In addition to the Local Authority making this information available, the duty must be delivered proportionately, but without regard to eligible need.

Actions should include:

d) working with adults, representatives and partners to communicate messages about the benefits of financial information and advice
e) considering an adult’s need for financial information and advice when they make first contact with the authority (and throughout assessment, care and support planning and review processes)
f) consideration of adult’s who become known through a referral (including self-referral)
g) consideration of adult’s who are currently in need of, or who are receiving care and support
h) adult’s whose care is being reviewed
i) family members with care and support needs (or likely to develop them)
j) identification of carers, with identified actions to reduce needs for support
k) adults who are subject to adult safeguarding concerns
l) or anyone who may benefit from financial information and advice on matters concerning care and support.

Local authorities must have regard to identifying these adults; to help them understand the financial costs of their care and to support and help them access independent financial information and advice including that from regulated financial advisers. Where this includes advice on welfare benefits it should be provided by specialist personnel.

### 16.4 Commissioners and contract officers

Commissioners should have regard to the need for appropriate services to be available to assist service users with the management of their money and other assets and of the need to prevent and protect service users from financial abuse. Service specifications should set appropriate high standards for the safe keeping and management of adult’s money and assets. For care homes and supported accommodation these should be at least in accordance with the Fundamental Standards for Quality and Safety issued under Care Standards Act 2000\(^\text{14}\). The contract monitoring process should measure performance against these standards and any additional standards within the service contract.

### 16.5 Regulators/inspectors (CQC)

National minimum standards for all client groups were issued under the Care Standards Act 2000. The Fundamental Standards were later issued. The standards provide requirements to enable service users to control their own money except where they do not


Adult Safeguarding Guidance

wish to or they lack capacity to do so. Providers are also required to protect service users from financial abuse.

16.6 Safeguarding and Accountability Standards / Controls of Service Users’ Finances within Residential and Nursing Homes and Supported Living Settings.

This section is to remind organisations to ensure that service users’ finances are safeguarded in residential and nursing homes and supported living services within the statutory and independent sectors.

16.6.1 Financial Safekeeping

Robust financial controls must be in place in all residential, nursing homes and supported living settings in both the statutory and independent sectors. This sets out the mandatory controls that must be in place within the statutory sector to ensure robust financial controls are in place and seeks assurances that similar controls (as appropriate) are in place within the Independent and Supported Living sector:

a) Within the Statutory sector, Financial Accountants must ensure that these controls are operating successfully, are in compliance with financial and Health & Social Care regulators and that they are reviewed on a regular basis.

b) Within the Independent and Supported Living sector, Financial Accountants must be able to demonstrate that they have taken reasonable steps to ensure that adequate financial controls are in place within Independent and Supported Living settings to ensure that the adult’ interests are protected.

c) Providers have a statutory duty of care to its service users’, regardless of the particular setting in which care is delivered, whilst it is accepted that Financial Accountants must ensure there is a proportionate level of oversight of service users' finances. There are a number of existing controls within Care providers to ensure that robust arrangements are in place for handling service users’ finances. These include entering into contractual arrangements with the independent care home/supported living service which provides recourse where the level of care is not as expected or where there are circumstances involving financial issues. This also includes liaison with service providers re: implementation of Internal Audit recommendations. It is further recognised that the care management review arrangements, together with the reporting procedures for complaints and untoward incidents reporting mechanisms provide additional control mechanisms for each provider. Notwithstanding this, it is important that providers can also demonstrate that they have taken appropriate steps to ensure that adequate financial controls are in place to safeguard service users’ interests.

17. Managing Confidential Information in Documents, Reports and Minutes of Meetings

The Data Protection Act 1998 (DPA) came into force in March 2000 and gives individuals a general right of access to the personal data that relates to them. The local authority 'data subject access request' procedures provides more details on what information can be disclosed and what is exempt from disclosure.

The DPA provides for sharing of information when required by other bodies as long as this is 'the minimum necessary to meet the requirements of the situation' and is necessary to enable the authority itself to discharge its statutory functions. Protection of adults at risk is one of those functions.
Any decisions made by the local authority to seek confidential information from another agency should be recorded on the alert/referral form and/or in the minutes of any planning meeting, as well as on any individual record held for the adult or the person suspected of the abuse or neglect. Consent to the disclosure of third party information should be obtained when the information is provided if at all possible. This will enable third party information provided in the course of safeguarding enquiries, at planning meetings or case conferences: to be marked ‘Open for access' or ‘not to be disclosed beyond the remit of the adult safeguarding process'. All confidential adult safeguarding information marked 'Not to be disclosed' will be placed with all other adult safeguarding information in the closed Section of the client's file.

Minutes to be circulated should be marked 'Highly Confidential' and care should be taken to ensure secure storage and appropriate access controls are in place. The file copy of the minutes will show the full names of all of the attendees and those who sent apologies together with the authorities/ agencies/services they represent. Only the file copy will include the full names of the victims, vulnerable witnesses and vulnerable person(s) alleged to be responsible for the abuse. When the minutes are circulated, the initials should be substituted for the full names of the victims, vulnerable witnesses and vulnerable adults deemed responsible.

The formal minutes of planning meetings and case conferences are a record of the issues, outcomes, decisions and recommendations. They should be marked 'Confidential' and be available only to those participating in or invited to the meetings. It is the responsibility of the Local Authority circulating the minutes to ensure that they are sent by securely.

The reports and information gathered to inform the meeting and the decision-making process should only be available to those professionals directly involved in the process. However, in certain circumstances it may be necessary to make the minutes of adult safeguarding meetings available to solicitors, the civil and criminal courts, psychiatrists, professional staff employed by other social services or other professionals involved in the welfare of the adult(s). Any such disclosure must be recorded.

If requested, a summary of outcomes and recommendations from the case conference should be made available to other parties on a 'Need to Know' basis and when it is in the 'Best Interest' of the adult(s). A statement of confidentiality together with the equal opportunities statement below should be placed at the top of the attendance list for meetings and on the first page of the minutes.

17.1 Statement of confidentiality

This meeting/conference is held under the multi-agency adult protection policy and protocols and Guidance for Kent and Medway. The matters raised are confidential to the members of the meeting/conference and the agencies that they represent and will only be shared in the best interests of the adult, and with their consent where it is appropriate to obtain it.

The minutes of adult safeguarding meetings are not a verbatim record of the discussions but they are a summary of the discussions and a record of the actions identified to be completed by whom and when. Minutes of the meeting/conference are distributed in the strict understanding that they will be kept confidential and in a secure place.

The information you have provided will be held and used by Kent / Medway authorities for the purpose of this adult safeguarding enquiry. This process may require us to share this
information with partner organisations and other local authorities or agencies to support
the protection of adults at risk or children.

In certain circumstances it may be necessary to make this information and/or the minutes
of this meeting available to solicitors, the civil and criminal courts, the Disclosure and
Barring Service in relation, psychiatrists, professional staff employed by other local
authorities or other professionals involved in the welfare of adult(s) at risk or children. Any
such disclosure must be recorded. Information may also be disclosed under strict controls

17.2 Equal opportunities statement

The Kent and Medway adult safeguarding policy and protocols recognise that certain
people are the subject of discrimination and disadvantage. Comments that contribute to
this discrimination are not acceptable and will be challenged by the chair and other
meeting/conference members.

18. Seriousness of the Abuse

18.1 Introduction

This Section is designed to assist in the assessment of the seriousness of the abuse, the
risk of it being repeated. Seriousness is broken down into 8 elements that should be
considered separately by marking a point on each scale where the left is less serious and
the right hand end is most serious.

The 8 elements are:

a) The extent of the abusive act(s)
b) Whether the abuse was a one off event or part of a longstanding relationship or
pattern
c) The impact of the abuse on the adult at risk
d) The impact of the abuse on other adults at risk or children
e) The intent of the person alleged responsible for the abuse
f) The illegality of the alleged adult deemed responsible’s action(s)
g) The risk of the abuse being repeated against this adult
h) The risk of the abuse being repeated against other adults at risk or children

18.2 Extent of the Abusive Act(s)

Try to consider the extent and scope of the abusive act(s). The following grid can be used
as a rough guide, but must not replace your own professional judgement.

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Lower Level Harm</th>
<th>Significant Harm</th>
<th>Very significant Harm</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Could be addressed via agency internal process/procedures e.g. disciplinary, care management or consider referral to safeguarding to be made. It is not always the case that concerns falling into this section would be dealt with internally. If you are unsure, please contact 03000 335674 (Kent) or 01634 334466 (Medway) for advice.</td>
<td>Addressed under Safeguarding Procedures - referral to safeguarding to be made. If potential criminal matter - contact Police/Emergency Services - could be addressed as MAPPA, MARAC, Hate Crime.</td>
<td>Addressed as potential criminal matter - contact Police/Emergency Services - could be addressed as MAPPA, MARAC, Hate Crime.</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>Medication</td>
<td>Sexual</td>
<td>Psychological</td>
<td>Financial</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>• Staff error causing no/little harm, e.g. skin friction mark due to ill-fitting hoist sling</td>
<td>• Adult does not receive prescribed medication (missed/wrong dose on one occasion — no harm occurs)</td>
<td>• Isolated incident of teasing or low-level unwanted sexualised attention (verbal or by gestures) directed at one adult by another whether or not capacity exists</td>
<td>• Isolated incident where adult is spoken to in a rude or inappropriate way — respect is undermined but no or little distress caused</td>
<td>• Money is not recorded safely or recorded properly</td>
</tr>
<tr>
<td>• Minor events that still meet criteria for ‘incident reporting’</td>
<td>• Recurring missed medication or administration errors that cause no harm</td>
<td>• Verbal sexualised teasing or harassment</td>
<td>• Occasional taunts or verbal outbursts which cause distress</td>
<td>• Adult not routinely involved in decisions about how their money is spent or kept safe - capacity in this respect is not properly considered</td>
</tr>
<tr>
<td>• Isolated incident involving service user on service user</td>
<td>• Recurring missed medication or administration errors that affect more than one adult and/or result in harm</td>
<td>• Sexualised touch or masturbation without valid consent</td>
<td>• The withholding of information to disempower</td>
<td>• Adult’s monies kept in a joint bank account – unclear arrangements for equitable sharing of interest</td>
</tr>
<tr>
<td>• Inexplicable marking or lesions, cuts or grip marks on a number of occasions</td>
<td>• Deliberate maladministration of medications</td>
<td>• Being subject to indecent exposure</td>
<td>• Treatment that undermines dignity and damages esteem</td>
<td>• Adult denied access to his/her own funds or possessions</td>
</tr>
<tr>
<td>• Inappropriate restraint</td>
<td>• Covert administration without proper medical authorisation</td>
<td>• Contact or non-contact sexualised behaviour which causes distress to the person at risk</td>
<td>• Denying or failing to recognise an adult’s choice or opinion</td>
<td>• Misseuse/ misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards</td>
</tr>
<tr>
<td>• Withholding of food, drinks or aids to independence</td>
<td>• Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death</td>
<td>• Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent</td>
<td>• Frequent and frightening verbal outbursts</td>
<td>• Personal finances removed from adult’s control</td>
</tr>
<tr>
<td>• Inexplicable fractures/injuries</td>
<td>• Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user</td>
<td>• Being made to look at pornographic material against will/where valid consent cannot be given</td>
<td>• Radicalisation (Prevent/counter-terrorism concern)</td>
<td>• Fraud/exploitation relating to benefits, income, property or will</td>
</tr>
<tr>
<td>• Assault</td>
<td></td>
<td>• Sex without valid consent (rape)</td>
<td></td>
<td>• Theft</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Voyeurism</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Neglect** | • Isolated missed home care visit - no harm occurs  
• Adult is not assisted with a meal/drink on one occasion and no harm occurs  
• Inadequacies in care provision leading to discomfort - no significant harm e.g. occasionally left wet.  
• No access to aids for independence  
• Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs  
• Hospital discharge, no adequate planning and harm occurs  
• Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence  
• Failure to arrange access to life saving services or medical care  
• Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk |
| **Discriminatory/ Hate Crime** | • Isolated incident of teasing motivated by prejudicial attitudes towards an adult’s individual differences  
• Isolated incident of care planning that fails to address an adult’s specific diversity associated needs for a short period  
• Recurring taunts  
• Inequitable access to service provision as a result of diversity issue  
• Recurring failure to meet specific care/support needs associated with diversity  
• Being refused access to essential services  
• Denial of civil liberties e.g. voting, making a complaint  
• Humiliation or threats on a regular basis  
• Hate crime resulting in injury/emergency medical treatment/fear for life  
• Hate crime resulting in serious injury/attempted murder/honour-based violence |
| **Institutional (any one or combination of the other forms of abuse)** | • Lack of stimulation/opportunities to engage in social and leisure activities  
• Not enabled to be involved in the running of service  
• Denial of individuality and opportunities to make informed choices and take responsible risk  
• Care-planning documentation not person-centred  
• Rigid/inflexible routines  
• Service users’ dignity is undermined e.g. lack of privacy during support with intimate care needs,  
• Bad practice not being reported and going unchecked  
• Unsafe and unhygienic living environments  
• Staff misusing position of power over service users  
• Over-medication and/or inappropriate restraint managing behaviour  
• Widespread, consistent ill treatment |
| **Professional** | • Service design where groups of service users living together are incompatible  
• Poor, ill informed or outmoded care practice no significant harm  
• Denying adult at risk access to professional support and services such as advocacy  
• Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted  
• Failure to refer disclosure of abuse  
• Failure to support vulnerable adult to access health, care, treatments  
• Punitive responses to challenging behaviours  
• Entering into a sexual relationship with a patient/client, |

### 18.3 Guide to Seriousness

With your case in mind, ring all the aspects of seriousness. Anything towards the right of the guide represent very serious issues which must be taken into account in decision making and risk management. This guide can be used to share thinking with your supervisor and in meetings e.g. planning meetings or a case conference.
## Adult Safeguarding Guidance

### Factors

<table>
<thead>
<tr>
<th>1. Vulnerability of adult at risk</th>
<th>Less vulnerable</th>
<th>More vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the adult have needs for care and support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Can the adult protect themselves?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the adult have the communication skills to raise an alert?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does the person lack mental capacity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the person dependent on the alleged perpetrator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has the alleged victim been threatened or coerced into making decisions?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The abusive act

<table>
<thead>
<tr>
<th>The abusive act</th>
<th>Less serious</th>
<th>More serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions 2-9 relate to the abusive act and/or the alleged perpetrator. Less serious concerns are likely to be dealt with at initial inquiry stage only, whilst the more serious concerns will progress to further stages in the safeguarding adults process.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Guidance and considerations

<table>
<thead>
<tr>
<th>2. Seriousness of abuse</th>
<th>Low</th>
<th>Significant</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to the table in 18.2. Look at the relevant categories of abuse and use your knowledge of the case and your own professional judgement to gauge the seriousness of the concern.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Patterns of abuse</th>
<th>Isolated incident</th>
<th>Recent abuse in an ongoing relationship</th>
<th>Repeated abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most local areas have an escalation policy in place, e.g. where safeguarding adult’s procedures will continue if there have been a repeated number of concerns in a specific time period. Please refer to local guidance.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Impact of abuse on victims</th>
<th>No impact</th>
<th>Some impact but not long-lasting</th>
<th>Serious long-lasting impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of abuse does not necessarily correspond to the extent of the abuse – different people will be affected in different ways. Views of the adult at risk will be important in determining the impact of the abuse.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Impact on others</th>
<th>No one else affected</th>
<th>Others indirectly affected</th>
<th>Others directly affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other people may be affected by the abuse of another adult.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are children, relatives or other residents/service users affected or distressed by the abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are other people intimidated and/or their environment affected?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Intent of alleged perpetrator</th>
<th>Unintended / ill-informed</th>
<th>Opportunistic</th>
<th>Deliberate/ Targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the act/omission a violent-serious unprofessional response to difficulties in caring?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the act/omission planned and deliberately malicious?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the act a breach of a professional code of conduct?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>the act/omission doesn’t have to be intentional to meet safeguarding criteria</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Illegality of actions</th>
<th>Bad practice – not illegal</th>
<th>Criminal act</th>
<th>Serious criminal act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek advice from the Police if you are unsure if a crime has been committed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is the act/omission poor practice (but not...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. **Risk of repeated abuse on victim**

<table>
<thead>
<tr>
<th>Unlikely to recur</th>
<th>Possible to recur</th>
<th>Likely to recur</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Is the abuse less likely to recur with significant changes (e.g. training, supervision, respite, support) or very likely even if changes are made / more support is provided?</td>
</tr>
</tbody>
</table>

9. **Risk of repeated abuse on others**

<table>
<thead>
<tr>
<th>Others not at risk</th>
<th>Possibly at risk</th>
<th>Others at risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are other adults and/or children at risk of being abused?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Very unlikely?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Less likely if significant changes are made?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. This perpetrator/setting represents a threat to other vulnerable adults or children.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


19.1 **Disclosure and Barring Service Referral Guidance**

DBS caseworkers make decisions about who should be placed in the child barred list and/or adults barred list and are prevented by law from working with children or vulnerable groups.

Referrals should be made to DBS when an employer or organisation believes a person has caused harm or poses a future risk of harm to vulnerable groups, including children. Employers must refer someone to DBS if they:

- sacked them because they harmed someone
- sacked them or removed them from working in regulated activity because they might have harmed someone
- were planning to sack them for either of these reasons, but they resigned or retired first

An employer or volunteer manager is breaking the law if they knowingly employ someone in a regulated activity with a group from which they are barred from working.

A barred person is breaking the law if they seek, offer or engage in regulated activity with a group from which they are barred from working.

**Contact the barring helpline for help referring someone to DBS.**

DBS barring helpline
Telephone: 01325 953795

For a quick guide see: [DBS barred lists](https://www.gov.uk/government/collections/dbs-referrals-guidance--2)
20. DSO Responsibilities and good practice guidelines for organising and managing adult safeguarding meetings/case conferences

20.1 Before Meeting

a) Give the admin officer as much notice as possible of all adult safeguarding meetings.
b) Ensure that there is an appropriately trained and skilled minute taker for the meeting.
c) Provide options for dates and venues.
d) Ensure that the admin officer arranging the meeting is informed about the nature of the meeting. Is it a planning or review planning meeting, a case conference an establishment meeting or a post abuse review meeting? How urgent is it?
e) Give the admin officer a full list of the people to invite and what agencies they represent. e.g. commissioners, health, police, CQC, provider, advocate. Clarify who is essential to enable the meeting to take place.
f) If different people are to be present during separate Sections of the meeting ensure that sufficient time is allowed for discussions, to avoid attendees being kept waiting.
g) Make appropriate accommodation and refreshment arrangements for people who are not attending the whole meeting. Ensure suitable arrangements are in place to alert the Chair of the meeting to the arrival of additional participants. Be clear who will organise refreshments. Don't assume that the minute taker will do this.
h) Ensure that the minute taker is prepared for the meeting by providing details of the nature of the alleged abuse and any matters likely to be discussed.
i) The minute taker should be advised if there are any whistleblowers who wish to remain anonymous. Their names should be anonymised for the purposes of the meeting/minutes. (If any criminal or civil proceedings follow, the whistleblower(s) will be identified to the courts or other civil proceedings).
j) Prepare an agenda for the meeting to enable the minute taker to understand how the meeting will be structured) see the Aide-Memoire in the Safeguarding Checklists for Practitioners in Kent – Section 3 which may assist with setting the agenda.
k) Consider the minute taker in arrangements particularly in relation to travelling time and transport arrangements. If the meeting is away from the minute takers normal base ensure that transport arrangements have been made.
l) Ensure that all appropriate paperwork and any reports are passed to the admin officer. This will ensure that the safeguarding concern is on the system and any papers needed for the meeting are copied and passed to the minute taker.
m) Make sure that the minute taker is aware of any papers that need to be distributed during the meeting, read out at the meeting or subsequently summarised and distributed with the minutes.
n) Ensure that appropriate support has been provided to an adult (s) and his or her representative (s) prior to the meeting.

20.2 During meeting

a) Ensure that the minute taker sits next to you, that they have adequate space and a suitable chair and writing area.
b) Make sure that the attendance sheet with the confidentiality and equal opportunities statements is circulated before the main business of the meeting is discussed. The two statements must be read out at the start of the meeting.
c) Ensure that the minute taker is introduced as part of the meeting and that they are aware of the names of all those present and, where relevant, the organisations they represent.
d) Consider the pace of the meeting, make sure that only one person speaks at a time, try to keep to the agreed agenda and summarise at regular intervals.
e) Make it clear that the minute taker can ask for clarification at any time during the meeting.
f) Clarify any particular points you want minuted.
g) If the meeting is lengthy or very difficult arrange for a short break if possible. This is important for the minute taker and essential if vulnerable adult(s) are present.

h) You should summarise the agreed actions at the end of the meeting. Agree with the attendees if necessary to send out a copy of these as a priority.

i) Check with the minute taker that any issues that need clarifying by attendees are addressed before the meeting closes.

20.3 Post meeting

a) Thank and debrief the minute taker immediately following the meeting. Discuss the format for the minutes and check if any clarification is needed, particularly in relation to any urgent action points that need to be circulated.

b) If the minute taker is distressed about any issues discussed during the meeting ensure that they receive appropriate support.

c) Make sure the minute taker is aware who should have the minutes or part of the minutes, and any reports.

d) Where possible allow the minute taker allocated time away from normal duties to write up the draft minutes. If you are not the line manager for the minute taker liaise with the line manager to agree some protected time away from normal duties.

e) When you receive the draft minutes, ensure that they are checked, amended and returned to the minute taker as soon as possible preferably within 5 working days.

f) It is your responsibility to agree the final version of the minutes which will be placed in the client’s file. Please note that the names of the victims, vulnerable witnesses and perpetrators must be replaced with initials only for all copies circulated.

g) The distribution of minutes should be in line with Guidance Section Managing Confidential Information in documents, reports and minutes.

h) The action points from the meeting should be distributed within 2 working days of the meeting and the agreed minutes should be circulated within 10 working days unless exceptional circumstances make this impossible.

i) Any matters arising from the minutes should be dealt with by you and not the minute taker.

j) If future meetings related to this case are required, it may be helpful for the same minute taker to be available as they will be aware of the issues and many of the people involved in the case.
21. Administrator's/minute taker's responsibilities and good practice guidelines for organising and managing adult safeguarding meetings/case conferences

21.1 Before Meeting

a) If you are asked to arrange an Adult Safeguarding (AS) meeting or take minutes you should have an understanding of the adult safeguarding process. If possible you should have attended Adult Safeguarding Awareness training.

b) You should have had an opportunity to attend minute takers training, when available. This training should be specifically designed for adult safeguarding cases.

c) If you have never minuted an AS meeting before discuss an induction with your line manager. This may include attending an AS meeting as an observer, and then attending another in a super numary capacity to practise minute taking.

d) When asked to arrange any meeting related to adult safeguarding make sure that you are aware of the type of meeting to be arranged and how urgent it is. It may be an initial or review planning meeting, case conference, establishment case conference or a post case monitoring and review meeting.

e) Compile a list, in liaison with the DSO, of those who are essential to enable the meeting to go ahead and those who should be invited but who are not vital. Check availability by phone prior to sending out invitations. The invitation must clearly state the nature of the safeguarding meeting and if any information if required to be brought to the meeting by any representatives this must be clarified in the invitation to attend.

f) Discuss the agenda and structure of the meeting with the Chair of the meeting or the DSO.

g) Send out invitations by e-mail or letter. Adults and or their representatives should be sent a personalised invitation rather than the formal invitation.

h) Ensure that a room has been booked at a suitable venue. Is disabled access, loop system or a translator required?

i) If you have been asked to take the minutes of an adult safeguarding meeting that is not at your normal work place, discuss travel arrangements to and from the venue with your line manager or the chair of the meeting.

j) Familiarise yourself with the case and discuss with your line manager/ the chair of the meeting the main issues that are likely to arise.

k) Prepare an attendance sheet with the confidentiality and equal opportunities statements at the top. List those people who have been invited and where appropriate the organisations they represent. If the meeting is divided with different participants attending separate parts of the meeting ensure that the attendance sheet(s) reflects this.

l) Prepare a list of apologies and collate any reports, give to the chair of the meeting before the start of the meeting. Familiarise yourself with the contents of any reports as these will assist in compiling the minutes. If the reports are not circulated their contents may assist you to summarise the main issues.

m) Advise reception staff of the meeting and the names of those attending and check that there are suitable waiting areas. Also advise if security assistance may be needed.

n) Provide paper and pens for participants.

o) Consider providing name labels on the table to assist with communication and minute taking.

p) Once the meeting begins, you should not be asked to leave the meeting unless a formal break is agreed or the meeting is closed.

q) When arriving in the meeting room, ensure that a space is available for you to sit next to the chair of the meeting. Discuss with the chair how you will gain their attention if necessary to clarify points or catch up.
21.2 During meeting

a) Sit next to the chair of the meeting.
b) Don't be afraid to ask for clarification during the meeting.
c) Ensure that everyone signs the attendance sheet on arrival.
d) If name labels are being used make sure that you can see them. Otherwise familiarise yourself with the attendees and the organisations they represent.
e) The formal minutes which will be placed in the clients file should be written in the past tense and all names should be typed in full.
f) The names of whistle blowers who wish to remain anonymous at this stage should be anonymised. This should have been part of the pre-meeting briefing.
g) If any reports are tabled during the meeting ensure that you have a copy.
h) It is important that the minutes accurately reflect the facts, concerns, risks, recommendations and action points. The discussions and decisions taken may lead to legal proceedings.
i) Unless you take shorthand or the meeting is being tape-recorded it will not be possible for the minutes to reflect everything that is said. If you have been well briefed about the case before the meeting you will be aware of the important points.
j) Listen carefully and record essential/factual information.
k) Separate facts from opinion.
l) Write down key words; don't try to write down everything being said.
m) Rely on the chair to advise you if an essential point needs to be noted.

21.3 Post meeting

a) Try to have a short de-brief with the chairperson immediately after the meeting.
b) Ensure that no papers related to the meeting are left in the meeting room.
c) Aim to produce a record of the action points which need to be agreed with the chairperson and then circulated to the attendees within 2 working days of the meeting.
d) Aim to produce a full draft of the minutes as soon as possible after the meeting and pass them to the chairperson for approval. If the Chairperson is not your line manager, agree with your line manager a timescale that reflects the urgency and priority that should be awarded to the task.
e) If you are distressed by the content of the discussions during the meeting talk through the issues with the Chair of the meeting or arrange to meet with your line manager to discuss the issues in confidence.
f) The responsibility for the content of the minutes rests with the chair of the meeting and they rely on you to produce the draft and the final version of the minutes as soon as possible after the meeting has concluded. The file copy of the minutes must contain the full names of all professionals and vulnerable people involved.
g) The copies of the minutes to be circulated should be adjusted to show only the initials of the victims, vulnerable witnesses and vulnerable perpetrators.
h) Ensure that you know exactly who should have the minutes or part of the minutes and any additional papers that may have been agreed.
i) The agreed safeguarding adult minutes should be sent out within 10 working days of the meeting unless exceptional circumstances make this impossible. They should be sent either by secure e-mail or fax, or by recorded delivery.
j) If another meeting has been discussed ensure that an appropriate meeting room is booked.
22. Framework for Responding to Adult Safeguarding Concerns

22.1 Introduction

The following can be used to determine the most appropriate level of response to an adult safeguarding concern. When utilising this tool, a worker should be mindful that as additional information becomes available, the safeguarding response level should be reviewed as risk levels change.

22.2 Response Diagram – Levels of Response:

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>PRESENTING INFORMATION</th>
<th>ACTION &amp; OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 – Service provider enquiry</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Concern reported to LA by provider  
• Alert form completed  
• Discussion with DSO  
• Discussion with Adult at risk or representative  
• Adult's expressed outcomes recorded.  
• MSP is a priority  
• Decision by DSO if S42 criteria met  
• Consideration of independent advocate / IMCA appointment.  
• DSO decides/agrees if provider can carry out enquiries, sends SP enquiry form with terms of reference to include time frame.  
• Service provider produces enquiry report to DSO in time frame  
• DSO can challenged report if insufficient to enable s42 duty to be satisfied  
• Monitoring format agreed |
| • 'one-off', isolated incident that has not adversely affected the physical, psychological or emotional well-being of the vulnerable adult  
• no previous history of similar incidents recorded for the vulnerable adult  
• no previous history of similar incidents recorded for the service provider  
• no previous history of abuse by the person alleged to be responsible  
• not part of an apparent pattern of abuse  
• no clear criminal offence described in referral  
• there is not a clear intent to harm or exploit the vulnerable person |
| • Service provider must recognise and record concern under their AP procedures  
• Action taken by Service Provider to address 'presenting concerns' AND report outcomes to care manager/social worker  
• May lead to minor alterations in the way service is provided to a vulnerable adult and/or alterations to the way staff or other resources are deployed in the delivery of health and social care  
• No on-going risk to the vulnerable adult or other vulnerable people |
| **Level 2 – Social Care Enquiry** |
| • Concern reported to LA, alert form completed  
• Discussion with DSO/ Senior manager  
• Discussion with Adult at risk or representative  
• Adult's expressed outcomes recorded and MSP is priority  
• Consideration of advocate appointment  
• Decision by DSO re S.42 eligibility  
• DSO allocates to IO to review |
| • The physical, psychological or emotional well-being of the vulnerable adult may be being adversely affected  
• The concerns reflect difficulties and tension in the way health and/or social care services are provided to the vulnerable adult(e.g. Some perceived inadequacy in the services being provided)  
• The concerns reflect difficulties and tensions within the network of |
| • The 'needs' of the vulnerable adult and if appropriate a vulnerable perpetrator are formally assessed or reviewed by a care manager/social worker/health care professional  
• Determine if abuse occurred  
• If abuse confirmed or there was insufficient information for a determination to be made a post abuse care plan may include:  
• Possible adjustments to the way health and social care services are provided to the vulnerable adult or
### Level 3 – Multi-Agency response

- Adult safeguarding concern reported to local authority
- Alert form completed
- Discussion with DSO/ Senior manager
- Discussion with Adult(s) at risk or representative(s)
- MSP outcomes recorded
- Consideration of independent advocate or IMCA appointment
- Decision by DSO re S.42 eligibility
- DSO allocates to IO to undertake multi-agency consultation/enquiry including police if a criminal offence may have been committed
- Notify commissioners and regulators

### Presenting Information

- The physical, psychological or emotional well-being of the adult has been adversely affected by the alleged incident(s)
- Criminal offence(s) may have been committed
- There is a possible breach of regulations under the Care Standards Act (2000)
- Possible breach of Professional Codes of Conduct
- There is an actual or potential risk of harm or exploitation to other vulnerable people
- There appears to be a deliberate intent to exploit or harm a vulnerable adult
- There is a significant breach in an implied or actual ‘duty of care’ between the vulnerable adult and the alleged perpetrator.
- There are clear inequalities of power and/or authority between the vulnerable adult and the person alleged responsible
- The concerns form part of a pattern of abuse either, against a particular individual, by a particular individual or by a health or social care service

### Action & Outcomes

- Multi agency planning discussion/meeting held to agree an ‘Investigation Plan’
- Investigation Plan implemented with further AP review discussions/meetings, if appropriate
- Evaluation of investigation activity and evidence obtained
- Report to be completed by investigating officer(s) to enable the case conference to determine the status of the allegations
- Case conference to agree a ‘Protection Plan’ that prevents or reduces risk of further abuse
- Agree Protection Plan
- Agree review time scales for protection plan and allocate to named people
- Agree circumstances where re-evaluation of the situation will be required

### Level 4 – Multiple victims involved

- Complex adult protection investigations / assessments undertaken with multiple service users / victims
- Adult Protection Alert/Referral form to be completed for all clients assessed/reviewed in relation to the alleged abuse
- Investigation of initial concerns for one service user identifies serious concerns for others
- Institutional abuse
- Number of vulnerable adults adversely affected
- Criminal offences may have been

### Presenting Information

- Notify senior managers
- Allocate resources to undertake, and co-ordinate investigation/assessment
- Planning/strategy meeting held to agree an ‘Investigation/assessment Plan’
**Adult Safeguarding Guidance**

| Decision by DSO re S.42 eligibility | Possible multiple breach of Care Standards Act | Investigation / assessment plan implemented with further review meetings, if appropriate |
| MSP outcomes recorded for any suspected victims | | Evaluation of Investigation /assessment activity and evidence obtained |
| Consideration of advocate appointment | | Report completed by investigator(s) |
| IO’s allocated to work with partner agencies to carry out enquiries in line with agreed terms of reference | | Determine if abuse has taken place |
| Consult with police, if crime possible refer issues to police including S.44 MCA (ill treatment or neglect) | | Case conference to agree a 'Protection Plan' that prevents or reduces risk of further abuse |
| Notify commissioners and regulators | | Agree Protection Plan |
| | | Agree review time scales for protection plan and allocate to named people |
| | | Agree circumstances where re-evaluation of the situation will be required |
| | | Establishment case conference/review meeting |
| | | Agree action plan for the service |
| | | Monitoring and review of action plan for service provider |
23. Adult Safeguarding Response Framework – Timeline

- Adult safeguarding concern reported to social services
- Discussion with adult or their representative to establish their desired outcome
- Advocate appointment?
- Decision made that it appears to be a safeguarding case
- Alert form commenced
- Risk considered with appropriate action
- Carry out consultations/informal enquiries, evaluate information and consider response

Possible responses:
- Section 42 Enquiry; signposting or info and advice to be given?
- Community or Carer’s Assessment needed
- Quality in Care: refer to CQC, contracts and contact should be made with the lead commissioning authority
- Non Statutory e.g. possible referral to others e.g. housing, GP, leisure; voluntary sector?

Possible crime? Consult police & make formal referral if appropriate

Record and notify referrer and agencies of the agreed response, if appropriate

Complete planning process following consultation (planning meeting)

Possible responses:
- Decide if Section 42 or non-statutory enquiry is required?
- Agree level of response (1 – 4)
- Agree who will take the lead (DSO)
- Review risk level
- Record and agree a protection plan

Within 24 hours

Within 2 working days

Within 5 working days

- Consider need for planning meeting
- Reconsider risk level
- Decide who will take the lead in the Enquiry
- Record and agree a protection plan

Level 1 S42 or non-statutory Enquiry
Service provider must report back the outcome of their assessment

Review level if necessary

Level 2 S42 or non-statutory Enquiry
Urgently assess or review the needs of adult(s) within the context of the presenting concern(s)

Review level if necessary

Level 3 or 4 S42 or non-statutory Enquiry
Complex safeguarding enquiry undertaken with multiple victims

At review planning meeting
Formal review of enquiry findings

At case conference:
Decision re outcome of statutory enquiry. Evidence reduced risk and achievement of Making Safeguarding Personal Outcomes
Agree post abuse plan. Close case. Inform relevant people
24. Safeguarding vulnerable people from radicalisation and extremism (Prevent) and Counter Terrorism

The Prevent strategy is focused on safeguarding people from radicalisation or extremism. This includes work to stop people becoming terrorists or supporting terrorism. Kent County Council (KCC) has the lead role in delivering the Prevent strategy in Kent in accordance with the Prevent duty guidance, working alongside multi-agency partners such as the Police, health and district councils. As a Unitary Authority Medway Council has the lead role in Medway.

Prevent has three key objectives:

- Respond to the ideological challenge of terrorism
- Support vulnerable people and prevent people from being drawn into terrorism
- Work with key sectors and institutions to address the risks

Prevent is a formal duty for KCC and Medway Council under the Counter Terrorism and Security Act 2015. We all have a role in protecting vulnerable children, young people and adults from being drawn into terrorism, keeping our county and the people in it safe. Extremism and radicalisation in our community are very real threats and being aware is the first step. The threat from terrorism, radicalisation and extremism can be reduced by being vigilant, knowing what to report and reporting it.

24.1 Report it

Immediate threat

If you have seen a person acting suspiciously, an unattended package or bag, or a vehicle which might be an immediate threat, move away and call 999.

Safeguarding concerns – No immediate threat

If you’re concerned about possible terrorist activity or risk of radicalisation and there is no immediate threat, you can either:

- Complete a Prevent Referral Form for Kent or Medway
- Call the Police on 101 and 0800 789 321
- Complete an online report form

Please try to provide as much information as possible.

24.2 Information found online

Stop Terrorists’ and Extremists’ Online

If you’ve found illegal or harmful information, pictures or videos online, report your concerns anonymously.

24.3 How can I support Prevent?

- Be vigilant. Radicalisation is usually a process, not an event, and factors or events may contribute towards the radicalisation for an individual
- Complete the mandatory eLearning (KCC staff only)
• Complete the Home Office E-learning Training on Prevent.
• Complete the National Centre for Applied Learning Technologies e-learning package to raise awareness of Channel.
• Familiarise yourself with the factors that contribute towards radicalisation and how to make a referral to Channel using the Prevent Referral Form for Kent or Medway.
• For a greater understanding of the support Prevent can offer, visit Let’s Talk About It

Prevent is a shared responsibility. Don’t rely on others – report any concerns you have immediately.
Appendix 1 - Useful Addresses, Telephone and Fax numbers

For referrals to Kent Adult Social Services (updated September 2017)

If you have a safeguarding adults concern phone Kent contact point number - **03000 41 61 61**

If your concern is about someone Kent Social Services are already working with you will be transferred to the appropriate team, if this is not the case you will be transferred to the Central Referral Unit.

If you wish to consult about a safeguarding concern before making a referral you will be transferred to the Central Referral Unit for a consultation.

KASAF referral forms Kent-adult-safeguarding-alert-form.doc can be faxed or e-mailed (using the secure email address found on the form) or for out of hours 01233 646596, this will be passed to the correct team within Social Services.

For referrals to Medway Council Adult Social Care (updated April 2016)

Phone 01634 334466 and a referral will be taken. You may also fax through your SAF referral form SAF Referral Form on 01634 334504.

You may e-mail your referral on access&info@medway.gov.uk

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**MEDWAY ADULT SOCIAL SERVICES**

Medway Council HQ’s
Level 4, Gun Wharf
Dock Road, Chatham
Kent ME4 4TR

Tel: **01634 33 44 66**
ss.access&info@medway.gov.uk

Out of Hours
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

Emergency Out of Hrs: **03000 41 91 91**
General Enquiries: **03000 41 41 41**

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**KENT ADULT SOCIAL SERVICES**

General Contact Numbers for Kent:

Contact point: **03000 41 61 61**
Emergency Out of Hrs: **03000 41 91 91**
General Enquiries: **03000 41 41 41**
Website: www.kent.gov.uk
Email: social.services@kent.gov.uk

Kent County Council HQ’s
General Enquiries

West Kent Area Office
Invicta House,
### Appendices

<table>
<thead>
<tr>
<th>County Hall</th>
<th>Maidstone ME14 1XX</th>
</tr>
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<tbody>
<tr>
<td>Maidstone</td>
<td>Maidstone ME14 1XQ</td>
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<table>
<thead>
<tr>
<th>Swale</th>
<th>Ashford</th>
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<tr>
<td>Avenue of Rememberance</td>
<td>Kroner House</td>
</tr>
<tr>
<td>Sittingbourne</td>
<td>Eurogate Business Park</td>
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<tr>
<td>Kent. ME10 4DD</td>
<td>Ashford, TN24 8XU</td>
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<thead>
<tr>
<th>Canterbury, Dover, Thanet</th>
<th>Shepway</th>
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<tbody>
<tr>
<td>Brook House, Reeves Way</td>
<td>Queens House</td>
</tr>
<tr>
<td>John Wilson Business Park</td>
<td>Guildhall Street</td>
</tr>
<tr>
<td>Whitstable, CT5 3SS</td>
<td>Folkestone, CT20 1DX</td>
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<thead>
<tr>
<th>Dartford, Gravesend &amp; Swanley</th>
<th>Tonbridge and Sevenoaks</th>
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<tbody>
<tr>
<td>Joynes House</td>
<td>Kings Hill</td>
</tr>
<tr>
<td>New Road</td>
<td>30 Kings Hill Avenue</td>
</tr>
<tr>
<td>Gravesend</td>
<td>West Malling</td>
</tr>
<tr>
<td>Kent DA11 OAT</td>
<td>Kent, ME19 4AE</td>
</tr>
<tr>
<td>Tel: 03000 41 02 05</td>
<td>Tel: 03000 41 14 00</td>
</tr>
<tr>
<td>E: <a href="mailto:nkbst@kent.gov.uk">nkbst@kent.gov.uk</a></td>
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<table>
<thead>
<tr>
<th>Tunbridge Wells</th>
<th></th>
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<tbody>
<tr>
<td>Montague House</td>
<td></td>
</tr>
<tr>
<td>9 Hanover Road</td>
<td></td>
</tr>
<tr>
<td>Tunbridge Wells</td>
<td></td>
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<tr>
<td>Kent, TN1 1EZ</td>
<td></td>
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<tr>
<td>Tel: 01892 51 50 45</td>
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</table>

### Area Referral Management Services (ARMS)

**Refer to central contact point:**

Tel: 03000 41 61 61

**Out of Hours**

If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

Out of hours contact: 03000 41 91 91 in the First Instance

Or 24hr contact: 03000 41 41 41

### Central Duty Team – New Cases Only – Kent Only

**Email:** AdultsSafeguardingCRU@kent.gcsx.gov.uk (secure email)

AdultSafeguardingCRU@kent.gov.uk (Standard Email)

**Tel:** 03000 41 61 61

**eFax:** 443000 42 20 94

**Out of Hours**

If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

Telephone: 03000 41 91 91 in the First Instance

Fax: 03000 41 73 45

(Safe haven fax)
## Kent & Medway NHS and Social Care Partnership Trust Integrated Mental Health Teams

### Out of Hours
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

<table>
<thead>
<tr>
<th>Team</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **DGS Community Mental Health Team** | Arndale House  
18-20 Spital Street  
Dartford DA1 2DL  
Tel: 01322 62 22 30 |
| **Swale Mental Health Team**         | Sittingbourne Memorial Hospital  
Bell Road  
Sittingbourne  
Kent County Council ME10 4DT  
Tel: 01795 41 83 59 |
| **Maidstone**                        | Maidstone Community Mental Health Team  
23-29 Albion Place  
Maidstone ME14 5TS  
Tel: 01622 76 69 00 |
| **Ashford**                          | Eureka Place  
Trinity Road  
Ashford TN25 4BY  
Tel: 01233 65 81 00 |
| **Thanet**                           | The Beacon  
Manston Road  
Ramsgate CT12 6NT  
Tel: 01843 85 52 00 |
| **Canterbury and Coastal**           | Kings Road Clinic  
Herne Bay  
Kent CT6 5DD  
Tel: 01227 59 48 50 |
| **Medway**                           | Canada House  
Barnsole Road  
Gillingham  
Kent ME7 4JL  
Tel: 01634 58 30 20 |
| **South West Kent**                  | Highlands House,  
10-12 Calverley Park Gardens, Tunbridge Wells  
TN1 2JN  
Tel: 01892 70 92 11 |
| **East Kent – Dover & Deal**         | Coleman House  
Brookfield Avenue  
Dover CT16 2AH  
Tel: 01304 21 66 66 |
| **Shepway**                          | Ask Eton  
Radnor Park Avenue  
Folkestone  
Kent CT19 5HL  
Tel: 01303 22 75 10  
Fax: 01303 22 75 12 |
# Medway Deaf Services

**Deaf Services**  
Medway Council  
Gun Wharf, Dock Road  
Chatham, ME4 4TR

<table>
<thead>
<tr>
<th>Phone/Minicom:</th>
<th>01634 33 17 27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile (SMS only) Text:</td>
<td>07795 951465</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:deaf.services@medway.gov.uk">deaf.services@medway.gov.uk</a></td>
</tr>
</tbody>
</table>

**Out of Hours**  
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

<table>
<thead>
<tr>
<th>Out of Hours:</th>
<th>03000 41 91 91</th>
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<tbody>
<tr>
<td>Or 24hrs:</td>
<td>03000 41 41 41</td>
</tr>
</tbody>
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# Kent Sensory and Autism Services

**Out of Hours**  
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

<table>
<thead>
<tr>
<th>Out of Hours:</th>
<th>03000 41 91 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Enquiries:</td>
<td>03000 41 41 41</td>
</tr>
</tbody>
</table>

**Kent Sensory and Autism Services**  
Kent County Council  
Kroner House  
Eurogate Business Park  
Ashford  
TN24 8XU

<table>
<thead>
<tr>
<th>Tel:</th>
<th>03000 41 81 00</th>
</tr>
</thead>
<tbody>
<tr>
<td>E:</td>
<td><a href="mailto:SensoryandAutism@kent.gov.uk">SensoryandAutism@kent.gov.uk</a></td>
</tr>
</tbody>
</table>

**Sensory Services**  
Tel: 03000 418900  
Mobile/SMS: 07920 154315  
Minicom: 01233 66 63 35  
E: sensoryservices@kent.gov.uk

**Autistic Spectrum Conditions Team**  
Tel: 03000 41 81 00  
E: SensoryandAutism@kent.gov.uk

**Kent Association for the Blind (KAB) Rehabilitation Teams**  
Maidstone: 01622 69 13 57  
Canterbury: 01227 76 33 66  
Gravesend: 01474 54 44 40

**Hi Kent Maidstone**  
01622 69 11 51  
**Hi Kent Canterbury**  
01227 76 00 46

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# Appendixes
Appendices

Kent Social Care Health and Wellbeing Older Persons and Physical Disability (OPPD) - Area Community Team Telephone numbers and emails:

Out of Hours
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

Out of Hours: 03000 41 91 91
General Enquiries: 03000 41 41 41

<table>
<thead>
<tr>
<th>Area</th>
<th>Email</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford</td>
<td><a href="mailto:ashfordact@kent.gov.uk">ashfordact@kent.gov.uk</a></td>
<td>03000 41 04 05</td>
<td>03000 41 27 49</td>
</tr>
<tr>
<td>Canterbury</td>
<td><a href="mailto:ACTCanterbury@kent.gov.uk">ACTCanterbury@kent.gov.uk</a></td>
<td>03000 42 11 54</td>
<td>03000 42 28 72</td>
</tr>
<tr>
<td>North Kent</td>
<td><a href="mailto:MKACTAP@kent.gov.uk">MKACTAP@kent.gov.uk</a></td>
<td>03000 41 31 04</td>
<td>03000 42 27 67</td>
</tr>
<tr>
<td>Dover</td>
<td><a href="mailto:doveract@kent.gov.uk">doveract@kent.gov.uk</a></td>
<td>03000 41 61 61</td>
<td>03000 42 00 13</td>
</tr>
<tr>
<td>Maidstone</td>
<td><a href="mailto:ACTWestKentSafeguarding@kent.gov.uk">ACTWestKentSafeguarding@kent.gov.uk</a></td>
<td>03000 41 77 00</td>
<td>03000 42 23 67</td>
</tr>
<tr>
<td>Sevenoaks &amp; Malling</td>
<td><a href="mailto:ACTWestKentSafeguarding@kent.gov.uk">ACTWestKentSafeguarding@kent.gov.uk</a></td>
<td>03000 41 77 00</td>
<td>03000 42 23 67</td>
</tr>
<tr>
<td>Shepway</td>
<td><a href="mailto:shepwayact@kent.gov.uk">shepwayact@kent.gov.uk</a></td>
<td>03000 41 14 44</td>
<td>03000 42 28 77</td>
</tr>
<tr>
<td>Swale</td>
<td><a href="mailto:ACTSwaleAP@kent.gov.uk">ACTSwaleAP@kent.gov.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thanet</td>
<td><a href="mailto:thanetact@kent.gov.uk">thanetact@kent.gov.uk</a></td>
<td>03000 41 61 61</td>
<td>01843 86 04 61</td>
</tr>
<tr>
<td>Tonbridge &amp; Tunbridge Wells</td>
<td><a href="mailto:ACTWestKentSafeguarding@kent.gov.uk">ACTWestKentSafeguarding@kent.gov.uk</a></td>
<td>03000 41 23 00</td>
<td>03000 42 27 46</td>
</tr>
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Kent and Medway NHS and Social Care Partnership Trust (M H)

Telephone the Local Team for your area where known, who will advise you whom to email the KASAF to.

Tel: 03000 41 61 61 (when the Local Team is not known)
Out of Hours: 03000 41 91 91
Or 24hrs: 03000 41 41 41

Learning Disability (LD) Community Teams for Kent Case Managed Adults
(If the adult is placed by another authority please refer to central duty team 03000 41 61 61)
Out of Hours
If your concerns require urgent attention outside of normal office hours (8.30am-5.00pm Monday-Friday, excluding bank holidays) and cannot wait until the next working day:

Tel: 03000 41 61 61
Out of Hours: 03000 41 91 91
General Enquiries: 03000 41 41 41

Ashford and Shepway
E: ash.shep.id.comm.team@kent.gov.uk
Tel: 03000 41 05 01
Fax: 01303 71 70 02

Canterbury and Swale
E: canterbury.LD.community.team@kent.gov.uk
E: swale.LD.community.team@kent.gov.uk
Tel: 03000 42 28 00
Fax: 03000 42 15 11
This is a shared fax, so a front sheet will be required

Dartford, Gravesend and Swanley
E: DGSDLCTeam01@kent.gov.uk
Tel: 03000 41 05 05
Fax: 03000 42 27 65

Dover and Thanet
E: dover.thanetldduty@kent.gov.uk
Tel: 01304 82 85 55
Fax: 03000 42 27 36

Maidstone and Malling
E: MMLDDuty@kent.gov.uk
Tel: 03000 41 03 33
Fax: 03000 42 27 36

South West Kent (Tonbridge, Tunbridge Wells and Sevenoaks)
E: SWKLDCTeam01@kent.gov.uk
Tel: 03000 41 72 22
Fax: 03000 42 27 40

OUTSIDE ORGANISATION

Care Quality Commission
CQC South East
Citygate, Gallowgate
Newcastle Upon Tyne
NE1 4PA
Tel: 03000 61 61 61
Fax: 03000 61 61 71
E: enquiries@cqc.org.uk

Forced Marriage Unit
Tel: 020 7008 0151
From Overseas: +44 (0)20 7008 0151
Monday to Friday, 9am to 5pm
E: fmu@fco.gov.uk
Out of hours: 020 7008 1500
(ask for the Global Response Centre) in an emergency call 999

Kent Hate Crime - Incident Line
Freephone: 0800 138 1624
Kent Police: dial 101 for your local officer

To raise concerns you can contact your local officers by calling 101 or by emailing them directly.
Go to the homepage of our website: www.kent.police.uk
and enter your post code to find details of your local officer.

Text service for the deaf or speech impaired
If you are deaf, speech impaired or find speaking on the telephone difficult you can text us. Type "Police" followed by your message and send to

Kent Police
Safeguarding Team
Countywide number 101
or contact local social services
Tel: 03000 41 61 61
Out of Hours: 03000 41 91 91
Or 24hrs: 03000 41 41 41
<table>
<thead>
<tr>
<th><strong>Businesses seeking advice about compliance with legislation or licensing issues can contact Trading Standards in the following ways:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashford, Canterbury, Dover, Shepway, Swale and Thanet</td>
</tr>
<tr>
<td><strong>Tel:</strong> 03000 41 20 20</td>
</tr>
<tr>
<td>Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells</td>
</tr>
<tr>
<td><strong>Tel:</strong> 03000 41 20 20</td>
</tr>
<tr>
<td><strong>Email:</strong> <a href="mailto:tsbusinessadvice@kent.gov.uk">tsbusinessadvice@kent.gov.uk</a></td>
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<table>
<thead>
<tr>
<th><strong>Medway Council – Trading Standards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gun Wharf, Dock Road, Chatham, Kent, ME4 4TR</td>
</tr>
<tr>
<td><strong>Tel:</strong> 01634 33 35 55</td>
</tr>
<tr>
<td><strong>E:</strong> <a href="mailto:consumer.protection@medway.gov.uk">consumer.protection@medway.gov.uk</a></td>
</tr>
<tr>
<td><a href="http://www.medway.tradingstandards.uk/">www.medway.tradingstandards.uk/</a></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>Contact Details for Nominated Hospital Safeguarding Leads</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Darent Valley NHS Hospital Trust</strong></td>
</tr>
<tr>
<td><strong>Tel:</strong> 01322 428865</td>
</tr>
<tr>
<td>Safeguarding Adults Lead</td>
</tr>
<tr>
<td><strong>TEL:</strong> 01322 428865</td>
</tr>
<tr>
<td>Or ask for the Director of Nursing &amp; Quality/ Deputy Director of Nursing &amp; Quality.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Queen Elizabeth Queen Mother Hospital (East Kent NHS Hospital Trust)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Adult Safeguarding, PREVENT Lead</td>
</tr>
<tr>
<td><strong>Tel:</strong> 079644 37558</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>Director of Nursing or Lead Nurse for Safeguarding Adults</td>
</tr>
</tbody>
</table>
**Medway NHS Foundation Trust**  
Chief Nurse’s Office  
Windmill Road  
Gillingham  
Kent ME7 5NY  
**Tel:** 01634 830000 ex: 3127  
or  
Safeguarding Vulnerable Adults Coordinator  
**Tel:** 07884 181615

**Maidstone and Tunbridge Wells NHS Hospital Trust**  
Ask for Safeguarding Lead  
**Tel:** 01622 224821

**Tunbridge Wells Hospital**  
(Pembury)  
**Tel:** 01892 63 43 77
Appendix 2 – Body map

Adult’s name: Date of birth: Case number:
Address: 

Please mark any noticeable marks that you may have seen on the body of the adult giving rise to this concern. Please describe injury(ies)

Date: Time: Name of person completing this form:
Signature: Position: