April 2016

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
Introduction and Contents

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....

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 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.

1 Statutory Guidance, Care Act 2014
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.

Part 3 - Guidance & Checklists
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
- 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 and Medway Care Alliance
- Kent Care Homes Association
- Kent Community Care Association
- Kent Fire and Rescue Service
- Kent Prison Service

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.
## Adults Safeguarding Policy

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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:²

**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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² Care and Support Statutory Guidance, Section 14, June 2014
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
Requirements 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.

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

5.2 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.

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**
Safeguarding Enquiries carried out on behalf of adults who fit the criteria outlined in Section 42 of the Care Act 2014. Local Authorities are required by law to carry out safeguarding enquiries for these individuals. The criteria for a Section 42 response is: an adult who is believed to:
- a) be experiencing, or at risk of, abuse or neglect; AND
- b) have needs for care AND support (whether or not the Local Authority is meeting any of those needs); AND
- c) as a result of those care AND support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

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 (whether or not the authority is meeting any of those needs)
- 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 in the adult's case and, if so, what should happen and by whom. This then constitutes a statutory Section 42 enquiry.

7.4 **Non-Statutory Safeguarding Enquiry**
- a) 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 discretion (e.g. they may be regarding a carer) Local Authorities are NOT required by law to carry out enquiries for these individuals and do so at their own discretion.

These enquiries may relate to an adult who:
- b) is believed to be experiencing, or is at risk of, abuse or neglect
- c) does not have care AND support needs (but might just have support needs)

7.5 **Who may be considered for statutory and non-statutory enquiries?**
This may include people with learning disabilities, mental health issues, older people, and people with a physical disability or impairment. It may also include adult victims of abusive care practices; neglect and self-neglect; domestic abuse; 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, 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.


**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**

Some instances of abuse will constitute a criminal offence. This may lead to criminal proceedings and appropriate intervention must take this into account. 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.

**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 SAB [Appendix 5](#). 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 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 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.
8. Types 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.

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.

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
Adult Safeguarding Policy

h) Failure to provide access to appropriate social skills and educational development training
i) Faith abuse

8.4 Exploitation
a) opportunistically or premeditated
b) unfairly manipulating someone for profit or personal gain
c) modern slavery
d) human trafficking
e) Radicalisation

8.5 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

8.6 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

8.7 Self-Neglect or self-injurious behaviour
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

This is the link to Kent and Medway Multi-agency Policy and Procedures to Support People who Self-Neglect Self-Neglect Policy and Procedure

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 Essential 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 occur 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 very 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 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 13th 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/

8.12 Inappropriate Restraint
Department of Health Guidance: Positive and Proactive Care: 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:

- 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
- 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
- staff must not use seclusion (this may differ if the person is subject to detention under Mental Health Act 1983)
- People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support
- 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:
   i. 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.

8.13 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.

8.13.1 Reporting
Reporting to trained officers, helps police to investigate an incident which may contribute to an arrest and/or prosecution; understand patterns of behaviour; gives a true picture of what is happening within the community and helps to prevent these types of crimes happening in the future.
8.14 Modern Slavery or Human Trafficking

8.14.1 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:

*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.*

There are three main elements:

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

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](http://www.nationalcrimeagency.gov.uk/crime-threats/human-trafficking).

8.14.2 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](http://www.nationalcrimeagency.gov.uk/crime-threats/human-trafficking)

[Kent and Medway Protocols for Adults who are at risk of Sexual Exploitation, Modern Slavery and Human Trafficking](http://www.nationalcrimeagency.gov.uk/crime-threats/human-trafficking)

8.15 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.

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8.15.1 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 sentence of up to 7 years in prison.

8.15.2 Forced marriage Protection Orders
The Forced Marriage Unit (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 sentence of up to 5 years in prison.

8.15.3 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).

8.15.4 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 or contact the nearest British embassy if they are already abroad, providing 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.

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

8.16 Female Genital Mutilation (FGM)
According to the NSPCC, female genital mutilation (FGM) is the partial or total removal of external female genitalia for non-medical reasons and it can be 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. There are four types of FGM and all are illegal and have serious health risks. 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. FGM is usually performed by someone with no medical training and no anaesthetic or antiseptic treatment is used. Victims are often forcibly restrained and cutting is made using instruments such as a knife, pair of scissors, scalpel, glass or razor blade and serious health problems are common.\(^5\)

FGM has been a criminal offence in the UK since 1985 and in 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison.

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

8.16.1 Offences

The Female Genital Mutilation Act 2003\(^6\) 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 they, aid, abet counsel or procure 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.

Section 5b of the Female Genital Mutilation Act 2003 introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report “known” cases of FGM in under 18’s which they identify in the course of their professional work to the police. The duty applies from 31st October 2015 onwards. For further information please see link below:

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

8.17 Child Sexual Exploitation (CSE)

This is a form of child abuse\(^7\) 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.

\(^{7}\) Safeguarding children and young people from sexual exploitation statutory guidance https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00689-2009
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, 19 March 2014⁸ 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 are 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 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’s 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

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⁸ P v Cheshire West and Chester Council and another P and Q v Surrey County Council
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

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.
10. 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'\(^9\)

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.

\(^9\) Bennett D.G: Shifting Emphasis from Abused to Abuser, May 1990
11. **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-ordinator or safeguarding lead, will be involved ([Protocols, Section 16](#)).

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](#)
12. 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) A decision regarding the case reaches the criteria for a Statutory s42 enquiry
b) reliability/credibility of the information received need for any emergency or other protective action
c) possibility that the alleged abuse is a criminal offence
d) impact of the alleged abuse on the adult(s)
e) capacity of the adult(s) for self determination
f) vulnerability of the adult(s)
g) extent of the abuse to this or other adults or children
h) length of time it has been occurring
i) risk of repeated or escalating acts involving this or other adults or children
j) information about the alleged perpetrator(s)
## 13. The function of a Section 42 Enquiry

<table>
<thead>
<tr>
<th>What a Section 42 Enquiry must take into account</th>
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<tbody>
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<td>Level of risk to others</td>
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<td>Adult’s Outcomes e.g. restricted contact with perpetrator/criminal justice/access to community</td>
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14. Safeguarding Children

Under the Children Act 2004 everyone has responsibility to carry out their normal functions with regard to the need to safeguard and promote the welfare of children and young people and for ensuring that they are protected from harm. This includes work carried out in relation to assessments and reviews of adults and their carers; provision of services and adult safeguarding processes.

14.1 Allegation management

In all children and adult safeguarding cases where an alleged or confirmed perpetrator of abuse is a staff member or volunteer working with adults at risk in any setting, an assessment must be carried out through the children or adult safeguarding process to determine if the perpetrator poses a risk to identified children or young people. If this assessment indicates that there is a possible risk to children or young people, a referral may be made to the local Children’s Social Services team or the Local Authority Designated Officers (LADO) who will be responsible for addressing any reported concerns of harm or possible harm to children as a result of the referral from Adult Social Care.
15. Safeguarding Adults at Risk

Under the Care Act 2014 the Local Authority has a duty to ensure that adults at risk are able to live their lives in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted.

15.1 In any child safeguarding case where an alleged or confirmed perpetrator of abuse is a staff member or volunteer working with adults at risk in any setting a referral must be made to the adult LADO using the adult LADO referral form and an assessment will be carried out through the allegation management processes to determine if the perpetrator poses a risk to adults and to determine what action may be indicated.

Where an alleged or confirmed perpetrator of abuse of a child or an adult at risk is a staff member or volunteer working with adults and there is no ongoing safeguarding adults enquiry, the allegation management form should be completed and sent to the central duty team (in Kent) or to the access and information service (in Medway) where it will be recorded and passed to the appropriate LADO for adult services. This will enable a risk assessment to be carried out and to determine what action may be indicated.
16. Escalating Concerns

16.1 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.

16.2 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

What Do These Protocols Cover?

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
- Statutory Care and Support Guidance (2014)
- 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 26) 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 Adult Social Services 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 closest to 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 both care and support needs, a Section 42 enquiry will be required.

Where the safeguarding alert is received and the adult has care or support needs, and the concerns need to be addressed, then a non-statutory enquiry should be undertaken.

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 social services. 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, team manager 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 leading the investigation 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.
4. Raising a Concern

4.1 Who should report concerns?
Anyone may report concerns regarding actual, alleged or suspected abuse or neglect directly to social services. 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:

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 staffs 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, social services 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. 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 locality of social services 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 authority. A host 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 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 social services in line with Section 4.3 above. Referrals may be made by telephone and backed up in writing from 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 social services, 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 social services, that an identifiable adult(s) with care and support needs have been abused or is at significant risk of abuse or neglect, social services has a duty to cause or make enquiries.

If during the consultation with social services 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 4.8.

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 social services 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 Social services response to an allegation of abuse or neglect

The qualified staff member from social services 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

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, 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; 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.

Factors to be also 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. If there is any disagreement with this decision that cannot be resolved between the social services 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 fulfils 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 this 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 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. 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 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).

However, 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 social services 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 Sections 11.6 and 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 referring 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 social services and must also be reported to the regulatory authority.

Following consultation with the local social services, it may be agreed that a ‘Level 1 response’ is appropriate (see Guidance section 26 - Framework for Responding to Adult Safeguarding Concerns). As part of a Section 42 Enquiry the Level 1 ‘process’ can be challenged by social services 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 social services, 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 show:

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 social services as only they can sign the case off as and when the Section 42 duty has been satisfied.

Where the adult protection 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, social services 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 social services become 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 vulnerable adult of another within a service setting should be addressed as an adult safeguarding issue. This situation has traditionally been framed in terms of the perpetrator’s challenging behaviour and is often not identified as an abusive act. 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.

Many organisations have become accustomed to responding internally to incidents of vulnerable service users who abuse other service users. This has meant that regulatory, contract and commissioning agencies for both the victim and the perpetrator may not have been informed of the concerns, or been given an opportunity to engage in decision making around the issues. It has also resulted in the multi-agency adult safeguarding protocols being ignored and abuse, which may have constituted a criminal offence, not being addressed.

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. 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?
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 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 organisations are present, for example in a planning meeting, then a Chair may ask them to adjourn whilst information is appropriately shared. 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 18).
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 recorded. Where the issues are complex and/or more than one agency is involved, a formal planning meeting of all appropriate agency 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.

- Check with the other agencies as to whether the adult, alleged perpetrator or setting is known under what circumstances they have been involved. Examples of who may be contacted are general practitioner, police (Combined Safeguarding Team (CST) or Central Referral Unit (CRU)) 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 social services 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
Adult Safeguarding Protocols

f) any disclosure or witness reports have been completed, prior to social services or police involvement
g) there are any issues related to potential discrimination e.g. cultural, religious, gender or disability issues
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 where the alleged perpetrator is an employee of social services
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).

If 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, if there is enough information 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 social services 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 adult safeguarding issues as a matter of urgency. The police will take responsibility for any investigations and will liaise with the Coroner.

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 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 other interested parties of the concerns and possible risk factors. This may include commissioning authorities outside Kent or Medway.

For organisations with contracts with the social services in Kent or Medway this may be achieved by the use of the flag system within commissioning records maintained. Even 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 of Green, Amber, and Red will be applied to all services.

This information will be made visible to the General Public and health and social care organisations via the Kent online Care Directory.

<table>
<thead>
<tr>
<th>Colour</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green (Level 1)</td>
<td>Contractor is operating within the acceptable levels of Performance and Quality.</td>
</tr>
<tr>
<td>Amber (Level 2)</td>
<td>The Contractor has been issued a Restriction Notice and is in the process of corrective action</td>
</tr>
<tr>
<td>Red (Level 3)</td>
<td>The Contractor is under a Suspension Notice. KCC is not currently placing new people within this service.</td>
</tr>
</tbody>
</table>

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.

Safeguarding Adults Boards have a much broader strategic role than those covered by operational Section 42 enquiries and may set criteria for when they would need to be informed to be assured that improvements take place and are sustained over time.

8.2 What protective actions may be considered?

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

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.
9. Planning an Enquiry

9.1 Decision Making

Social services 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 and before the case can be signed off.

If the adult at risk who has care and support needs is likely to have difficulty in managing 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 carried out. 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 time scale 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 a 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. A formal planning/strategy meeting must be considered where any or all of the following factors are present:
   a) Several people/agencies have concerns and a meeting will aid decision-making;
   b) Several individuals may be at risk;
   c) Several agencies are likely to be involved in an enquiry;
   d) A criminal prosecution is possible;
   e) Other legal or regulatory action may be necessary;
   f) One or more members of staff have been implicated/suspended;
   g) Where there is a need to clarify employment status of one or more individuals; This will be important in regard to personalised services including people employed via direct payment
   h) The issue may attract media interest.

In complex cases there may be a need for more than one meeting during the enquiry process.
If a DSO thinks a Section 42 Enquiry should go ahead then the Enquiry MUST address the following:

<table>
<thead>
<tr>
<th>The adult’s expressed outcomes</th>
<th>Ensure suitable advocacy in place if it is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the level of risk of abuse or neglect and risk of repeated acts</td>
<td>Decide on the ability of adult(s) to self-protect or increase their protection network(s)</td>
</tr>
<tr>
<td>Assess risk to children and others</td>
<td>Assess the impact on adult(s) and their important relationships</td>
</tr>
<tr>
<td>Empower people and make safeguarding personal and person centred</td>
<td>Assess if action may increase risk to adult and others</td>
</tr>
<tr>
<td>Take account of human rights of all adults at risk and carers</td>
<td>Cause or responsibility for abuse</td>
</tr>
<tr>
<td>Decide on care and support needs</td>
<td>Protective factors and strengths</td>
</tr>
<tr>
<td>Assess what outcomes the adult(s) wants e.g. restricted contact with perpetrator/criminal justice/access to community</td>
<td>Decide who needs to be involved, what actions are necessary and keep records of decisions; incidents and events</td>
</tr>
<tr>
<td>Timescales for reporting and actions</td>
<td>Agree reporting and feedback mechanisms</td>
</tr>
</tbody>
</table>

9.2 **Holding a planning meeting**

This meeting forms part of the statutory enquiry into the allegations received and should be attended by the adult and or their representative and all relevant professionals/agencies and any other person that the adult thinks may positively contribute. Any action planned must reflect the outcome/s of a capacitated adult and or the representative of the adult, if they lack capacity.

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 therefore would be required.

The Chair will explain the status and purpose of the meeting and confidentiality and equal opportunities issues will be clarified. All present have a responsibility to contribute and will be invited to share any information or concerns they may have, in light of the concern received. If some relevant professionals cannot attend, they may elect to send a representative or a written report. The meeting will be formally minuted detailing those attending together with relevant apologies. The alert document and any attached papers will be entered into the record of the Enquiry at this stage. The minutes of the planning meeting will only be circulated to those participating in or invited to the meeting or that part of the meeting. The Chair may exercise discretion to send the minutes to other agencies to enable them to fulfil their statutory obligations.
If any attendee disagrees with consensual decisions taken at the meeting they should formally register their concerns at the meeting. The Chair will refer the matter to their line manager for further consideration as a matter of urgency. (Safeguarding Checklists for Practitioners.pdf – Section 4).

Any interviews with witnesses and/or complainants and others who are able to set the scene must be carried out by two people. Joint interviews and/or joint visits are preferable to prevent the adult having to repeat their story. In criminal cases, one interviewer will always 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.

9.3 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) at risk using the safeguarding assessment/risk assessment and protection plan form SAF as appropriate
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.

9.4 Responsibilities and accountabilities
Social services are the lead agency and must be clear in planning the Enquiry roles, responsibilities and time frames need to be clear. Interviews with vulnerable victims or vulnerable witnesses must always be formally recorded and be carried out with the support of appropriate staff, for example police may appoint an Appropriate Adult or an Intermediary.

a) if the police are not involved social services 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 video evidence should a case go to court.
c) where police have initially taken the lead for investigation and subsequently determined that there will be no further police action and a Section 42 duty exists, social services will establish the desired outcomes of the adult 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) carers must be offered an assessment
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 may require input from their own professional bodies, unions or legal services.

i) employees, service proprietors or managers can face disciplinary action under the Care Standards Act 2000 or from their own professional bodies.

j) members of the public who abuse will probably be subject to police investigation and may also be subject to action by housing authorities, race equality units etc. As they are outside service or professional frameworks, action through or civil or criminal courts may be considered.

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, these other actions.

The co-ordination role involves sharing 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 time frames 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.

9.5 Interviewing adult at risk and witnesses
The adult should not be interviewed alone or in the presence of the alleged perpetrator. 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 social services 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

9.6 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.

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 perpetrator(s)
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. Case Conference

10.1 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 so far 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.

10.2 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. Where it is important that an individual's General Practitioner attends the case conference, the meeting should be held between 12.00pm and 4.00pm to facilitate this.

10.3 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:

a) establishing and recording the established facts; discussion and joint decision making about findings and the circumstances surrounding the alleged abuse
b) deciding if 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 perpetrator
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 people, agencies and services on a 'need to know basis', including the referrer.
h) ensuring that, where ongoing concerns exist appropriate monitoring systems 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 issues should be referred to the Chair or Deputy Chair of the Safeguarding Adults Board.

10.4 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. 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 representative or advocate 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) Professionals involved may be:

i. Care Manager
ii. Social Worker
iii. CPN
iv. GP
v. District Nurse
vi. Continuing Health care Nurse
vii. Safeguarding Lead Nurse
viii. Contracts Manager
ix. CQC
x. Police
xi. Office of the Public Guardian
xii. DWP
xiii. Trading Standards
xiv. Solicitor from Kent County/Medway Council legal services
xv. Representatives from relevant voluntary organisations
xvi. Provider agencies
xvii. HR

e) person who was alleged to be responsible for the abuse/neglect should only be invited to the case conference in exceptional circumstances and the DSO will take such a decision in discussion with a senior manager. Where this is deemed appropriate they would only be invited to the parts of the conference where discussion relates to them. If the person is another client, then a separate conference may be convened to address their needs.

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.

10.5 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.

10.6 Chairing a case conference
The DSO will usually chair the case conference and formal 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) responsible for the abuse and the setting. If any member of staff is implicated the employer should be invited to attend the relevant part of the conference together with an HR representative if appropriate. If a carer or manager from a regulated setting is implicated, the service provider needs to consider the use of their disciplinary processes and referral to Disclosure and Barring Service or a professional body. If a service user is implicated a separate meeting may be held to consider the issues for them.

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 Vetting & 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. They will be circulated to participants marked 'Highly Confidential' on a 'need to know basis'. Written reports provided by agencies will not be circulated with the minutes, unless this has been agreed at the meeting. They will be retained in the closed section of the client's file together with all other adult protection papers related to the case.

In cases where the case conference makes a recommendation that the employer considers taking disciplinary action or making a referral to the Disclosure and Barring Service, the DSO will make a copy of the minutes, or a summary report, available to the employer.

10.7 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 police, social services and other relevant agencies are essential.
11. Responsibilities

11.1 Designated Senior Officer (DSO) responsibilities

As the DSO you are responsible for deploying the Section 42 duties, the overall co-ordination and management of the safeguarding case and chairing any meetings that may be necessary. In complex cases involving care de which have been managed as level 4 cases within the framework, the DSO will have been heavily involved in coordinating the various strands of the Enquiry. It is therefore recommended that consideration be given to commissioning an independent chair for the case conference and any establishment case conferences (this may be a senior manager from another locality or team).

You should delegate the task of making enquiries and assessing the findings to appropriately trained and experienced staff, who will report back to you. This person will be referred to as the Inquiries Officer (IO). You will need to provide support, supervision and advice to the IO and ensure that they have the resources necessary to carry out their task (this includes time, admin support and another person with whom to share the task of interviewing).

If you are the DSO managing the case you are responsible for:

a) seeing that there is a completed alert form on file and in Medway the concerns will be recorded within Framework Adult Safeguarding Alert Episode and in Kent the Kent Adult Safeguarding Alert Form will be completed and information recorded on SWIFT.
b) ensuring steps are taken to keep the adult safe while initial enquiries are made
c) using initial enquiries to decide if the adult is at continuing risk of harm. These initial checks with other agencies and departments will also be necessary to determine whether there are other adults or children who may be at risk. It is important that any contacts or visits by care managers, social workers, health staff or regulatory staff do not alert possible perpetrators to the issues of concern unless this is unavoidable.
d) Deciding the status of the enquiry: Does it meeting the criteria for a Statutory Section 42 enquiry or will a non-statutory enquiry be required.
e) consulting police if there is a possibility that a crime has been committed. Any emergency action to protect the adult may alert the alleged perpetrator resulting in evidence being removed or altered. Hence the police may wish to be involved in any emergency action to preserve forensic evidence or documentation.
f) in the event of the death of an adult at risk and where safeguarding concerns already exist or are raised around the time of death, ensure that Coroner's Office is informed of the safeguarding issues as a matter of urgency, if the police have not already done so. The Coroner will make arrangements for any investigations considered necessary.
g) if abuse is alleged against a staff member who is providing ongoing care or support to adults at risk it will be necessary to consider, prior to any planning meeting, if action needs to be taken to reduce any further risk that this staff member might pose to others. This may also serve to protect the staff member from further allegations being made against them. You should inform the service's manager as soon as possible about the issues to enable them to take appropriate action to protect the 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 appropriate professionals, agencies, services and departments and any other person who has information
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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 8).
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 in the closed/restricted part of 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 with or without the support of other agencies 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. This is a major responsibility and the DSO should have appropriate training and support to undertake the task (see Guidance Section 22)
p) ensuring that a minute-taker is appropriately trained and skilled; identified in advance of the meeting; be updated regarding the case and possible issues that are likely to arise (Guidance Section 23)
q) 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.
r) 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
s) As chair of the planning meeting or case conference you should take responsibility for recommending that the employer makes a referral to the Disclosure and Barring Service (DBS) in appropriate cases. Where they 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 may have placed an adult or child at risk.
t) If the employer is reluctant or refuses to make the referral, this should be reported to CQC, who will take responsibility for following this up with the employer. This should be recorded.
u) ensuring that action points from formal meetings are circulated within 2 working days and minutes to be circulated in 10 working days unless exceptional circumstances make this impossible.
v) ensuring that the outcomes of the case are conveyed to relevant parties.
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w) where an inquest or court case is likely the DSO must alert senior managers in all agencies involved. If witnesses may be called from the social services, a Senior Manager must be informed. It is also recommended that any vulnerable witnesses have access to support when attending court and in criminal cases it could be necessary to work closely with police and or agencies like Victim Support to assist with the possible need for a witness management system to be in place.

11.2 Inquiries Officer (IO) responsibilities
The role of the IO is central to the safeguarding process. You 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. 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 to ensure that:

a) an appropriate alert/referral form has been completed by the professional receiving the initial information and that this is updated on the form and data base as additional information becomes available.

b) the safeguarding data has been entered onto the adult protection Section of the client database

c) the safety of the adult(s) in liaison with the DSO

d) wider issues of communication, language, culture, religion and gender are taken into account when planning the Enquiry

e) a complete record of contacts, meetings, phone calls, interviews and decisions is made and kept in the closed Section of the adult’s file

f) the Enquiry is made with other services (where appropriate) to assess the facts and producing a written summary of findings to aid decision-making (Safeguarding Adults Checklists for Practitioners – Section 6).

g) any other actions identified throughout the Enquiry are appropriately dealt with

11.3 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 protection 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 social services, 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 13). If they decide that an adult protection referral should be made to social services, they may decide to withhold the name of the member of staff who originally identified the abuse.

e) if the alleged abuser 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.
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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 15).

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) an accurate detailed record of the adult safeguarding concern should be made as soon as possible (Guidance Section 4). Care must be taken to ensure that the recording is kept in a secure place to ensure that an alleged abuser does not have access to it. This could compromise any Enquiry.

i) if the alleged abuser 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.

j) if an adult safeguarding referral has been made to social services or to the police, if a crime is suspected, no attempts should be made, by the service, to question the adult(s) or vulnerable witnesses. This will be done as part of a statutory enquiry and assessment of the issues which will be agreed as part of the adult safeguarding planning process. The service provider should be involved in the planning and the Enquiry and attend meetings unless there are very clear reasons to suspect that their involvement would compromise any stage of the process.

k) there is an expectation that managers and staff providing services to adults will co-operate fully in any adult safeguarding Enquiry and comply with any recommendations made in a post abuse action plan.

11.4 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 social services or the DSO for the appropriate client group.

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 KCC or Medway.

d) all commissioners should support the adult safeguarding process by attending any relevant planning meetings and carrying out agreed actions.

e) 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.
f) 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.

g) close liaison should be maintained between commissioners and the DSO with regard to any service contract changes that may be necessary, throughout the process.

11.5 Regulatory Authority, Care Quality Commission Responsibilities

a) CQC are responsible for setting essential standards of safety and quality by registration and by ongoing monitoring of a provider’s compliance
b) CQC can deploy a range of enforcement powers where registration requirements are not being met in services with poor quality outcomes
c) where CQC identify safeguarding concerns they advise the social services by means of referral form
d) when social services are aware of safeguarding concerns in regulated services, they will advise CQC and invite them to be part of the planning process.
e) CQC will either attend the meeting or provide the DSO with relevant information required to support safeguarding activity, they may also request the minutes of That meeting for more information about the role of CQC see CQC’s “Our Safeguarding Protocol” February 2013.

11.6 What are my responsibilities if I believe abuse has occurred in a service provided by an Acute Hospital Trust?

Abuse or neglect must be reported to social services in order to decide if a Statutory s42 responsibility exists. This duty will be deployed where necessary and social services can cause enquiries to be made by the Trust. This means that the patient’s preferred outcomes should be established and the Trust should enquire as to how, why and when and how the alleged abuse took place and by whom. They will co-ordinate these actions within agreed timescales, aiming to meet the patient’s desired outcomes. This will involve oversight from social services and the ability from that agency to challenge the Trust, should they find any outcomes to be substandard. (Protocol Section 13)

a) The Trust may at any time request advice and guidance from social services DSO and for social services to provide an independent advocate, if required.
b) If a carer is involved in the case, the Trust must advise social services so that a carer’s assessment can be offered.
c) If you are a visitor to the hospital and you think you have witnessed abuse or neglect you should report your concerns, preferably to a Trust Senior Manager; police (if you think a crime has taken place); the Patient Advice and Liaison Service (PALS); the local Clinical Commissioning Group or to local adult social care

d) If you are a member of Trust staff you must follow their adult safeguarding procedures and be mindful of the advice set out within this document. If you do not believe your concerns have been taken seriously you may use the hospitals escalation procedures or use the NHS whistleblowing policy. You may also consider approaching your professional body for advice.

11.7 Employer responsibilities

Employer is used as a generic term and includes all key personnel involved in the management of the service. 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
Adult Safeguarding Protocols

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 Local Authority Enquiry, which may involve a police investigation and advice is sought from social services where any doubts may exist
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 20).

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 social services, which are the lead agency.

11.8 Crown Prosecution Service responsibilities
When the police have gathered all available evidence, a decision will be made whether to refer the case to the CPS for charge advice. However, if the crime is of a minor nature and the offender admits to it, the police will determine the outcome of the case.

- The CPS will review the matter within agreed timescales in accordance with the Code for Crown Prosecutors and the CPS policy and guidance on prosecuting domestic violence, disability hate crime and crimes against older people and sexual exploitation. They will also take account of any local protocols to which the CPS has signified its agreement. The advice will be issued to the police for them to take any further action.
- If a prosecution is started, but in the course of continuing review, a decision is taken not to go ahead, the Crown Prosecutor who makes that decision will write to the victim to explain the reason for the discontinuance. In cases of violence or sexual exploitation, where discontinuance is being considered, a second opinion will be sought from another experienced prosecutor before any action is taken.
12. Adult Safeguarding Consultation Protocol between Police and Social Services

Adult Safeguarding Concern Form
Completed

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

Stage 2
Consultation with other agencies and services

Yes

Possibility

No

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.

Guidance Notes on Consultation
AS is a multi-agency responsibility and Social Services 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 any possibility 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
Social services are 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 Protection Protocol between Adult Social Services 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, any allegation of abuse or neglect occurring within the services provided by an Acute Hospital Trust must be reported to social services to enable them to decide if a Statutory Section 42 duty to make Enquiries exists.

The Local Authority social services statutory adult safeguarding duties mean that they are responsible for making Enquiries although it may require others to undertake them. Social services 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 social services 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. Adult Social Services representatives may be asked to provide support to the patient and or their family during the enquiry process.

Where it is determined by social services 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 social services 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 social services and request that social services commissions an independent advocate to support the patient if required.

If a carer is involved in the case, the Trust must advise social services 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 social services to enable the Community Based Adult Social Services Senior Manager/Service 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/FRAMEWORKI.
14. Allegations of fraud or deception against NHS service or a staff member employed by an NHS body

All adult safeguarding concerns that may also be a crime must be the subject of consultation with the police (please see Protocol Section 16). If a concern refers to alleged fraud or deception by an NHS staff member, police have responsibility to advise the NHS Counter Fraud Service (NHSCFS) (please see Guidance Section 27). If appropriate an NHSCFS representative may attend or send a report to the safeguarding meetings, which will assist with decision making regarding roles and responsibilities and achieving outcomes, as part of the Section 42 Enquiry. Should the NHSCFS discover safeguarding concerns in any of their own investigations, they in turn, will advise social services.

The Financial Toolkit has been developed to aid good practice in making enquiries where financial abuse has been reported: Financial-abuse-toolkit.pdf
15. 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.
Thresholds for Managing Concerns About Pressure Ulcers

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?

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?

Critical
Urgent statutory police and/or social care action/investigation required

Serious Concerns Established
Raise KASAF immediately
There may be ongoing risk to the individual and/or others

Concern remains
Discussion with line manager (or equivalent), safeguarding lead and/or social services
Has concern prompted an internal investigation?
KASAF may be raised in light of known facts

AP1 COMPLETED AT THIS TIME
Pressure ulcer concern – Establish the facts not opinion
Is the person an adult at risk?
Do you know the person’s wishes or feelings re: what they want to happen?
Location of where care was provided?
What is the category of pressure ulcer assessed?
How long has person had the PU?
Who has been involved in the care/treatment?
Is the treatment appropriate for the care of the PU?
Have you discussed your concern with the care provider?
Have they given responses to relieve your concerns?
Are controls in place to reduce risk/further harm?

Yes
Concerns remain

No
Concerns remain

Please see Threshold Guidance sheet for examples of concern

Source Acknowledgement: Newcastle Safeguarding Adults Board – Safeguarding Threshold Guidance

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 221846

Medway Adult Social Care Contact Details
For a telephone consultation 9—5pm
(01634) 334466
Out of hours service 08457 62677
Fax: During working hours (01634) 334504 or out of hours service (01233) 545596
Secure Email: During working hours:
ss.accessinfo@medway.gov.uk clsrm.net
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

No, but further actions required
- Discuss with local safeguarding lead
- Gather more information
- Referral for specialist advice/input e.g. tissue viability nurse (TVN)
- Carry out internal RCA investigation, the outcome of which could lead to raising an KASAF
- Consultation with social services
- Re-evaluate information/facts
- Do you still have concerns?

Yes
Concerns remain

No
Concerns remain

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.

<table>
<thead>
<tr>
<th>Lower Level Pressure Ulcer Concern</th>
<th>Significant</th>
<th>Very Significant Harm</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Remember the cumulative effect of low level concerns may lead to harm)</td>
<td>Concern Remains / Serious Concerns confirmed KASAF completed</td>
<td>Provider Incident investigation prompted</td>
<td>KASAF + Urgent statutory Police and/or Social Services action Investigation Multi agency contribution to Investigation/ SAR/DHR</td>
</tr>
<tr>
<td>Isolated missed home care visit - no harm occurs</td>
<td>Isolated incident</td>
<td>Inexplicable Pressure Ulcer development and deterioration within a care setting or where the person is supported with personal care by paid worker.</td>
<td>Inexplicable pressure ulcer Establishment of facts supports that there is no appropriate management of contributory factors.</td>
</tr>
<tr>
<td>Minor events that still meet criteria for ‘incident reporting’</td>
<td>Care provider immediately addresses concerns raised and provides report of investigation</td>
<td>Transfer of care where as a result of inadequate sharing of information and planning harm occurs</td>
<td>The concerns identified in this case may have implications for others in receipt of care from the same team or agency.</td>
</tr>
<tr>
<td>Patient not concordant with assessed care plan</td>
<td>Clear plan in place which introduces controls to reduce risk</td>
<td>Rigid/inflexible routines which fail to provide individual care needed.</td>
<td>There are known reports of other vulnerable adults developing inexplicable pressure sores by the same care provider(s).</td>
</tr>
<tr>
<td>Informal carer requiring additional support to meet adult’s needs</td>
<td>Multi-agency case conference called where required to meet needs of service user</td>
<td>Service user is aware of the risks of non concordance with care plan and this is clearly recorded.</td>
<td>Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pain, category 3 / 4 pressure ulcers, dehydration, malnutrition, loss of independence/confidence</td>
</tr>
<tr>
<td>MCA has been considered in least restrictive approach to manage pressure area care</td>
<td>Patient’s co-morbidities are such that PU development would have been likely.</td>
<td>Inadequacies in care provision leading to discomfort - no significant harm e.g. occasionally left wet</td>
<td>Bad practice not being reported and going unchecked</td>
</tr>
<tr>
<td>Patient’s care plan not person-centred</td>
<td>Poor access to aids for independence</td>
<td>No access to aids for independence</td>
<td>Failure to support adults at risk to access health, care, treatments</td>
</tr>
<tr>
<td>Patient was receiving planned and well provided end of life care</td>
<td>Poor informed care practice but no significant harm</td>
<td>Care planning documentation not person-centred</td>
<td></td>
</tr>
</tbody>
</table>

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

March 2015
16. Medication Errors

16.1 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

16.2 What is a medication error?

Every day approximately 2.5 million medicines are prescribed to patients in hospital or the community and while most medicines are used in a safe and effective way, errors are one of the most common causes of patient harm, accounting for 20% to 30% of reportable incidents in NHS organisations. 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).11

The Care Quality Commission (CQC) sets out Essential 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.12

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12 CQC Guidance, July 2013
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 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.

16.3 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 consultation/supervision
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.

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:

i) a death
j) an injury
k) abuse or a safeguarding concern
l) 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:

m) Health and Safety Executive (HSE)

n) National Patient Safety Authority (NPSA)
o) Medicines and Healthcare Regulatory Authority (MHRA)
p) Registrants Professional Body e.g. NMC, GMC, AHP
16.4 Threshold guidance for assessing and reporting medication errors

Kent Adult Social Care Contact details:
For a telephone consultation
9-5pm: 03000 416161
Out of hours: 03000 419 91
Secure Email: CentralDutyTeam@kentcsx.gov.uk
Secure Fax: 03000 419 91

Medway Adult Social Care Contact Details
For a telephone consultation
9-5pm: 01634 334 666
Out of hours: 03000 419 91
Secure Fax: 01634 334 504
Out of hours: 03000 412 345.
Secure Email: ss.accessandinfo@medway.gov.uk.cisf.net
Out of hours: CentralDutyTeam@kentcsx.gov.uk

CQC Contact details:
Tel: 9-5pm: 03000 616161
Fax: 03000 610171

HSCA notifications@ccc.org.uk

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

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**Threshold Guidance for Assessing and Reporting Medication Errors**

**High Risk**

**Tier 3 – 4**
Threshold for adult safeguarding met
Safeguarding referral to be made.
Actual harm or significant risk of harm to adult
Could be a single event where no harm has occurred but criminal/legal implications necessitate a referral.
Consider the need for internal SIRCA

**Complex**

Tier 4
Safeguarding referral to be made
Urgent Statutory Multiagency response required

**Tier 3**
Follow K&M Safeguarding Process

**Tier 2**
Follow local incident reporting procedure/investigation
Update risk assessment/s and documentation, review threshold criteria and consider adult safeguarding

In addition to Tier 1 - discussion with local safeguarding lead/social services/social services/management/management and updates under internal processes/protocols, e.g. internal investigation, HR policy of Serious Incident Root Cause Analysis investigation

**Tier 1**
Follow local incident reporting procedure/investigation
Update risk assessment/s and documentation, review threshold criteria and consider need to raise safeguarding referral

Patients/service user is safe and robust controls, procedures, processes and systems in place to manage risk; adult at risk consents to agency response or where patient/service user lacks capacity follow MCA guidance

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# 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)

## Lower Level Harm

**Tiers 1-2**
- Follow organisations incident reporting procedure
- Consider impact of recurrent minor incidents/ errors
- Consider impact of recurrent quality in care/practice concerns
- Discuss with line manager/GP/Doctor/Pharmacist
- Discuss with local safeguarding lead or Local Authority (KCC/Medway)
- Consider patient/service users ability to consent
- Consider need for safeguarding alert

**K&M Multi-Agency SA Protocols 2014**

- Missed medication/administration error on one occasion-no harm or distress experienced by Adults at risk
- Delay in administration of medication, but no significant harm or distress experienced by Adults at risk
- Sufficient organisational measures in place i.e. gaps in provision and/or uptake of training, supervision, audit
- Adults at risk and/or their representative identifies medication error, but are satisfied with agency actions/response

## Harmful

**Significant Harm**

**Tiers 3-4**
- Complete Safeguarding Alert
- Follow local incident reporting procedure/investigation
- Consider need to initiate SI/RCA investigation process
- CQC notification

These incidents/concerns should be addressed under Multi-agency safeguarding protocols for Kent and Medway.

## Critical Tier 4

- Complete Safeguarding Alert
- Agencies contribute to statutory investigation process
- CQC notification

These incidents/concerns should be addressed as potential criminal matter – contact Police/Emergency Services immediately

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**No harm to Adults at risk**
- Recurring missed medication or administration errors
- Medications not available when vulnerable adult is transferred or discharged from care environment
- Insufficient organisational measures in place to provide assurance
- Complaint from Adults at risk and/or their representative but, following investigation, they are satisfied with agency actions/response

**No harm to Adults at risk**
- Missed drug round or recurrent episodes of missed medication or error/ies
- Medication error involving controlled drug occurs
- Medication error involving insulin, anticoagulants, antipsychotics, dementia drugs
- Use of medication that is not consistent with the vulnerable adults needs or expressed wishes
- Pain inadequately controlled causing deterioration in physical and/or mental health
- Unsafe practice or systems for the prescription, dispensing, administration, storage or documentation of medicines
- Referer: vulnerable adult and/or representative express concerns not resolved

**Actual harm/ risk of significant harm to one or more Adults at risk**
- Deliberate maladministration of medications
- Covert administration of medication without proper medical authorisation or consent from Adults at risk
- Adverse side effects experienced as a result of the maladministration of medication.
- Medical intervention required following medication error e.g. GP consultation/ A&E attendance
- Inappropriate sedation of patient
- Absence of, or inadequate monitoring of drug levels
- Medication error involves medication often associated with drug misuse or abuse e.g. benzodiazepines, opioids
- MCA not considered when an Adult at risk chooses not to take medication.

**Serious harm or death of Adults at risk**
- Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death of a Adult at risk
- Adults at risk and/or their representative have identified serious concerns and Tier 4 response is their desired outcome
- Urgent remedial action required and implemented through safeguarding adults or quality improvement strategies
Guidance Section
1. **Preventative Strategies**

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

1.1 **Helping adults to protect themselves from abuse**
   a) what constitutes abuse and advice on self-protection
   b) trading standards; police; rogue traders, bogus callers and distraction burglars
   c) how to get help, e.g. support groups and self-advocacy schemes where adults can discuss issues of concern and rally mutual support
   d) making sure they are part of any decisions which affect their lives
   e) staying healthy, aware and involved

1.2 **How staff and carers can minimise risk**
   a) understanding the issues which constitute abuse
   b) acknowledging that ‘it could happen here’
   c) having open and honest discussions about care issues 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 the service can minimise risk**
   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 care plans and risk assessments to identify how the service will meet identified needs
   f) making sure care 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
   j) ensuring staff and volunteers receive training about how to use their practice 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) considering if apparently isolated incidents might be a reflection of problems within the organisation
   n) having clearly understood channels of communication
   o) having clear and easily accessible policies which promote good practice, prevention and wellbeing.
   p) ensuring staff receive regular, structured and recorded supervision which takes their development needs into account
   q) appropriate links with other agencies
   r) being prepared to listen and to respond to staff, users and carers when care practices are questioned
   s) information about standards of care or issues of concern are discussed internally and externally when appropriate
   t) visitors are welcomed and adults are supported to access their community
1.4 How contractors, commissioners and regulators can minimise risk
   a) ensuring that a care plan contains a properly documented needs analysis
   b) ensuring that the contract for care, records the specifications required for the adult
   c) ensuring that the service chosen can meet the needs of the adult
   d) monitoring service delivery from different perspectives
   e) reviewing care standards regularly with adults who may be at risk
   f) listening to adults, their families, visitors and staff about the service
   g) ensuring contracted services recognise the need to train staff to understand the
      importance of the principles of safeguarding
   h) reporting and recording concerns

1.5 Preventing risk in Direct Payments and self-protection

Personal Assistants employed directly by adults through the Direct Payments scheme are not subject to regulation by the Care Quality Commission (CQC). As a result, the responsibility for monitoring care standards rests with them as employer, with the support of direct payment scheme staff. Direct payment recipients should be advised that the contracts they have with their Personal Assistants should include reference to the Kent and Medway Adult Safeguarding Policy, Protocols and Guidance. Personal Assistants should be made aware of safeguarding issues by their employer and must be advised that concerns will be reported in accordance to the Policy. Local Authorities may place reasonable conditions on any agreement to make a Direct Payment and conditions might be introduced to protect an individual with an identified vulnerability. Such conditions need to be proportionate to the risk involved and must not defeat the principal purpose of the direct payment, which is to give people more choice and control over services.  

1.5.1 Direct Payments for adults lacking capacity to consent

All councils must offer Direct Payments to certain eligible adults who lack the capacity and payments can be made to a willing and appropriate ‘suitable person’, such as a family member or friend, who can receive and manages the payment on behalf of the adult.

1.5.2 Direct Payments for people subject to mental health legislation

Councils have the same duty to offer a Direct Payment to eligible people who are subject to mental health legislation as they do to anyone else, however the following exceptions apply:

- People who are on a conditional discharge from hospital under the Mental Health Act 1983 or the Mental Health (Care and Treatment) (Scotland) Act 2003, where local authorities have a power (but not a duty) to offer Direct Payments.

- In respect of a service which a person is obliged to accept as a condition of relevant legislation, councils are not required to offer Direct Payments for that particular service, but can exert a power to do so. This includes conditions attached to Guardianship, leave of absence from hospital or a Community Treatment Order under the Mental Health Act 1983 and certain provisions in criminal justice legislation. (This means that councils have a duty to offer Direct Payments to such a person in respect of a service which is not the subject of a condition, if the person is eligible.)

1.5.3 People who are excluded

People who are subject to drugs and alcohol-related provisions of some criminal justice legislation remain excluded from receiving a Direct Payment. The legislation in question is listed in Schedule 1 of the regulations.

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13 The Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations 2009
1.5.4 Appointing a suitable person
Kent Social Care Health and Wellbeing Directorate and Medway Council have developed a Suitable Person Protocol. This should be used when considering the appointment of a suitable person in relation to mental capacity assessment outcomes i.e. if the adult lacks the capacity to choose a direct payment option but it is in their best interests to benefit from the flexibilities that it could bring them.

Someone cannot just decide to be a suitable person in order to receive Direct Payments on behalf of another person and it will mostly be a family member or a close friend already involved in the provision of care for the person concerned. However, regardless of relationship, council must follow the process set out in The Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations (2009) to ensure that the best interests of the adult at risk are prioritised.

Before making Direct Payments for someone lacking capacity, the council has to gain agreement from the Suitable Person or a surrogate (a donee of a Lasting Power of Attorney created by the adult or a Court Deputy, appointed by the Court of Protection whose decision making extends to securing services to meet a person’s care needs).

Unless the council establishes that the representative is either unwilling, incapable of managing Direct Payments or for some other reason inappropriate to act as a suitable person, by virtue of the powers already given to them to manage the affairs of the person lacking capacity, they would normally be the first choice of suitable person. If the representative does not wish to act as a suitable person, the council should then look to see if there is an alternative person who would be willing to act.

Similarly, there may be specific circumstances in which a person other than the representative, in particular a close family member or a friend involved in the provision of care, is considered to be the most appropriate choice of suitable person by those consulted about making Direct Payments in respect of the person lacking capacity. If the council is satisfied that this arrangement would work in the best interests of the person lacking capacity, then it may, with the agreement of any existing surrogate, accept that individual as the suitable person, instead of the representative.

If there is neither a surrogate nor any other representative, then the council itself must make the decision about whether or not someone should act as a suitable person to manage the payments on behalf of the person who cannot consent.

In all cases, whether or not there is a surrogate to assist the council in its decision, and whether or not the proposed suitable person is a representative, the council should, so far as is reasonably practicable and appropriate, consult and take into account the views of the following people before making the decision to make Direct Payments to a suitable person:

a) Anyone who has been named by the direct payment beneficiary before they lost capacity as someone to be consulted, either on the subject of Direct Payments to the suitable person, or related matters such as matters regarding their personal welfare.

b) Anyone currently engaged in caring for the person lacking capacity to consent or anyone with an interest in their personal welfare.

c) As far as is practicably possible, the person who lacks capacity themselves. Councils should ensure that they have taken all reasonable steps to ascertain the wishes of the person lacking capacity regarding who should act on their behalf. This includes consideration of any written statement of wishes and preferences made by the beneficiary before they lost capacity.

d) Any representative or surrogate of the person lacking capacity. Generally speaking, an attorney or a deputy should always be consulted, even if they are not going to take on the role of suitable person. For instance, a professional person with a lasting
Adult Safeguarding Guidance

power relating to a person’s property and affairs might still have information about the person’s wishes and feelings which should be taken into consideration when deciding whether someone is a suitable person to act on their behalf.

There may be occasions where it is in the best interests of the person lacking capacity to consent for their personal information to be revealed to the people consulted. Councils should ensure that social care staff who are trying to determine a person’s best interests act lawfully at all times, following their own professional guidance, as well as other relevant guidance concerning confidentiality. Legal advice should be sought where necessary.

1.5.5 Conditions to be met by the suitable person
As with all Direct Payments, the council must be satisfied that the beneficiary’s needs can be met by means of the Direct Payments and that the recipient (in this case the suitable person) is capable of managing the Direct Payments. To help ensure that the suitable person does not mismanage or misuse the Direct Payments, the Regulations set out a number of conditions that the council should require of the suitable person before it makes Direct Payments to that person on someone else’s behalf.

Unless the council is satisfied that it is necessary to satisfactorily meet the person’s needs, Direct Payments may not be used to secure services from the spouse, civil partner or partner of a person lacking capacity. Neither can they be used to secure services from a close relative, spouse or partner of a close relative of the person lacking capacity who is currently living in the same household as the person lacking capacity. There may be occasions when the council decides that it is necessary for the suitable person to use the Direct Payments to secure services from a member of the family of the person lacking capacity. However, such situations are likely to be exceptional and the council should be satisfied at all times that arrangements are made in the best interests of the person lacking capacity.

Kent Social Care Health and Wellbeing Directorate and Medway Council have their own Exceptional Circumstance Procedures.

The suitable person manages the Direct Payments on behalf of the person lacking capacity, on the understanding that in doing so, they must act in the best interests of that person, within the meaning of the 2005 Act. This includes, as far as is reasonably practicable, encouraging and permitting the person lacking capacity to have the fullest input possible into decisions affecting them. The suitable person should be required to take all practical steps to ensure that decisions are taken in the best interests of the person who lacks capacity. This may involve consulting other people close to the person lacking capacity, or health and social care professionals where appropriate. To ensure that the service recipient can maintain as much control and independence as possible, the suitable person should be required to notify the council as soon as they believe the person has regained capacity.

1.5.6 Where disputes arise
The suitable person may face disagreements with Kent Social Care Health and Wellbeing Directorate or Medway Council, the Local Authority should refer to their own Suitable Person Protocol and the Direct Payment Guidance 2009 with others involved in or concerned for the welfare of the person lacking capacity to consent. Family members, partners and carers may disagree between themselves about how the Direct Payments should be spent, or they might have different memories about what views the person expressed in the past. Carers and family might disagree with a professional’s view about the person’s care or treatment needs.
Adult Safeguarding Guidance

The Local Authority should support the suitable person to balance these concerns and decide between them. The authority should include the person who lacks capacity (as much as they are able to take part) and anyone who has been involved in earlier discussions. It may or may not be possible to reach an agreement at a meeting to air everyone’s concerns, but any decision must always be in the person’s best interests, following the best interest’s principles in the 2005 Act.

1.5.7 Advocacy
An advocate may be useful in providing support for the person who lacks capacity to consent either in terms of deciding who should act as a suitable person on their behalf or, subsequent to that decision being made, how the Direct Payments should be used to meet their assessed needs. Advocates may be especially appropriate if:

a) the person who lacks capacity has no close family or friends to take an interest in their welfare
b) family members disagree about the person’s best interests
c) family members and professionals disagree about the person’s best interests
d) the person who lacks capacity has already been in contact with an advocate; or,
e) There is a concern about the protection of a vulnerable adult.

1.5.8 Approaches to risk
The changes to the direct payment scheme brought about by the Health and Social Care Act 2008 were designed to enable adults lacking mental capacity to consent to Direct Payments to benefit from the choice and flexibility that Direct Payments can bring. People lacking mental capacity may not be able to exercise the same level of choice and control as other direct payment recipients. However, Direct Payments can still provide a vital means of ensuring that choices about the person’s care and support can be made by those who are best placed to understand their needs and preferences and who know how to involve them as much as possible in decisions to support their best interests. However, councils should be very clear about the unique position of adults lacking capacity, who may not only be more vulnerable to abuse, but also less able to tell people when it is happening. Councils should therefore take steps to develop a comprehensive risk management strategy, which should inform the care plan and subsequent arrangements for monitoring and review. Application of a risk matrix determines the level of risk which in turn informs the frequency of reviews and whether they are carried out in person or otherwise eg. telephone, text, e-mail, Councils should consider involving other people known to the person lacking capacity, particularly those consulted when the suitable person was first appointed, as well as independent advocates where appropriate. The Mental Capacity Act Code of Practice specifies that Independent Mental Capacity Advocates (IMCAs) can be used in care reviews where the person concerned has no one else to be consulted.

1.5.9 Safeguarding
There are various legislative provisions that have been put in place to support safeguarding measures for adults lacking mental capacity. The Regulations specify that if the suitable person is not the spouse, civil partner, partner, close relative (or spouse or partner of a close relative) or friend involved in the provision of care of the person lacking capacity, then the council must obtain a CRB check for that suitable person, as a further protective measure for the person lacking capacity. For example, the suitable person may be an independent care broker or a solicitor acting as a professional deputy, who may not previously have been personally known to the service recipient.

Anyone caring for a person who lacks capacity for the purpose of the Mental Capacity Act 2005 who wilfully neglects or ill-treats that person can be found guilty of a criminal offence, punishable by up to five years in prison, or a fine, or both. In addition, the Fraud
Act 2006 created a new offence of ‘fraud by abuse of position’. This may apply to a range of people including attorneys under a lasting power of attorney (LPA) or enduring power of attorney (EPA) or deputies appointed by the Court of Protection to make financial decisions on behalf of a person who lacks capacity.

Someone acting as a suitable person receiving Direct Payments on behalf of someone lacking capacity to consent to the making of Direct Payments may be guilty of fraud if they dishonestly abuse their position, intend to benefit themselves or others, and cause loss or expose that person to the risk of loss. Without discouraging people from taking up the role of suitable person, councils should also make clear to anyone considering the role the consequences of financial misconduct or other forms of neglect or ill-treatment.

The Regulations also provide councils with the power to impose other conditions on the suitable person if they think fit. If councils believe that it is necessary to ensure the best interests of the person requiring services to impose other conditions, then this should be done. Kent Social Care Health and Wellbeing Directorate and Medway Council should refer the Direct Payment Guidance 2009.

The following information identifies particular areas of risk and makes some suggestions about how these risks may be minimised.

### 1.5.10 Risk factors and management for adults receiving direct payments

<table>
<thead>
<tr>
<th>Area of risk</th>
<th>Description of risks</th>
<th>How to minimise the risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to adult's home and identification details by strangers</td>
<td>Adult may be unable to protect themselves and risk of abuse is likely to be increased through the recruitment and selection process, if this is carried out by the adult in isolation. Non-bonafide strangers will have access to the adult's home, identity and contacts.</td>
<td>Direct Payments users are recommended not to carry out recruitment and selection from their home, but to use a PO box number, dedicated telephone line for job applications and a room for the interviewing process, both of which, with sufficient notice, are available from the social services. Those who are unable or unwilling to use this facility are advised to be accompanied by a third party or representative or Direct Payments support worker. The Direct Payments support service advises service users to carefully scrutinise candidates’ details and references. Direct Payments users are informed that they can purchase services through home care agencies that vet their employees and are regulated by CQC.</td>
</tr>
<tr>
<td>Lack of familiarity with recruitment and selection process</td>
<td>Adults may have little understanding of recruitment, selection and employment procedures. This could potentially result in the unwise selection of personal assistants.</td>
<td>The Direct Payments support service provides guidance and support to adults regarding employment issues. This decreases the risk of unwise selection of personal assistants.</td>
</tr>
<tr>
<td>The lack of requirement for police checks through the Criminal Record Bureau</td>
<td>Care workers employed by adults at risk through the Direct Payments Scheme are not required by law to be police checked through the Criminal</td>
<td>Adults are encouraged to ask social services to carry out enhanced CRB checks for personal assistants they have interviewed and wish to employ. Adults are strongly recommended to await the outcome</td>
</tr>
</tbody>
</table>
The requirements for adults who lack the capacity to choose the Direct Payment option.

| Records Bureau. It is not possible for service users to undertake these checks themselves. An adult lacking capacity may be more vulnerable and less able to recognise or voice areas of concern. | of the CRB check, wherever possible before employing a personal assistant. If a Suitable Person is receiving a direct payment on behalf of someone else because they lack capacity, and they are not a family member or friend, then a CRB check in accordance with the Direct Payment Regulations 2009 MUST be carried out on anyone that they employ. |

The lack of regulation

| Care workers employed through Direct Payments Schemes are not subject to regulation by the CQC so there is no monitoring of care standards. This could increase the risk of abuse to the adult. Direct abuse has been experienced or is suspected. | When carrying out care plan reviews, care managers enquire about the standard of care and of care workers employed under the Direct Payments scheme. Direct Payments users are given information regarding risk, both at the outset of the process and at reviews, so that they may make informed decisions. Reviews of finances are also undertaken by the care manager as part of the review process. Adults should contact their care manager or direct payment support worker if they have concerns. Users or other concerned adults have access to advice and support through social services in all cases where abuse is suspected. |

Links to further information

https://www.gov.uk/apply-direct-payments

2. Possible signs of Abuse
This Section provides further information to assist in the identification of adult abuse and should be read in conjunction with Policy Section 4: Types 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 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 deployed and if there is suspicion that an adult at risk has been intentionally injured or as a result of carelessness or neglect, police and social services 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 abuse and exploitation

Sexual abuse and exploitation 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 both social services and the police who will advise on next steps and possible sexual offences. This should be done within 24 hours given the need to protect potential forensic evidence. Where allegations of sexual crimes are made, how the allegation came about, exactly what was said and the demeanour of the person making the allegation should be recorded and immediately referred to the police. This is likely to require a S42 Enquiry.

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

d) have deliberately ill-treated the person, or
e) 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 social services 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 take action to form 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 try and consider neglect which may result in abusive practice - which may have arisen from poor standards, poor clinical governance; poor leadership and a lack of knowledge or training, versus specific allegations regarding intentional abuse, particularly from a whistle blower.

Indicators of neglect in such circumstances may be:

a) inadequate clothing; food; fluids; heating; lighting or call bell access
b) poor assessment and recording about adult's needs
c) poor 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) un-characteristically becoming manipulative, uncooperative and aggressive.

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

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

2.7 Financial abuse
There is a duty to protect adults at risk from financial abuse and to report concerns or irregularities, with transparent actions, in the knowledge that dignity and privacy are very important. Financial assets and possessions are for the benefit of that person and use by others (without expressed permission) may constitute financial abuse: e.g. theft or misappropriation may 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 personal possessions
g) substandard living conditions compared to the adult’s accustomed lifestyle
h) extraordinary interest in adult’s financial affairs or assets

For more information please see: Assessment: Financial Crime Against Vulnerable Adults - Report 49

2.8 Discrimination

Discrimination happens in one of the following forms:

a) direct discrimination – this is when a person with a protected characteristic is treated less favourably than others
b) indirect discrimination – this is when a person with a protected characteristic is placed at an unfair disadvantage by putting rules or arrangements in place that apply to everyone
c) harassment – this is unwanted behaviour that is linked to a protected characteristic which violates a person’s dignity or creates an offensive environment for them
d) victimisation – this is when a person is treated unfairly because they’ve complained about discrimination or harassment

The legal basis for this is the Equality Act 2010 and it is against the law to discriminate against anyone because of:

e) age
f) being or becoming a transsexual person
g) being married or in a civil partnership
h) being pregnant or having a child
i) disability
j) race including colour, nationality, ethnic or national origin
k) religion, belief or lack of religion/belief
l) sex
m) sexual orientation

These are called ‘protected characteristics’ and a person is protected from discrimination when they are:

n) at work
o) in education
p) a consumer
q) using public services
r) buying or renting property
s) a member or guest of a private club or association
A person is also protected from discrimination if:

t) they are associated with a person who has a protected characteristic, e.g. a family member or friend
u) 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:

v) is at a disadvantage
w) has particular needs
x) 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:

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

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

bb) prejudicial decision making
cc) being treated differently or unfairly or rudely
dd) a lack of access to jobs; housing; services; education and opportunities
ee) withdrawal, isolation, fearfulness and anxiety
ff) being inappropriately excluded
gg) acute embarrassment
hh) depression and loss of self esteem
ii) resistance or refusal to access services that are required to meet need
jj) expressions of anger and or frustration

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)

Forcing someone to marry can result in a sentence of up to 7 years in prison.

2.10.2 Forced marriage Protection Orders
The Forced Marriage Unit (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 sentence of up to 5 years in prison.

2.10.3 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).

2.10.4 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 or contact the nearest British embassy if they are already abroad, providing 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.

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)
According to the NSPCC, female genital mutilation (FGM) is the partial or total removal of external female genitalia for non-medical reasons and it can be 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. There are four types of FGM and all are illegal and have serious health risks. 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. FGM is usually performed by someone with no medical training and no anaesthetic or antiseptic treatment is used. Victims are often forcibly restrained and cutting is made using instruments such as a knife, pair of scissors, scalpel, glass or razor blade and serious health problems are common.15

FGM has been a criminal offence in the UK since 1985 and in 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison.

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 200316 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 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 social services, 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 social services, or police (or CQC in a regulated setting) as soon as possible and within 24 hours
l) quickly record what was said, using exact words and phrases with ink that can be photocopied
m) describe the circumstances in which the disclosure came about
n) note the setting and anyone else who was there at the time
o) record factual information not opinion
p) Be aware that your report may be required later as part of a legal action or disciplinary procedure

You must not:
q) press the person for more details
r) 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
s) ask leading questions that could be interpreted as putting words or suggestions forward

You must:
t) promise to keep secrets because this information cannot be kept a secret but can be managed confidentially
u) make promises you cannot keep (such as: ’This will never happen to you again’)
v) contact or confront an alleged abuser
w) start an investigation on your own
x) be judgmental (for example ‘Why didn’t you run away?’)
y) 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

The Care Act 2014 has placed Adult Safeguarding on a statutory footing and if it is possible from the information you have received, that an allegation of abuse exists, you **must** contact social services 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 social services for advice. Keeping accurate records is essential.
5. Guidelines to report adult protection concerns to the Social Services 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 social services 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. Some concerns may be able to be dealt with informally but contact should be made to the relevant social services where the alleged abuse happened (Kent or Medway). 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
Or;
for older version on word Kent-adult-safeguarding-alert-form.doc

To make a safeguarding referral to Medway SAF document

For further information please refer to Guidance Section 6 for Kent and 7 for Medway.
6. **Flowchart for reporting Adult Safeguarding concerns to Kent Social Services**

This Section is to support anyone who works with or has contact with adults at risk who may need to report safeguarding concerns to social services where the alleged abuse has occurred in Kent.

**Abuse witnessed or suspected**

1. Where possible, ensure immediate safety and welfare of adult(s) or children.

   1a. Is urgent medical attention required? Call 999
   1b. Is urgent police attention required? Call 999

2. If you believe a crime may have been committed report your concerns to the police dialling 101. Be aware of the need to preserve forensic evidence

3. If you work in a service discuss your concerns with line manager. If you think line manager/service may be implicated you may consult the Police, Social Services or Regulatory Authorities

4. Decide on whether to raise a concern, gathering only essential information necessary to report to Kent Social Services, using the KASAF
   
   If you are having trouble using the form above, please use this version: [Kent-adult-safeguarding-alert-form.doc](#)
   
   or access a consultation and call **03000 41 61 61** between 8.30 and 5 pm or out of hours **03000 41 91 91**

5. If the person does not consent to referral, see if there justifiable reasons to act contrary to their wishes e.g. a crime, risks to others or children; conduct of an employee or volunteer who is part of an organisation providing services to the adult; mental capacity of the person to decide; inability to consent due to undue influence or intimidation; serious harm occurring?

6. Social services will acknowledge receipt of the initial form; will assess information and decide upon the most appropriate response to the concern. This may be a statutory or non-statutory enquiry.

7. Social services will advise the referrer how their concerns will be addressed. The referrer should advise social services of any changes to the adult’s situation.

8. Whenever possible social services will work in partnership with all agencies and services to address concerns, including informing regulatory bodies and relevant commissioners. They will also appoint an advocate for the adult should this be required.

If you have concerns that an issue reported to the Kent Social Services has not been appropriately addressed you should contact Kent’s Central Duty Team on: CentralDutyTeam@kent.gcsx.gov.uk (Secure e-mail*), Central.duty@kent.gov.uk (Standard e-mail) r phone **03000 41 61 61**
7. Flowchart for Abuse Witnessed or Suspected that has occurred in 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 person 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 Medway Council Adult Social Care Team (see contact details). 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. 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 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
8. Adult Safeguarding Guidance for Providers

If it is deemed necessary that an enquiry is launched in relation to an adult safeguarding concern, the following diagram will help to depict the likely flow of events:

<table>
<thead>
<tr>
<th>1. Adult safeguarding concern raised about adult at risk who is receiving care from a residential, nursing, health or domiciliary care service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Consultation takes place to gather information and to enable a decision to be made regarding if a need for a statutory or non-statutory enquiry to take place and if an advocate is needed for the adult. May be supported by a planning meeting led by social services and involving the adult or their representative</td>
</tr>
<tr>
<td>3. If it is decided that a planning meeting will go ahead, multi-agency professionals will probably invited. The referrer and or service provider may be invited to all or part of a planning meeting. If the decision regarding a statutory enquiry has not yet been made it can be made at this point and the level of risk is agreed</td>
</tr>
<tr>
<td>4. Service provider advised of agreed actions</td>
</tr>
</tbody>
</table>

5. **Risk Assessment**

Risks identified and actions detailed. Risks can reduce or increase. Referrals to other appropriate agencies may be needed e.g. DBS. Service may be flagged via social services contracts database and provider will be notified.

6. **Statutory enquiry**

If a criminal investigation is likely the police will lead the Enquiry but social services retains the overarching responsibility for deploying 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: social services; health, contracts or regulators. These enquiries may run concurrently. It will be important to address the scope of alleged abuse and impact on service users. Employers should be cognisant 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 vulnerable person(s) who have been responsible for the abuse

8. Decision taken re the outcome of case (have the desired outcomes of the adult been met) and its status (open/closed) and relevant people advised of the outcome of the Enquiry where it has concluded

9. Monitoring and review of service improvement plan by identified personnel
9. Concerns for d/Deaf and Deafblind people

9.1 Introduction

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 to 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.

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.

If the d/Deaf or Deafblind adult is involved in a safeguarding concern, the support of Sensory Services must be requested, if the adult has a social worker 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 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](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 and is unable to accept Designated Senior Officer (DSO) responsibility. The Team may however assume or support the role of the Inquiries Officer, should a Statutory Section 42 Enquiry have to be made. This will be agreed between the Area and the ASC Team Leader. Where the ASC Team have a current, open case and where safeguarding concerns may exist, exceptions can be made and in those circumstances, the case will be managed with the Area Safeguarding Co-ordinator.
11. Consent and Mental Capacity

11.1 Introduction
The content of this Section is informed by the Mental Capacity Act Statutory Code (View MCA Code of Practice) and its summary (View MCA Summary) (View MCA Easy Read Summary).

In law, every adult has the right to make their own decisions and is assumed to have capacity to do so unless it is proved that they do not. All adults have a right to determine what happens to their own bodies and (if they are able to give it) valid consent must be obtained from them before providing personal care, such as bathing and dressing.

When carrying out adult safeguarding enquiries, it is important to respect the right of an Adults at risk to make decisions with regard to their own safety. They should therefore be encouraged to make decisions that they are able to make. Difficulties arise when it is not clear whether the adult is capable of making a decision or whether the decision is being made under duress.

11.2 What is Mental Capacity?
This refers to the capacity to understand and retain the information in relation to a specific act, decision or transaction, to weigh up their consequences and to communicate the decision, at the time the decision needs to be made.

a) There is no universally accepted definition of mental capacity and the assessment of capacity.

b) Different levels of mental capacity are necessary for different types of decisions. An adult suffering from a mental disorder is not necessarily incapable of giving consent.

c) Mental capacity should always be assessed in relation to the specific issue and context that is being considered.

d) It is important to assess whether the adult is capable of making the particular decision that is required at that point in time.

e) This will recognise that an adult's mental capacity may change (may be regained or developed with support) over a period of time and/or they may have a condition that leads to fluctuations in mental capacity.

11.3 Consent
For an adult to give consent they should be able to understand and retain relevant information that is being given to them, believe it to be true and weighing it in the balance, be able to make a choice.

Within the adult safeguarding process it is always important to consider whether an adult is capable of giving their consent or not as the case may be. This may be in relation to whether they gave consent to:

a) the activity that is deemed to constitute an abusive act
b) whether the adult safeguarding enquiry should go ahead
c) whether certain decisions or actions should be taken during the process
d) whether recommendations set out in the safeguarding plan should be put into place.

It will be important to make a decision about the consent issue with regard to addressing the alleged abuse. An assessment should be made about how much a person understands and how far they are able to make a decision. It will be necessary to consider if:
e) the adult gave consent to any action that was taken
f) the adult is capable of giving consent i.e. do they understand what they have consented to?
g) their apparent consent should be disregarded if it was given under duress as a result of exploitation, intimidation, undue pressure or fear of reprisal. Consent given under such conditions is not legally binding

In law most adults are deemed to have capacity to make decisions. Exceptions to this are those who:

h) have severe learning disabilities and are not deemed able to give consent to sexual acts
i) have already been assessed as incapable of managing their own finances. e.g. their finances are subject to Court of Protection involvement
j) are subject to certain orders under current mental health legislation.

Where there is any doubt about an adult's mental capacity and/or their ability to consent it is important to have an appropriate medical/social assessments carried out. When an adult with capacity has made a decision that they do not want action taken to address alleged abuse, this will be respected unless failure to act will leave other adults or children at risk or a crime has been committed.

11.4 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 precede 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.

11.5 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 assessment a referral should be made to the appropriate health professionals. 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.

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

In some situations, in order to protect an adult who may lack capacity or others who may lack capacity; it may be necessary to take decisions on their behalf. In taking these decisions it is important that the person doing so, acts in the best interests of the adult and with due regard to their professional, lawful accountability and duty of care. In doing so the professional must:

a) act in a way that is necessary to promote the adult's health or wellbeing or to prevent deterioration in their quality of life

b) avoid discrimination and not make assumptions about the adult’s best interests simply on the basis of age, appearance, condition or behaviour

c) ensure that the intervention is as least restrictive as possible to maintain the safety of the adult.

d) ensure that any decision is made with proper regard for the due process of law.

e) ensure that the ascertainable past and present wishes and feelings, beliefs and values of the adult concerned are taken into account

f) ensure that the adult is encouraged and supported to participate in any decision made which affects the adult

g) be satisfied that the expressed wishes of the adult were not made under undue influence

h) consider any other factors the person would be likely to consider if they were making the decision or acting for themselves

i) if it is practical and appropriate to do so, consult other people for their views about the person’s best interests.

An Independent Mental Capacity Advocate (IMCA) identified within the Mental Capacity Act 2005 must be instructed for people lacking capacity who have no one else who ‘it would be appropriate to consult’ (other than paid staff) whenever:

j) an NHS body is proposing to provide serious medical treatment

k) an NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home and the person will stay in hospital longer than 28 days or in the care home longer than 8 weeks.

An IMCA may be instructed, subject to individual case discussion with the relevant commissioning Local Authority, to support someone who lacks capacity to make decisions concerning:

l) care reviews when no one else is available to be consulted

m) adult safeguarding concerns, whether or not family, friends or others are involved

For additional information regarding the IMCA Service please View IMCA Booklet
12. Learning Difficulties/Disabilities and Adults with Cognitive and Communication Difficulties/Disabilities

The following descriptors reflect good practice when adult safeguarding enquiries involves an adult with learning difficulties/disabilities or any cognitive and communication difficulties/disabilities.

a) The particular needs of the person must be taken into account when planning an adult safeguarding statutory or non-statutory enquiry.

b) Recognising abuse of people with learning difficulties/disabilities may be difficult due to communication problems and the likelihood that alternative explanations may be given for their behaviour.

c) A range of people who know the individual should inform the involvement with the adult during the enquiries.

d) Particular care should be taken to ensure that the adult’s communication needs are addressed. Speech and language specialist assessment may be indicated where the adult’s communication and comprehension of language is not clear.

e) Support needs to be in place for the adult, their carer and support staff throughout and following the adult safeguarding enquiries. An unpaid carer should be provided with a Carer’s Assessment.

f) The adult should be enabled to make informed choices about their participation in the safeguarding process and an independent advocate should be appointed if they are likely to struggle to understand the process and if they have no suitable representative.

g) Interviews need to be planned to take into account the adult’s method of communication and individual need. It is important to plan the style of questioning to be used.

h) The development of a safeguarding plan should give due regard to any therapeutic services or additional support that is needed by the adult.
13. 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.

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 who will deal with complaints from staff about their concerns about what is happening in the workplace.

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 serious 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 social services, or to the police if they consider that a criminal offence may have been committed.

From 1 January 2012, the Government-funded whistleblowing helpline became a free-phone service provided by the Royal Mencap Society, to provide free, independent and confidential whistleblowing advice. This operates weekdays between 08:00-18:00 with an out of hours answering service available weekends and public holidays and is available to all health and social care staff. A web-based service is also being developed. If you have concerns but are unsure how to raise them or simply want advice on best practice, from 1 January 2012 you can call free on: **08000 724 725**.

There is also a helpful website called public concern at work: [www.pcaw.com](http://www.pcaw.com)
14. Staff Disciplinary Procedures

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 take action to protect them.

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

d) The employer should report their adult safeguarding concerns to the local adult social care office/mental health trust office and advise what actions they have taken to protect adults at risk or children from the risk of abuse.

e) If it appears that a safeguarding enquiry is necessary then police or social services 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 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.
15. **Working with the Police**

15.1 **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 for Kent and Medway.

15.2 **Consent of the adult**

Staff should obtain the consent of an individual before calling the police unless to do so would danger any person or interfere with the effective investigation of crime or result in the interference with, 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.

15.3 **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  
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.
15.4 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

15.5 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 victims 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.

e) where possible, leave things as they are. If anything has to be handled, keep this to a minimum. Do not clean up. Do not touch anything you do not have to.

f) leave weapons where they are unless they are handed to you. If a weapon is handed to you, take care not to destroy fingerprints.

g) 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 alleged perpetrator. 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.

15.6 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 alleged perpetrator 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.
16. The Role of Trading Standards

16.1 Introduction

There is a range of activities that may be accompanied by criminal offences, which can be addressed by referral to Trading Standards as well as to the police. These include the activities of rogue traders, bogus callers and distraction burglary, scams and loan sharking. Rogue traders often intimidate, manipulate or threaten their victims into parting with large amounts of cash and in some cases, into signing over their properties. These incidents often remain hidden. Victims are targeted through cold calling either by telephone, or more often by doorstep visits. The rogues will often target an area meaning that any identified victim may indicate other unknown victims in the vicinity. They will often use lines like:

“I noticed you appear to have a roof tile loose, I’ll have a look for you”
“We are doing work down the road for the Council and have some tarmac left over”
“We’ve done some work for your neighbour and she said you might be interested”

The “traders” will not provide any paperwork, will quote prices that increase dramatically when the victim has to pay, or will find extra jobs that need doing and increase the final price charged.

16.2 Distraction Burglary

Often called ‘bogus callers’ or ‘burglary artifice’ is a crime primarily targeted at vulnerable older people. Offenders pose as officials (including council, police and utility workers) in order to gain access to homes. Once inside the victim is distracted and the burglary is committed. Other examples are where the offender(s) will pose as a motorist who needs some water for his/her car and whilst the victim goes to fetch the water, the offender(s) slips into the house quickly and steals money or other items within their reach. Sometimes it will be somebody engaging the victim at the front door while an accomplice goes to the back of the house and enters, if possible and commits the burglary.

16.3 Scams

These are forms of mass marketing fraud, perpetrated by criminals and aimed at the most fragile members of society by "working" from mailing lists which categorise people as being elderly or vulnerable in some way, they then contact them by letter, phone or email and try to trick them into parting with cash. Those who respond often end up having their details put on what criminals call "suckers lists". They sell these lists to other scammers all over the world. Millions of victims have a condition which the Think Jessica campaign is trying to get recognised as Jessica Scam Syndrome (JSS). The most common form of scam is Scam Mail, which can result in victims being delivered 100+ scam letters a day. Scam mail may use statements like:

a) You have won a lottery, sweepstake or competition... BUT YOU HAVE TO SEND MONEY
b) Money you have won is being held in a holding company... BUT YOU HAVE TO SEND MONEY
c) Somebody has left you an inheritance... BUT YOU HAVE TO SEND MONEY
d) A clairvoyant can stop bad luck or direct good luck towards you... BUT YOU HAVE TO SEND MONEY
e) There is a "secret" deal which will make you rich... BUT YOU HAVE TO SEND MONEY

Scammers send out catalogues selling food, pills, potions, jewellery, clothes, items for home and garden. They guarantee a prize to those who order and make it appear like 'you' are the only one to be getting this amazing offer. They never send the promised prize (though some do send "cheap" goods to keep the victim on the "hook") Instead they send out more promises to get more orders!
16.4 Loan Sharks

This is a well-known criminal activity involving unlicensed lending with high repayments for loans that may never end. The victims receive no paperwork. The lenders may use threatening or abusive behaviour to ensure they are paid, and this repayment may even increase. The victims may be targeted when they are due to get their pension or benefits. In many cases the victims are scared of the lenders, but they may also have a relationship where they believe that the lenders are friends and that the victims owe them. This can make loan sharks difficult to spot. If the victims have mental health issues this may also be exploited.

There is also the possibility that this is directly related to victims of scam mail and rogue trading where hat is why they may have targeted them.

The effects of these above events are often devastating for the victim. They may not have told anyone about what has happened to them so the first sign of problems may be when there is; an unexplained inability to pay for household shopping or bills, large unexplained withdrawals of money, possessions may have gone missing and/or living conditions deteriorate. It is often at this point that the possibility of abuse may be raised by family members, care workers, housing agencies or organisations whose bills are not being paid.

Research has highlighted the sense of guilt, and the effect it has had on the victim's sense of safety, sanity and health. Many may become withdraw, isolated, reclusive and fear going out or speaking to anyone. In some instances a move to a care home may be considered, as the victim is too frightened to remain at home.
17. Financial abuse
The Role of Assessment, Commissioning and Inspection

17.1 Roles and responsibilities
Effective prevention and detection of financial abuse is the responsibility of all parts of the health and social care 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 vulnerable people are as well protected as possible.

17.2 Assessors
The NHS and Community Care Act 1990 states that a Local Authority must assess a person's needs for community care services if it appears to the authority that he/she may be in need of such services. The assessment of an adult should include recognition of their present and likely future needs in respect of the management of their financial affairs, their money and other assets.

Adults with Care & Support Needs, as set out in the Care Act 2014 (Appendix 2) 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 evidence of Enduring/Lasting Power of Attorney/Deputyship during the assessment.

17.3 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\(^\text{17}\) 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.

17.4 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 Essential Standards for Quality and Safety issued under Care Standards Act 200018. The contract monitoring process should measure performance against these standards and any additional standards within the service contract.

17.5 Regulators/inspectors (CQC)
National minimum standards for all client groups were issued under the Care Standards Act 2000. The Essential Standards were later issued. The standards provide requirements to enable service users to control their own money except where they do not wish to or they lack capacity to do so. Providers are also required to protect service users from financial abuse.

17.6 Minimum financial and accounting standards/controls in care homes

17.6.1 Introduction
This Section relates to personal funds and monies collected on behalf of, or held for the personal use of, service users who need assistance in administering their financial affairs and who live (or are temporarily resident) in care homes or supported living settings. The level and type of assistance provided should be proportionate to the needs and risk assessment of the individual. The term ‘funds and monies’ is wide ranging and includes sums payable by way of earnings, welfare benefits such as the personal allowance or disability living allowance (mobility element), donations, bequests and gifts from families, and any allowances paid by a Local Authority for the personal use only of individual service users. Separate, detailed, records should be kept of all such sums received, collected or expended on behalf of the respective service user.

17.6.2 Safe keeping and banking
A separate, designated, bank, building society or post office account should be maintained by or for each service user. Advice received from the British Banking Association (BBA) states that, although there is not yet an agreed common approach, a bank may generally base the decision on whether to accept the risk of a third party running an account without obtaining a Court of Protection Order on two factors. These are whether the third party is able to provide evidence of vulnerability/incapacity and their relationship to the vulnerable person. BBA advice is that evidence of vulnerability/incapacity might include:

i. a letter addressed to the bank from the customer's medical practitioner clearly specifying that the customer is unable to manage their financial affairs;

Adult Safeguarding Guidance

ii. a letter from the court of protection, public guardianship office or solicitors acting for a proposed receiver/registered power of attorney advising the bank that an application to the court is being made;

iii. a letter from the Local Authority’s adult social care, advising that the customer is unable to manage their financial affairs.

Example of relationship to the adult might include:
• a letter from the DWP
• a DWP form

BBA advice is that when opening a bank account on behalf of a mentally incapacitated person, both the third party and the individual for whom the account is being opened will need to be identified and verified according to the bank’s usual procedures. The practice of ‘pooling’ funds belonging to more than one adult within one composite current account is not acceptable or prudent. Neither is the resident's account to be used by the home in connection with the carrying on or management of the home.

Where the service user has accumulated large sums of cash in their current bank, building society or post office account(s), the service provider should formally notify the respective care manager/social worker of this situation (if the service user has capacity their permission should first be sought).

The signatories authorised to make payments by cheque, or withdraw cash from the bank, should be determined by a senior level of management in the service provider organisation. In situations where the service provider organisation does not have different management tiers, e.g. a small home, the determination should be made by the owner/manager. Maximum financial limits should be set regarding the amount of any single cash withdrawal; and the amount for which cheques may be issued by a single authorised signatory. Cheque payments above the specified maximum limit should require two authorised signatories. Particular vigilance should be exercised by all parties with an interest in, or responsibility for, protecting the service user, to ensure financial limits are not evaded by splitting a single transaction into two or more smaller amounts.

The practice of using pre-signed, blank, cheques is extremely imprudent and should be forbidden.

At least once a month, a statement should be prepared reconciling the recorded balance(s) on each service user's Personal Cash and Bank Record with the Actual Total amounts held at the service user's residence and at their bank. This reconciliation should be formally certified, as correct, by an officer responsible for administering the adult’s personal finances; and verified, at least quarterly,

by a separate designated more senior manager. In situations where no separate senior management level exists, an appropriate alternative arrangement should be agreed as part of the commissioning and contracting process.

Cash or cheques held at the service user’s residence should be kept under secure conditions. This should involve a separate, lockable box for each service user's monies. Responsibility for the physical custody of, and access to such boxes should be specified by senior management.

17.6.3 Record keeping
It is important that all information is recorded clearly, concisely, accurately and promptly.

i. An accounting record should be maintained of all transactions involving the adult’s personal banking account including cheque payments made through the account together with any cash withdrawals from, or deposits into, the account. This personal banking record should also incorporate provision for a signature by the officer responsible for initiating transactions of any nature on the adult’s bank account; and
include balances brought/carried forward. These records should be verified against banking statements or pass books.

ii. A separate basic accounting record (i.e. cash account) should be maintained for each adult recording all cash received, or spent, on their behalf. Each account should normally cover a period of one month and incorporate balances brought/carried forward to the next month.

iii. The format of the cash account should provide for, among other things, a clear ‘audit trail’ regarding cash paid into, or withdrawn from, the adult’s bank account; and the signature of the officer responsible for initiating the respective transaction(s). This cash record should reflect a clear picture of monies spent/collected on behalf of the adult.

iv. Receipt and payment entries should be supported by relevant, verifiable, documentation. This should include weekly/monthly time sheets for carers, providing the care and weekly/monthly invoices from the care provider/personal assistant for the cost of the care they have provided. This information should be held by the client and made available to Care Managers or Auditors on request. Minimum financial limits should be set above which invoices/expenditure vouchers must be obtained; and below which supporting documentation may not be considered practicable or of material financial significance.

v. Manual deletion or erasure of entries on accounting records (including details on invoices supporting service user personal expenditure) should not be permitted, especially by use of tippex. All transaction entries on adults’ financial records should be in ink. Where, occasionally, it might be necessary to alter or amend, for example, recorded totals (for instance on discovering an arithmetical error) the following approach should be adopted: a short line should be drawn through the incorrect figure; the correct figure written next to it; and the amending entry clearly initialled by the originating officer.

vi. Financial and accounting records relating to service users personal expenditure should be retained for the current financial year and the preceding five years (total six). This includes situations where the service user moves or dies. (Please note this guidance should be cross referenced with Local Authority practice and procedures for when an adult at risk dies).

17.6.4 Expenditure

i. Clear guidance should be issued by service providers regarding what they (and the service commissioner) consider proper professional practice where the personal funds of adults at risk are being spent. This could comprise a list of ‘dos’ and ‘don’ts’; and cover contentious areas (such as the costs and expenses of care staff accompanying service users on holiday) where monies might be removed from the service user’s account to meet expenditure from which the service provider/staff may directly or indirectly benefit.

ii. Clear guidance should also be issued regarding the policy on care staff accepting (or otherwise) cash, personal gifts or hospitality from adults or from their families and friends.

17.6.5 Inventory of personal possessions

A simple basic inventory should be constructed, and kept up to date, of valuable personal property belonging to each service user. By way of a non-exhaustive list for illustrative purposes only, this could include items such as portable TVs, cassette players, music centres, personal jewellery, and leather handbags. The inventory should be updated and certified as correct, at least 6 monthly, by an officer responsible for administering service users’ financial affairs; and verified, annually, by a more senior manager. Any missing items should be fully investigated in accordance with local adult protection procedures where necessary and a proper explanation recorded on the adult’s personal file. The
inventory should also be formally amended, as necessary, and a brief explanatory note added to the inventory (and cross referenced to the service user’s personal file/records). Instances of suspected theft must be reported immediately in accordance with local adult protection procedures.

17.6.6 Personal credit cards
The use of staff members' personal credit, debit or loyalty card(s) to process the private expenditure of the adult should not be permitted.

17.6.7 Joint purchases
i. Whilst people in residential accommodation, who have full mental capacity, may opt for shared purchases/ownership e.g. purchase of a car with their disability living allowance, (mobility component), they should not be placed under any pressure to engage in joint purchases or partake in such arrangements. Providers and/or care managers/social workers should offer advice and support to ensure that any such agreements will facilitate proportionate benefit and be in the best interest of the adult and fit for purpose in the short, medium and long term.

ii. In the case of people who are assessed not to have mental capacity to manage their finance, consent to any proposed joint purchase on behalf of the adult user should be obtained in writing from the person who holds Power of Attorney. The best interests of the adult user should be paramount and any purchases must be fit for purpose in the short, medium and long term facilitating proportionate benefit to the adult.

iii. Any such joint purchases should be confined to use by the adult and should not be available for use by staff only, without the adult’s agreement. A written agreement should be provided to each adult confirming their continuing ownership rights of any joint purchases. Staff must ensure the proper care and servicing of any (joint) property, such as a vehicle, which is used by staff for the benefit of adults at risk.

17.6.8 Monitoring and periodic professional audit
Regular checks should be undertaken by both the provider and service commissioner to ensure the adult's interests are being protected. These checks may be undertaken by, for example, a contract monitoring section or line management staff in either the service provider or Local Authority. Whatever types of monitoring mechanism are adopted, the checks conducted should, as a minimum, seek to verify that:

i. expenditure is well documented
ii. it has been incurred for the adult’s benefit
iii. the recorded balance of monies on the adult’s cash account and personal bank record can be clearly corroborated by physical verification and independent documentation e.g. proper statements for the adult's bank, building society or post office account(s).
iv. Each care provider should also ensure that the personal funds of adult’s at risk for whom they have day-to-day responsibility are subjected to periodic, in-depth, professional audit at intervals not less than once every 4 years. If the service provider or care commissioner operates an established, suitably experienced, internal audit function the necessary review might, alternatively, be conducted through this mechanism.

17.6.9 Transparency and information sharing
i. Where an adult possesses capacity and does not wish details of their financial affairs to be disclosed to any other party (except those expressly authorised in law), the adult’s wishes should be respected.

ii. Where, however, the adult lacks mental capacity and for example, there is a Lasting Power of Attorney (for finance) or a Court appointed Deputy (for finance), then full access to information concerning the adult's financial affairs will be shared. It is noted that some providers already have the facility of making such records available, on
demand, to DWP inspectors, social services departments, health authorities and the advocate of the respective resident. Whilst it is impossible to prescribe for the circumstances surrounding every adult, transparency of practice should help minimise the possibility or risk of any misappropriation remaining undetected.
18. Managing Confidential Information in Documents, Reports and Minutes of Meetings

Any decisions made by social services 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 perpetrators.

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 social services '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.

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 secure email where available, secure fax or recorded delivery.

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.

18.1 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 protection 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 to Vetting and Barring, psychiatrists, professional staff employed by other social services 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 in relation to a Freedom of Information Act 2000.

18.2 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.
### 19. Seriousness of the Abuse

#### 19.1 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 perpetrators 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

#### 19.2 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></th>
<th>Physical</th>
<th>Sexual exploitation</th>
<th>Psychological</th>
<th>Financial/Material</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>bruising</td>
<td>Non-contact abuse including verbal harassment coercion grooming introducing alcohol and drug abuse isolation of victim</td>
<td>sexual touch trafficking for sexual purposes</td>
<td>frequent verbal outbursts</td>
<td>occasional teasing, taunts or verbal outbursts controlling behaviour causing deliberate embarrassment minimalizing an adult's experience</td>
</tr>
<tr>
<td></td>
<td>Lesions</td>
<td>Masturbation Further Coercion</td>
<td>humiliation and threats on a regular basis</td>
<td>vicious and personalised attacks</td>
<td>lack of good care leading to discomfort or inconvenience</td>
</tr>
<tr>
<td></td>
<td>assault requiring attendance at casualty or other medical treatment</td>
<td>attempted penetration by perpetrator or numerous perpetrators</td>
<td>rape, sexual assault, use of implements and weapons</td>
<td>repeated verbal assaults, threats and intimidation</td>
<td>lack of care to extent that bedsores or other medical</td>
</tr>
<tr>
<td></td>
<td>assault with weapon and/or leading to irreversible damage</td>
<td>grievous bodily harm or attempted murder</td>
<td>fraud, of property or wills</td>
<td>fraud to extent that person risks destitution</td>
<td>ongoing neglect such as causes malnutrition or other illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>failure to access life saving services or medical care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>neglect of medication or psychological needs leading</td>
</tr>
</tbody>
</table>
### 19.3 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.

#### Whether the abuse was a one-off event or part of a longstanding relationship or pattern

<table>
<thead>
<tr>
<th>Isolated incident</th>
<th>Repeated abuse in an ongoing relationship</th>
<th>Repeated abuse which has gone on for over 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious</td>
<td>Extremely serious</td>
<td></td>
</tr>
</tbody>
</table>

#### The impact of the abuse on the physical and/or mental health of the alleged victim

<table>
<thead>
<tr>
<th>Short term (Can take in their stride)</th>
<th>Lasting distress or injury</th>
<th>Potentially life threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious</td>
<td>Extremely serious</td>
<td></td>
</tr>
</tbody>
</table>

#### The impact on others, e.g. children, other relatives or other adults

<table>
<thead>
<tr>
<th>No-one else involved or witnessing abuse</th>
<th>Others relatives/residents are disturbed/distressed about or the abuse</th>
<th>Others are seriously intimidated and/or their environment distorted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious</td>
<td>Extremely serious</td>
<td></td>
</tr>
</tbody>
</table>

#### The intent of the person alleged to be responsible for the abuse

<table>
<thead>
<tr>
<th>Inadvertent or ill informed</th>
<th>Violent/serious unprofessional response to difficulties in caring</th>
<th>Planned and deliberately malicious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious</td>
<td>Extremely serious</td>
<td></td>
</tr>
</tbody>
</table>

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e.g. being left wet; cold; hungry; thirsty

<table>
<thead>
<tr>
<th>Discrimination</th>
<th>occasional harassment or slurs related to issues of difference</th>
<th>having difficulty getting access to services</th>
<th>being refused access to services or essential support</th>
<th>being taunted, harassed and threatened leading to fears for safety</th>
<th>hate crime result in injury or fear for life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious</td>
<td>Extremely serious</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### The illegality of the alleged perpetrator's action(s)

- Poor or bad practice but not illegal
- Maybe against the law
- Clearly a criminal offence

<table>
<thead>
<tr>
<th>Serious</th>
<th>Extremely serious</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The risk of the abuse being repeated against this adult

- Very unlikely
- Not if significant changes are made e.g. training, supervision, respite or support
- Very likely even if changes are made and/or more support provided

<table>
<thead>
<tr>
<th>Serious</th>
<th>Extremely serious</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The risk that abuse will be repeated against other adults or children

- No, very unlikely
- This perpetrator/setting may change but supervision/training needed
- This alleged perpetrator/setting represents a threat to other adults or children

<table>
<thead>
<tr>
<th>Serious</th>
<th>Extremely serious</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20.1 Disclosure and Barring Service Referral Guidance
Referral to the DBS can be made when relevant conduct has occurred. Referral to the DBS is a Local Authority power rather than a duty, which means that the employer has the duty to make the referral, however where they do and the person is believed to pose an ongoing risk to adults at risk or children and where ‘relevant conduct’ has occurred the Local Authority must consider making the referral.

Relevant conduct is defined as conduct which: endangers or is likely to endanger or harm a child or an adult at risk and if it is repeated against, or in relation to a child or adult at risk, would endanger or would be likely to endanger them. This also involves sexual material and images (including possession) relating to children; sexually explicit material depicting violence against human beings (including possession of such images) or it, appears to DBS to be inappropriate, or of a sexual nature, involving a child or adult at risk.

20.2 The Responsibilities of Employers or Volunteer Coordinators
The main responsibility for making a referral to the DBS rests with the regulated activity providers. They are employers or volunteer coordinators. They must make the referral when they withdraw a person from regulated activities or would have done so had the person not resigned, retired, been made redundant or been transferred to a non-regulated or controlled activity. (This does not apply to temporary suspension without prejudice, pending investigation).

20.3 Definition of Regulated Activity Relating to Adults
The definition of regulated activity identifies the activities which, if any adult requires them, lead to that adult being considered to be an adult at risk - at that particular time. This means that the focus is on the activities required by the adult and not on the setting in which the activity is received, nor on the personal characteristics or circumstances of the adult receiving the activities. There is also no longer a requirement for a person to do the activities a certain number of times before they are engaging in regulated activity.

There are six categories of people who will fall within the definition of regulated activity and a broad outline of these categories is set out below. (For more information please see the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012).

(i) Providing health care
This means any health care professional providing health care to an adult, or anyone who provides health care to an adult under the direction or supervision of a health care professional.

(ii) Providing personal care
This means anyone who:
• provides physical assistance with eating or drinking, toileting, washing or bathing, dressing, oral care or care of the skin, hair or nails because of an adult’s age, illness or disability
• prompts and then supervises an adult who, because of their age, illness or disability, cannot make the decision to eat or drink, go to the toilet, wash or bathe, get dressed or care for their mouth, skin, hair or nails without that prompting or supervision; or
• trains, instructs or offers advice or guidance which relates to eating or drinking, going to the toilet, washing or bathing, dressing, oral care or care of the skin, hair or nails to adults who need it because of their age, illness or disability.
(iii) Providing social work
This means the provision by a social care worker of social work which is required in connection with any health care or social services to an adult who is a client or potential client.

(iv) Assistance with cash, bills and/or shopping
This means the provision of assistance to an adult because of their age, illness or disability, if that includes managing the person’s cash, paying their bills or shopping on their behalf.

(v) Assistance in the conduct of a person’s own affairs
This means anyone who provides various forms of assistance in the conduct of an adult’s own affairs, for example by virtue of an enduring power of attorney.

(vi) Conveying
This means a person who transports an adult because of their age, illness or disability either to or from their place or places where they have received, or will be receiving, health care, personal care or social care; or between places where they have received or will be receiving health care, personal care or social care. This will not include family and friends or taxi drivers.

20.4 Withdrawal from Regulated Activity
Withdrawing a person from regulated activity in the context of making a referral does not necessarily mean permanently removing them. If enquiries have established harm or risk of harm to a child or adult at risk, a decision needs to be made as to the best way of managing this information. This may be:

a) Return the individual to work with additional training and / or a warning
b) Dismiss the individual
c) Return the individual to a non-regulated activity
d) Continue suspension due to risk of harm while seeking advice

If the decision is to remove the person either through points 2 to 4 above then permission to engage in regulated activity has been withdrawn and referral to the DBS must be made.

Where an individual has left employment due to harm or risk of harm to an adult, before any final disciplinary decision was made, information must also be referred to the DBS.

20.5 Responsibilities of Local Authorities Keepers of Registers, Supervisory Authorities, Health and Social Care (HSC) Bodies and Education and Library Boards
In all cases the trigger to make a referral to the DBS is when there is evidence that an individual who is engaged or may have been engaged in regulated activity has engaged in Relevant Conduct and has satisfied the Harm Test or received a caution or conviction for a relevant offence and they consider that the DBS may bar the worker. If the above conditions have been met the information must be referred to the DBS by the employer or the volunteer coordinator. The referral should be made to the DBS when the body (employer or volunteer coordinator) has gathered sufficient evidence as part of their enquiries to support their thinking that a person has engaged in relevant conduct, satisfied the harm test or received a caution or conviction for a relevant offence. At this point the body should think the person has a case to answer. Referral at this point will help to ensure that the DBS has sufficient evidence to commence its decision making process while providing adequate safeguarding for vulnerable groups.
20.6 All Groups: Making a referral without a legal duty to refer

The DBS will consider all information referred to it from any source in relation to whether an individual should be included in a barred list. For example:

a) regulated activity providers and other groups may provide information where following an internal investigation there is insufficient evidence to show relevant conduct occurred, but they still have concerns about that individual; or

b) where an employer may have concerns about an individual who has left their employ and they know or think that the individual works in regulated activity in another setting. Again there is no duty to refer to the DBS but they may.

20.7 Who Will Be Informed If An Individual Is Barred?

Following representations, if an individual is subsequently barred they will be notified in writing and they are ‘barred’. All organisations with a legitimate interest in the individual will be notified that the individual is ‘barred’. If the individual is not barred, they and legitimately interested parties will be advised in writing. The DBS does not have the power to inform any other individuals or organisations of the decision including an employer who may have dismissed the individual (as they no longer have a legitimate interest in the individual). 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, be it paid or voluntary.

20.8 Legitimate Interest

A person or organisation has a legitimate interest in another person if they:

a) have engaged or are considering engaging them in regulated activity, and

b) the person or organisation has registered any interest and

c) the registered interest relates to the activity that the person or organisation has permitted the individual to engage in and

d) the person or organisation has notified the DBS of the address to which any notification is to be sent or

e) if they are a Keeper of Register or Supervisory body as mentioned in the 2006 Act or 2007 Order and the individual concerned is registered with that body.

It will be apparent from this information that neither the ex-employer nor Local Authority that made the referral to the DBS will be informed of the outcome of the referral. So the records held by the employer and the Local Authority will be a record that a referral was made by to the DBS in respect of the individual. Those with a duty or power to refer should send new referrals to the following address:

Disclosure and Barring Service
PO Box 181, DARLINGTON DL1 9FA

The DBS Referral Guidance and referral form are now available on: DBS Referral Form and Guidance
21. Body Map

Adult's name:    Date of birth:    Case number:
Address:

Right          Left          Left    Right

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:
22. DSO Responsibilities and good practice guidelines for organising and managing adult safeguarding meetings/case conferences

22.1 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.

22.2 During meeting
   a) Ensure that the minute taker sits next to you, that they have adequate space and 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.

22.3 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.
23. Administrator's/minute taker's responsibilities and good practice guidelines for organising and managing adult safeguarding meetings/case conferences

23.1 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.
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 AP 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 can 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) You should provide paper and pens for participants.
o) Consider providing name labels on the table to assist with communication and minute taking.
p) Ensure that arrangements are in place for refreshments. 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.

23.2 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 client’s 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.

n) A lot of information will be repeated or not relevant to include in minutes.

o) You may be able to develop your own form of speed writing.

p) It is likely that some action points will be agreed at the meeting.

q) Remember to ask for clarification if you need to. If it does not make sense in the meeting it is unlikely to when you come to write up the minutes.

23.3 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 adult protection 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.
24. How Social Services may respond to Statutory Enquiries

Everyone has a responsibility to ensure that concerns about alleged adult abuse are addressed in a proportionate, timely and effective manner. The lead responsibility for coordinating responses to adult protection concerns lies with the Local Authority adult social care and other agencies now have a statutory responsibility to work cohesively with them. Every reported incident of abuse, or suspected abuse, must be taken seriously and addressed with appropriate urgency to enable prevention and recovery.

Whenever concerns about the abuse of an adult at risk an Alert form should be completed, forwarded to the relevant team and backed up with phone contact. Initial assessment and evaluation of the available information will be carried out and consequent decisions will be made about the most appropriate response.

The following represent possible responses that can be made at any point following initial risk assessment:

a) Information and advice given
b) A statutory Section 42 enquiry or non-statutory enquiry is made or caused to be made
c) Social work or clinical intervention e.g. brief therapy; motivational interviews; restorative justice; provision of support services
d) Referral or signposting to a more appropriate agency e.g. housing or Women's Aid
e) If concerns are related to poor care standards of care in a regulated setting a referral will be made to CQC and or the Commissioners of that service
25. Framework for Responding to Adult Safeguarding Concerns

25.1 Introduction

The following can be used to determine the most appropriate level of response to an adult safeguarding concern and enables prompt for consistent decision making. However, it is not exhaustive in its content and is not intended to be used as a checklist or scorecard. 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.

25.2 Response Diagram – Levels of Response:

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>TYPE OF INFORMATION</th>
<th>TYPE OF ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 (service provider enquiry)</strong></td>
<td>Examples of presenting Information</td>
<td>Examples of actions &amp; outcomes</td>
</tr>
<tr>
<td>Concern reported to Social Services by provider</td>
<td>One-off, isolated incident that has not adversely affected the physical, psychological or emotional well-being of adult</td>
<td>Service provider must recognise and record concern under their safeguarding procedures</td>
</tr>
<tr>
<td>Alert form completed</td>
<td>No previous history of similar incidents recorded for the adult</td>
<td>Action taken by provider to address 'presenting concerns' and report outcomes to DSO</td>
</tr>
<tr>
<td>Discussion with DSO</td>
<td>No previous history of similar incidents recorded for service provider</td>
<td>May lead to some changes in service provision; practice or resource allocation or management</td>
</tr>
<tr>
<td>Discussion with Adult at risk or representative</td>
<td>No previous history of abuse by alleged perpetrator</td>
<td>No on-going risk to the adult or others</td>
</tr>
<tr>
<td>Adult's expressed outcomes recorded.</td>
<td>Not part of an apparent pattern of abuse</td>
<td></td>
</tr>
<tr>
<td>MSP is a priority</td>
<td>No clear criminal offence</td>
<td></td>
</tr>
<tr>
<td>Decision by DSO if S42 duty does or does not exist.</td>
<td>Not a clear intent to harm or exploit the adult</td>
<td></td>
</tr>
<tr>
<td>Consideration of independent advocate /IMCA appointment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSO can challenged report if insufficient to enable s42 duty to be satisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring format agreed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level 2 Social Care Enquiry</strong></td>
<td>Needs of the adults at risk are assessed or reviewed</td>
<td></td>
</tr>
<tr>
<td>Concern reported to Social Services, alert form completed</td>
<td>Recovery, prevention and safety are enabled</td>
<td></td>
</tr>
<tr>
<td>Discussion with DSO/ Senior manager</td>
<td>Care plan may be adjusted</td>
<td></td>
</tr>
<tr>
<td>Discussion with Adult at risk or representative</td>
<td>additional support provided to</td>
<td></td>
</tr>
<tr>
<td>Adult's expressed outcomes recorded and MSP is priority</td>
<td>enable adult to explore and negotiate relationships with 'significant others' in their support network e.g. family group conferencing</td>
<td></td>
</tr>
<tr>
<td>Consideration of advocate appointment</td>
<td>Carers assessment and support provided</td>
<td></td>
</tr>
<tr>
<td>Decision by DSO if S42 duty does or does not exist</td>
<td>Current and future risks are significantly reduced or eradicated by changes</td>
<td></td>
</tr>
<tr>
<td>DSO allocates to IO to review; if a criminal offence may have been committed or if health involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Adult Safeguarding Guidance

<table>
<thead>
<tr>
<th><strong>Level 3</strong></th>
<th>Multi-agency response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult safeguarding concern reported to Social Services, alert form completed</td>
<td>Maybe, physical, psychological or emotional well-being of adult(s), is being adversely affected</td>
</tr>
<tr>
<td>Discussion with DSO/ Senior manager</td>
<td>Criminal offence(s) may have been committed</td>
</tr>
<tr>
<td>Discussion with Adult(s) at risk or representative(s)</td>
<td>Possible breach of statutory regulations (Care Standards Act 2000)</td>
</tr>
<tr>
<td>MSP outcomes recorded</td>
<td>Possible breach of professional codes of conduct</td>
</tr>
<tr>
<td>Consideration of independent advocate or IMCA appointment</td>
<td>Actual or potential risk of harm or exploitation to other adults at risk</td>
</tr>
<tr>
<td>Decision by DSO if S42 duty does or does not exist. DSO allocates to IO to engage multi-agency consultation/enquiry including police if a criminal offence may have been committed involve health or other agency support where appropriate</td>
<td>Possible deliberate intent to exploit or harm</td>
</tr>
<tr>
<td></td>
<td>Significant breach in an implied or actual 'duty of care' between adult(s) and alleged perpetrator</td>
</tr>
<tr>
<td></td>
<td>Clear inequalities of power and/or authority between adult(s) and alleged perpetrator</td>
</tr>
<tr>
<td></td>
<td>Alert forms part of a pattern of abuse either, against a particular adult, by another or by a health or social care service</td>
</tr>
<tr>
<td></td>
<td>Multi-agency planning discussion/meeting held to agree method of enquiry</td>
</tr>
<tr>
<td></td>
<td>Section 42 enquiry implemented with further review discussions/meetings, if appropriate</td>
</tr>
<tr>
<td></td>
<td>Evaluation of enquiries activity</td>
</tr>
<tr>
<td></td>
<td>Report to be completed by IOs to enable recovery of adult; risk management and future prevention</td>
</tr>
<tr>
<td></td>
<td>Case conference to agree a safeguarding plan that prevents or reduces risk of further abuse</td>
</tr>
<tr>
<td></td>
<td>Agree review time scales for safeguarding plan, scheduling content</td>
</tr>
<tr>
<td></td>
<td>Agree circumstances where re-evaluation may be required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Level 4</strong></th>
<th>Multiple victims involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSP outcomes recorded for any suspected victims</td>
<td>Enquiries about initial concerns for the adult(s) identifies concerns for others and or possible organisational abuse</td>
</tr>
<tr>
<td>Consideration of advocate appointment</td>
<td>Number of adults at risk are adversely affected</td>
</tr>
<tr>
<td>Decision by DSO that S42 duty does or does not exist. DSO allocates to IO to urgently assess wider risks and to work with partner agencies to carry out enquiries in line with terms of reference agreed.</td>
<td>Criminal offences may have been committed</td>
</tr>
<tr>
<td>Complex adult safeguarding Enquiry and multiple assessments may be made if numerous adults deemed to be at risk</td>
<td>Possible multiple breaches of Care Standards Act</td>
</tr>
<tr>
<td>Consider MC Act s44 neglect issues</td>
<td>Notify senior managers if serious impact on service or victims</td>
</tr>
<tr>
<td>Refer to commissioners</td>
<td>Allocate resources to undertake, and co-ordinate range of Section 42 enquiries</td>
</tr>
<tr>
<td>Refer to regulators</td>
<td>Planning meeting held ToR agreed, enquiries made.</td>
</tr>
<tr>
<td>Refer to adult's representatives</td>
<td>Enquiry report completed by IOs</td>
</tr>
<tr>
<td></td>
<td>Evaluation of outcome of enquiries</td>
</tr>
<tr>
<td></td>
<td>Recovery, risk reduction and management are prioritised</td>
</tr>
<tr>
<td></td>
<td>Case conference agrees safeguarding plans for victims.</td>
</tr>
<tr>
<td></td>
<td>Agree review time scales for protection plan and allocate to named people</td>
</tr>
<tr>
<td></td>
<td>Agree circumstances where re-evaluation of the situation will be required</td>
</tr>
<tr>
<td></td>
<td>Consider establishment case conference, agree action/improvement plan for the service</td>
</tr>
<tr>
<td></td>
<td>Agree monitoring and review of action plan for service provider</td>
</tr>
</tbody>
</table>

- 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 an 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?

- Complete planning process following consultation (planning meeting)
- 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

- Consider need for planning meeting
- Reconsider risk level
- Decide who will take the lead in the Enquiry
- Record and agree a protection plan

**Possible crime? Consult police & make formal referral if appropriate**

**Record and notify referrer and agencies of the agreed response, if appropriate**

**At review planning meeting**

Formal review of enquiry findings

**At case conference:**

Decision re outcome of statutory enquiry. Evidence reduced risk and recovery
Agree post support plan. Agree monitoring plan. Close case. Inform relevant people

---

**Level 1 S42 or non-statutory Enquiry**
Service provider must report back the outcome of their assessment

**Level 2 S42 or non-statutory Enquiry**
Urgently assess or review the needs of adult(s) within the context of the presenting concern(s)

**Level 3 or 4 S42 or non-statutory Enquiry**
Complex safeguarding enquiry undertaken with multiple victims

**Timescales**
- Within 24 hours
- Within 2 working days
- Within 5 working days

**Level 2**
- Urgently assess or review the needs of adult(s) within the context of the presenting concern(s)

**Level 3 or 4**
- Complex safeguarding enquiry undertaken with multiple victims

---

**Level 1**
- Service provider must report back the outcome of their assessment

**Review**
- if necessary
27. Role of NHS Counter Fraud Service and Safeguarding

Arrangements to address Counter Fraud and Corruption were initiated in September 1998 and have been embodied in the Secretary of State directions as part of the National Health Service Act 1977. This initiated the creation of the Counter Fraud and Security Management Service (CFSMS). The NHS Counter Fraud Service has a remit of tackling all losses to fraud and corruption in every area of NHS spending. Every NHS Health body in England and Wales has a designated Local Counter Fraud Specialist (LCFS) who is responsible for tackling fraud at a local level. South Coast Audit is a not-for-profit consortium that provides a Local Counter Fraud Service to all NHS Trusts in Kent and Medway under the authority of the NHS Counter Fraud Service on behalf of the Secretary of State for Health.

Every Local Counter Fraud Specialist who is involved in the detection, investigation, or prosecution of fraud and corruption within the NHS has undertaken training that is comparable with Police training. A Memorandum of Understanding exists between the NHS Counter Fraud Service and the Association of Chief Police Officer and establishes guidelines to:

a) Facilitate effective lines of communication by promoting clear understanding of NHS Counter Fraud Service and Police responsibilities, working procedures, and respective legal constraints.
b) Assist police and NHS Counter Fraud Specialists to co-operate at an operational level.
c) Facilitate effective investigation and exchange of information with the objective of detecting all forms of serious crime as well as fraud involving the NHS.

Activities that may be accompanied by criminal offences, which can be addressed by referral to the NHS Counter Fraud Service will more commonly include:

Suspicion of theft from an adult that involves a NHS member of staff. This may include theft of property or misuse of patient’s money or property.

The NHS Counter Fraud Service will consider a range of sanctions including, criminal, disciplinary and civil proceedings. Criminal Prosecutions can be undertaken using the Office of Solicitors for Department of Health or the Crown Prosecution Service. The designated Local Counter Fraud Specialist will ensure that the investigation and reporting procedures defined within this document are complied with. All relevant contacts can be found in Appendix 1.
28. Prevent and Counter Terrorism

The UK Government’s policy on Counter-Terrorism and Security Act 2015 is the statutory footing for ‘Prevent’ which is 1 of the 4 elements of CONTEST (the government’s counter-terrorism strategy). It aims to stop people becoming terrorists or supporting terrorism.

The UK 2011 counter terrorism Strategy (CONTEST) is structured around four ‘P’s:

- Pursue - to stop terrorist attacks.
- Prevent - to stop people becoming terrorists or supporting terrorism.
- Protect - to strengthen our protection against a terrorist attack.
- Prepare - to mitigate the impact of a terrorist attack.

Our focus is primarily on Prevent which has three main objectives, to:

- 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 focuses on early intervention to reduce the chances of individuals who support extreme ideology becoming terrorists. Prevent is a statutory duty for local authorities under the Prevent Duty guidance; and in light of daily reported threats we must all take responsibility in the shared challenge of tackling radicalisation and extremism by supporting Prevent:

- Be vigilant. Extremism and radicalisation in our community are very real threats to our society and being aware is the first step. We all have a responsibility to keep our county and the people in it safe.
- KCC and Medway Council have mandatory e-learning on Prevent training for staff
- Watch the Kent Police Counter Terrorism film

If you have concerns that an adult may be at risk of becoming a victim of radicalisation please progress a referral through the CHANNEL Referral Process via the Kent Police CHANNEL Co-ordinator.

If there is an immediate threat please dial 999.
# Useful Addresses, Telephone and Fax numbers

## Appendix 1

### For referrals to Kent Adult Social Services (updated April 2016)

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](mailto:access&info@medway.gov.uk)

---

## MEDWAY ADULT SOCIAL SERVICES

<table>
<thead>
<tr>
<th>Medway Council HQ's</th>
<th>Tel: 01634 33 44 66</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dock Road, Chatham</td>
<td>ss.access&amp;<a href="mailto:info@medway.gov.uk">info@medway.gov.uk</a></td>
</tr>
<tr>
<td>Kent ME4 4TR</td>
<td></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:

- **Emergency Out of Hrs:** 03000 41 91 91
- **24hr Contact:** 03000 41 41 41

## KENT ADULT SOCIAL SERVICES

<table>
<thead>
<tr>
<th>General Contact Numbers for Kent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact point:</td>
</tr>
<tr>
<td>Emergency Out of Hrs:</td>
</tr>
<tr>
<td>24hr Contact:</td>
</tr>
<tr>
<td>Website:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
</tbody>
</table>

### Kent County Council HQ's

- County Hall
- Maidstone
- Kent ME14 1XQ

### West Kent Area Office

- Invicta House,
- Maidstone ME14 1XX
<table>
<thead>
<tr>
<th>Swale</th>
<th>Ashford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avenue of Rememberance</td>
<td>Kroner House</td>
</tr>
<tr>
<td>Sittingbourne</td>
<td>Eurogate Business Park</td>
</tr>
<tr>
<td>Kent. ME10 4DD</td>
<td>Ashford, TN24 8XU</td>
</tr>
</tbody>
</table>

<table>
<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>Whistable, CT5 3SS</td>
<td>Folkestone, CT20 1DX</td>
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<table>
<thead>
<tr>
<th>Dartford, Gravesend &amp; Swanley</th>
<th>Tonbridge and Sevenoaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joynes House</td>
<td>Kings Hill</td>
</tr>
<tr>
<td>New Road</td>
<td>Worrall House</td>
</tr>
<tr>
<td>Gravesend</td>
<td>30 Kings Hill Avenue</td>
</tr>
<tr>
<td>Kent DA11 OAT</td>
<td>West Malling</td>
</tr>
<tr>
<td>Tel: 03000 41 02 05</td>
<td>Kent, ME19 4AE</td>
</tr>
<tr>
<td>E: <a href="mailto:nkbst@kent.gov.uk">nkbst@kent.gov.uk</a></td>
<td>Tel: 03000 41 14 00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tunbridge Wells</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Montague House</td>
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</tr>
<tr>
<td>9 Hanover Road</td>
<td></td>
</tr>
<tr>
<td>Tunbridge Wells</td>
<td></td>
</tr>
<tr>
<td>Kent, TN1 1EZ</td>
<td></td>
</tr>
<tr>
<td>Tel: 01892 51 50 45</td>
<td></td>
</tr>
</tbody>
</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

Email: [CentralDutyTeam@kent.gcsx.gov.uk](mailto:CentralDutyTeam@kent.gcsx.gov.uk)
[central.duty@kent.gov.uk](mailto:central.duty@kent.gov.uk)

Tel: **03000 41 61 61**
Fax: **03000 41 23 45**

**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>Kent &amp; Medway NHS and Social Care Partnership Trust Integrated Mental Health Teams</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out of hours telephone:</strong></td>
<td>03000 41 91 91</td>
</tr>
<tr>
<td><strong>Or 24hr Contact:</strong></td>
<td>03000 41 41 41</td>
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</table>

<table>
<thead>
<tr>
<th>DGS Community Mental Health Team</th>
<th>Swale Mental Health Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amdale House</td>
<td>Sittingbourne Memorial Hospital</td>
</tr>
<tr>
<td>18-20 Spital Street</td>
<td>Bell Road</td>
</tr>
<tr>
<td>Dartford DA1 2DL</td>
<td>Sittingbourne</td>
</tr>
<tr>
<td>Tel: 01322 62 22 30</td>
<td>Kent County Council ME10 4DT</td>
</tr>
<tr>
<td></td>
<td>Tel: 01795 41 83 59</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Maidstone</th>
<th>Ashford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maidstone Community Mental Health Team</td>
<td>Eureka Place</td>
</tr>
<tr>
<td>23-29 Albion Place</td>
<td>Trinity Road</td>
</tr>
<tr>
<td>Maidstone ME14 5TS</td>
<td>Ashfordf TN25 4BY</td>
</tr>
<tr>
<td>Tel: 01622 76 69 00</td>
<td>Tel: 01233 65 81 00</td>
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</table>

<table>
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<tr>
<th>Thanet</th>
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<tr>
<td>The Beacon</td>
<td>Kings Road Clinic</td>
</tr>
<tr>
<td>Manston Road</td>
<td>Herne Bay</td>
</tr>
<tr>
<td>Ramsgate CT12 6NT</td>
<td>Kent CT6 5DD</td>
</tr>
<tr>
<td>Tel: 01843 85 52 00</td>
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<table>
<thead>
<tr>
<th>Medway</th>
<th>South West Kent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada House</td>
<td>Highlands House,</td>
</tr>
<tr>
<td>Barnsole Road</td>
<td>10-12 Calverley Park Gardens, Tunbridge Wells</td>
</tr>
<tr>
<td>Gillingham</td>
<td>TN1 2JN</td>
</tr>
<tr>
<td>Kent ME7 4JL</td>
<td>Tel: 01892 70 92 11</td>
</tr>
<tr>
<td>Tel: 01634 58 30 20</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>East Kent – Dover &amp; Deal</th>
<th>Shepway</th>
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<tbody>
<tr>
<td>Coleman House</td>
<td>Ask Eton</td>
</tr>
<tr>
<td>Brookfield Avenue</td>
<td>Radnor Park Avenue</td>
</tr>
<tr>
<td>Dover CT16 2AH</td>
<td>Folkestone</td>
</tr>
<tr>
<td></td>
<td>Kent CT19 5HL</td>
</tr>
<tr>
<td>Tel: 01304 21 66 66</td>
<td>Tel: 01303 22 75 10</td>
</tr>
<tr>
<td></td>
<td>Fax: 01303 22 75 12</td>
</tr>
</tbody>
</table>
### Medway Deaf Services

**Deaf Services**  
Medway Council  
Gun Wharf, Dock Road  
Chatham, ME4 4TR

**Phone/Minicom:** 01634 33 17 27  
**Mobile (SMS only) Text:** 07795 951465  
**Email:** deaf.services@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:

**Out of Hours:** 03000 41 91 91  
**Or 24hrs:** 03000 41 41 41

### 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:

**Out of Hours:** 03000 41 91 91  
**Or 24hrs:** 03000 41 41 41

**Kent Sensory and Autism Services**  
Kent County Council  
Kroner House  
Eurogate Business Park  
Ashford TN24 8XU

**Tel:** 03000 41 89 00  
**E:** sensoryservices@kent.gov.uk

**Autistic Spectrum Conditions Team**  
Tel: 03000 41 81 00  
E: autisticspectrumconditions@kent.gov.uk

**Sensory Services**  
Tel: 03000 418900  
**Mobile/SMS:** 07920 154315  
**Minicom:** 01233 66 63 35  
**E:** sensoryservices@kent.gov.uk

**Royal Association for Deaf People (RAD)**  
**Interpreting Service**  
Voice Phone: 0845 688 2626  
Mobile: 07974 325563 (24 hour emergency service)  
Fax: 0845 688 2627  
Text: 0845 688 2628  
E: Interpreting@royaldeaf.org.uk

**Kent Association for the Blind (KAB)**  
**Rehabilitation Teams**

- **Maidstone:** 01622 69 13 57  
- **Canterbury:** 01227 76 33 66  
- **Dover:** 01304 85 85 75  
- **Gravesend:** 01474 54 44 40

**Hi Kent Maidstone**  
01622 69 11 51  
**Hi Kent Canterbury**  
01227 76 00 46
## 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
Or 24hrs: 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><a href="mailto:gcsxcanterburyact@kent.gcsx.gov.uk">gcsxcanterburyact@kent.gcsx.gov.uk</a></td>
<td>03000 42 11 54</td>
</tr>
<tr>
<td>Dartford, Gravesend and Swanley</td>
<td><a href="mailto:NKACTAP@kent.gov.uk">NKACTAP@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><a href="mailto:doveract@kent.gcsx.gov.uk">doveract@kent.gcsx.gov.uk</a></td>
<td>03000 41 61 61</td>
</tr>
<tr>
<td>Maidstone</td>
<td><a href="mailto:ACTWKMaid@kent.gov.uk">ACTWKMaid@kent.gov.uk</a></td>
<td>03000 41 77 00</td>
<td>03000 42 27 38</td>
</tr>
<tr>
<td>Sevenoaks &amp; Malling</td>
<td><a href="mailto:ACTWKSM@kent.gov.uk">ACTWKSM@kent.gov.uk</a></td>
<td>03000 41 61 61</td>
<td></td>
</tr>
<tr>
<td>Shepway</td>
<td><a href="mailto:shepwayact@kent.gov.uk">shepwayact@kent.gov.uk</a></td>
<td><a href="mailto:gcsxshepwayact@kent.gov.uk">gcsxshepwayact@kent.gov.uk</a></td>
<td>03000 41 44</td>
</tr>
<tr>
<td>Swale</td>
<td><a href="mailto:ACTSwale@kent.gov.uk">ACTSwale@kent.gov.uk</a></td>
<td>03000 41 48 88</td>
<td></td>
</tr>
<tr>
<td>Thanet</td>
<td><a href="mailto:thanetact@kent.gov.uk">thanetact@kent.gov.uk</a></td>
<td><a href="mailto:thanetact@kent.gcsx.gov.uk">thanetact@kent.gcsx.gov.uk</a></td>
<td>03000 41 62 34</td>
</tr>
<tr>
<td>Tonbridge &amp; Tunbridge Wells</td>
<td><a href="mailto:ACTWKTTW@kent.gov.uk">ACTWKTTW@kent.gov.uk</a></td>
<td>03000 41 23 00</td>
<td></td>
</tr>
</tbody>
</table>

**Kent and Medway NHS and Social Care Partnership Trust**  
(M)  
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  
Or 24hrs: 03000 41 41 41
### Appendices

**Ashford and Shepway**  
E: ash.shep.ld.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: DGSLDCTeam01@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: 01304 82 85 72

**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

**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

**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 60066.
### NHS Counter Fraud Service

Andrew Ede | Counter Fraud Specialist  
Tel: 07979 645948  
Email: andrew.ede@nhs.net

Steffan Wilkinson | Counter Fraud Specialist  
Tel: 07799 263978  
Email: steffanwilkinson@nhs.net

### Kent County Council – Trading Standards

Kent County Council Trading Standards does not give advice about disputes between a business and a consumer.


Businesses seeking advice about compliance with legislation or licensing issues can contact Trading Standards in the following ways:

- **Ashford, Canterbury, Dover, Shepway, Swale and Thanet**  
  Tel: 03000 41 20 20

- **Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Tunbridge Wells**  
  Tel: 03000 41 20 00  
  Email: tsbusinessadvice@kent.gov.uk

### Medway Council – Trading Standards

Gun Wharf, Dock Road, Chatham, Kent, ME4 4TR  
Tel: 01634 33 35 55  
Email: consumer.protection@medway.gov.uk  
www.medway.tradingstandards.uk/

### Contact Details for Nominated Hospital Safeguarding Leads

**Darenth Valley NHS Hospital Trust**  
Tel: 01322 428865  
Lead Nurse for Adult Protection  
Or ask for the Director of Nursing

**Queen Elizabeth Queen Mother Hospital (East Kent NHS Hospital Trust)**  
Head of Adult Safeguarding, PREVENT Lead  
Tel: 079644 37558  
or  
Director of Nursing or Lead Nurse for Safeguarding Adults  
Tel: 01843 22 55 44

Or ask for a site based Matron Out of Hours or ask for the Site Clinical Nurse Manager at relevant hospital.
<table>
<thead>
<tr>
<th>Medway NHS Foundation Trust</th>
<th>Maidstone and Tunbridge Wells NHS Hospital Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Nurse’s Office</td>
<td>Ask for Safeguarding Lead</td>
</tr>
<tr>
<td>Windmill Road</td>
<td>Tel: 01622 224821</td>
</tr>
<tr>
<td>Gillingham</td>
<td>Tunbridge Wells Hospital</td>
</tr>
<tr>
<td>Kent ME7 5NY</td>
<td>(Pembury)</td>
</tr>
<tr>
<td>Tel: 01634 830000 ex: 3127</td>
<td>Tel: 01892 63 43 77</td>
</tr>
<tr>
<td>or</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults Coordinator</td>
<td></td>
</tr>
<tr>
<td>Tel: 07884 181615</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

The Care and Support (Eligibility Criteria) Regulations 2014 - Care Act 2014

An adult’s needs meet the eligibility criteria if:
(a) The adult’s needs arise from or are related to a physical or mental impairment or illness;
(b) As a result of the adult’s needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and
(c) As a consequence there is, or is likely to be, a significant impact on the adult’s well-being.

The specified outcomes are:
(a) Managing and maintaining nutrition
(b) Maintaining personal hygiene
(c) Managing toilet needs
(d) Being appropriately clothed
(e) Being able to safely make use of their home
(f) Maintaining a habitable home environment
(g) Developing and maintaining family or other personal relationships
(h) Accessing and engaging in work, training, education or volunteering
(i) Making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
(j) Carrying out any caring responsibilities the adult has for a child.

An adult will be regarded as being unable to achieve an outcome if they:
(a) Are unable to achieve it without assistance
(b) Are able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety
(c) Are able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others, or
(d) is able to achieve it without assistance but takes significantly longer than would normally be expected.

If the adult’s needs fluctuate and you are trying to establish if the adult meets eligibility criteria, the Local Authority must take into account the adult’s circumstances over such period as it considers necessary to establish accurately the adult’s level of need.
Appendices

Appendix 3

Carers Needs which meet eligibility criteria - Care Act 2014

A carer’s needs meet the eligibility criteria if:
(a) the needs arise as a consequence of providing necessary care for an adult
(b) the effect of the carer’s needs is that any of the circumstances specified above apply to the carer, and
(c) as a consequence, there is, or is likely to be, a significant impact on the carer’s well-being.

The circumstances specified are:
(a) the carer’s physical or mental health is, or is at risk of, deteriorating
(b) the carer is unable to achieve any of the following outcomes:
   (i) carrying out any caring responsibilities the carer has for a child
   (ii) providing care to other persons for whom the carer provides care
   (iii) maintaining a habitable home environment in the carer’s home (whether or not this is also the home of the adult needing care)
   (iv) managing and maintaining nutrition
   (v) developing and maintaining family or other personal relationships
   (vi) engaging in work, training, education or volunteering
   (vii) making use of necessary facilities or services in the local community, including recreational facilities or services; and
   (viii) engaging in recreational activities.

A carer is to be regarded as being unable to achieve an outcome if the carer:-
(a) is unable to achieve it without assistance;
(b) is able to achieve it without assistance but doing so causes the carer significant pain, distress or anxiety; or
(c) is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the carer, or of others.

Where the level of a carer’s needs fluctuates, in determining whether the carer’s needs meet the eligibility criteria, the Local Authority must take into account the carer’s circumstances over such period as it considers necessary to establish accurately the carer’s level of need.
Safeguarding enquiries and reviews, Care Act 2014

(1) Where there is to be:
   (a) an enquiry under Section 42(2),
   (b) a review under Section 44(1) of a case in which condition 2 in Section 44(3) is met or a review under Section 44(4).

(2) The Local Authority must, if the condition in sub Section (3) is met (below) arrange for a person who is independent of the authority (an “independent advocate”) to be available to represent and support the adult to whose case the enquiry or review relates for the purpose of facilitating his or her involvement in the enquiry or review (also see sub Sections (4) and (6) below).

(3) The condition is that the Local Authority considers that, were an independent advocate not to be available, the individual would experience substantial difficulty in doing one or more of the following:-
   understanding relevant information;
   retaining that information;
   signing or weighing that information as part of the process of being involved communicating the individual’s views, wishes or feelings (whether by talking, using sign language or any other means).

(4) The duty under sub Section (2) does not apply if the Local Authority is satisfied that there is a person:
   who would be an appropriate person to represent and support the adult for the purpose of facilitating the adult's involvement, and who is not engaged in providing care or treatment for the adult in a professional capacity or for remuneration.

(5) For the purposes of sub Section (4), a person is not to be regarded as an appropriate person unless:
   (a) where the adult has capacity to consent to being represented and supported by that person, the adult does so consent, or
   (b) where the adult lacks capacity so to consent, the Local Authority is satisfied that being represented and supported by that person would be in the adult's best interests.

(6) If the enquiry or review needs to begin as a matter of urgency, it may do so even if the authority has not yet been able to comply with the duty under sub Section (2) (and the authority continues to be subject to the duty).

(7) “Relevant Local Authority” means:-
   (a) in a case within sub Section (1) (a), the authority making the enquiry or causing it to be made;
   (b) in a case within sub Section (1) (b), the authority which established the SAB arranging the review.
Safeguarding Adult Board Responsibilities, Care Act 2014 Duty to Set up a Competent Statutory Board

Every Local Authority (LA) MUST set up a Safeguarding Adults Board and:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect
- take action to prevent or stop abuse or neglect
- set up an advocate for a person involved with an enquiry or a SAR if they have ‘substantial difficulty’ on being involved
- co-operate with all relevant partners to protect a person
- and partners must co-operate with the LA to protect a person

Any Section 42 Enquiry objectives should be to:

- Ensure safety & well being
- Establish facts
- Ascertain views/wishes of person or their representative
- Assess needs for protection
- Support redress
- Decide follow up action
- Enable adult to achieve resolution and recovery

Board Members must:

- Be skilled & experienced rep
- Pay regard to any guidance from Secretary of State
- Be able to present issues in writing and in person & explain their organisational priorities
- Able to promote aims of SAB
- Able to commit their organisation to agreed action
- Have thorough understanding of abuse & neglect & its impact
- Understand pressures facing front line practitioners

Policy and Procedures

These should:

- reflect legal provision & statutory guidance & include agency specific info for access to legal advice
- assist the person to recover
- be personalised and ensure person is involved
- be proportionate
- utilise Decision Trees noted in Statutory Guidance at diagrams 1a and 1b
- be reported on annually in the Annual Report
- be updated to include research outcomes; peer reviews; case law and lessons from SARS
- describe access to independent advocacy arrangements (for SARS)
- reflect how partners will implement risk management to prevent escalation to the SAB procedures
- reflect how abuse and neglect will be responded in regulated care settings (‘level one enquiries’); conflicts of interest & multiple concerns (LSIs)

They may include:

- a statement of purpose; roles & responsibilities & response
- Lists of referral and information access points; access details; where to get expert advice & all support services
- Description of how agencies will share information (channels & communications)
n) How professional disagreements will be resolved (e.g. Section 42 enquiries and their outcomes)
o) Guidance on utilisation of the MCA 2005

**Strategic Plan**
Members must:
a) publish a strategic plan for each financial year ending 31st March
b) publish strategy for achieving objectives
c) publish what each member will do to implement the strategy
d) consult Health Watch
e) involve the community

**Annual Report**
Members must as soon as possible after 31st March, publish a report on:
a) What SAB has done to achieve objectives
b) What SAB and each Member has done to implement strategy
c) Findings of SARs concluded in year & arranged SARS which are ongoing
d) What SAB has done to implement findings of SARS
e) Reasoned explanation if recommendations from SAR findings are not deployed
f) This must be shared with the CEO of the LA; the Leader of LA; the Police Commander; Health watch and Chair of the HWB

**Safeguarding Adult Reviews (SARs)**
The Board must:
a) arrange review of a case where adult has care & support needs (met or unmet) where reasonable cause for concern exists about how SAB member(s)/rep worked together to safeguard the adult, and either:
b) the adult has died, and SAB knows/suspects death resulted from abuse or neglect
c) the adult is living and SAB knows/suspects adult experienced serious abuse or neglect

The Board must co-operate in and contribute to review with a view to identifying lessons learned and applying this to future cases. The Board can arrange review of any case with care & support needs in area (met or unmet)

**In Relation to a SAR, Board Members can:**
a) make payments towards incurred expenditure
b) provide staff, goods, services, accommodation or other resources for connected purposes
c) regulate SAB procedure as a result

**Supply of information**
If the Board requests information it must be complied with, if it is to enable the Board to exercise its function;

AND - the request is made to a person whose functions/activities are considered to have information relevant to the above

AND - that the information relates to: (a) the person to whom the request is made (b) a function or activity of that person, or (c) a person in respect of whom that person exercises a function or engages in an activity

OR - information is requested from a person to whom information was supplied in compliance with another request from SAB

AND – it is the same as, or is derived from the information supplied.
Section 47 Protection of Property, Care Act 2014

If an adult with care and health needs is involved with a move to care home or hospital (or both) and it appears there is danger of loss or damage to their movable property AND - the adult is unable (permanent or temporarily) to protect property AND - no suitable arrangements have or are being made then the Local Authority (LA) must take reasonable steps to prevent or mitigate the loss or damage. In these circumstances the LA can enter where the adult lived (with reasonable notice) immediately prior and can deal with movable property to prevent or mitigate loss or damage. The LA cannot do this if an adult able to consent has disagreed. If a person lacks capacity, a person authorised under the MCA 2005 can consent for the adult, or if no such person exists the LA can deploy a best interest’s decision. If LA exercises this power it must produce a valid authorisation document if a person (without reasonable excuse) obstructs the protection of property they will commit an offence, and are liable to be fined. The LA may recover reasonable expenses incurred.