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**Kent Adult Safeguarding Concern Form**

**Purpose of this Form**

This form should be used by all agencies to report concerns where a person is believed to have suffered abuse or neglect or is at risk of abuse or neglect by the actions or omissions of another person(s). This form should also be used to report self-neglect concerns.

**Please complete on the day that the concern is identified.**

Please note that this Form was formally known as the Kent Adult Safeguarding Alert.

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| **INITIAL DETAILS** |  |
| **Adult at risk surname**  |            |
| **Title** |  |
| **Adult at risk first name*(s)***  |       |
| **Any alternative name** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **NHS or Hospital Number** *(If available)*  |  |
| **Ethnic Origin** |  |
| **Religion** |  |
| **First language** |  |
| **Does the person have communication needs?**  | Yes [ ] No [ ]  |
| **If ‘Yes’, please give details (uses a hearing aid, interpreter needed (British / Makaton / Lip speaker)** |  |
| **Home Address** **Post Code:****Telephone number/s:** **Email address** |  |
| **Any other relevant addresses *(e.g., respite place or hospital):*****Post Code:** **Telephone number/s:** **Email address:** |  |
| **GP Name:**  |  |
| **GP Surgery & Address:** |  |
| **Telephone No.** |  |

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| **PRIMARY CARE AND SUPPORT NEED OF THE ADULT AT RISK** |  |
| Please tick **ONE** of the options on the right-hand side | Adult at Risk [ ] Adult Former Self Funder [ ] Carer[ ] Learning Disability Support (18-64)[ ] Learning Disability Support (65+)[ ] Mental Health Support (18-64)[ ] Mental Health Support (65+)[ ] Physical Support Access and Mobility only (18-64)[ ] Physical Support Access and Mobility only (65+)[ ] Physical Support Personal Care and Support (18-64)[ ] Physical Support Personal Care and Support (65+)[ ] Sensory Support for Dual Impairment (18-64)[ ] Sensory Support for Dual Impairment (65+)[ ] Sensory Support for Hearing Impairment (18-64)[ ] Sensory Support for Hearing Impairment (65+)[ ] Sensory Support for Visual Impairment (18-64+)[ ] Sensory Support for Visual Impairment (65+)[ ] Substance Misuse Support (18-64+)[ ] Substance Misuse Support (65+)[ ] Support with Memory and Cognition (18-64)[ ] Support with Memory and Cognition (65+)[ ]  |
| **Secondary Care and Support need of the Adult at Risk** *(if relevant)* |  |

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| **NEXT OF KIN, NEAREST RELATIVE OR SIGNIFICANT OTHER DETAILS** |  |
| **Name** |       |
| **Home Address** |       |
| **Post Code** |  |
| **Telephone number/s** |  |
| **Email address** |  |
| **Relationship to Adult at Risk** |  |

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| **SAFEGUARDING CONCERN COMPLETED BY** |  |
| **Name** |  |
| **Agency** |  |
| **Role** |  |
| **Telephone number/s** |  |
| **Email address** |  |
| **Date Completed** |  |
| **Are you completing this on behalf of another person?** | Yes [ ]  No [ ]  |
| **If ‘Yes’ give details (name, relationship, contact details):** |  |
| **Do they wish to remain anonymous?** | Yes [ ]  No [ ]  |
| **Funding Authority**If OTHER, please give details: |       |

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| **INCIDENT DETAILS** |  |
| **Details of the allegation, incident of concern or information about self-neglect** |  |
| **Date and Time of Incident** | Date: Time:       |
| **Location Abuse Occurred**If other, please specify  |  |
| **Details of the allegation, incident of concern or information about self-neglect** | *Factual account of allegation (who/where/when/what). Details of witnesses. Details of harm or risks, or potential for either. Any other supporting information:*      |
| **Are there any concerns of immediate risk to the individual or any other adults or children?**  | Yes [ ]  No [ ]  |
| **If yes is clicked to the question above, please give further details and action taken:**  |  |
| **Do you have reason to believe a crime has been committed?** **If yes, consult with police on 101 or 999 in emergencies.** | Yes [ ]  No [ ]  |
| **Outcome of Consultation with Police (if applicable) – Crime Reference No. (if available):**  |  |
| **Is the adult at risk aware of this referral?**  | Yes [ ]  No [ ]  |
| **Does the person at risk have capacity to consent to this safeguarding concern?** | Yes [ ]  No [ ]  |
| **Essential information about the adult at risk’s current social situation which is relevant to these concerns.** *(If currently in Hospital please state ward and telephone number)* |  |
| **Is there anything that you know of that would affect the adult’s ability to make decisions in respect of this concern? (Either temporary or permanent)** | *Details of any Involvements such as MCA, DoLS, IMCA, LPA:* |
| **Has a Mental Capacity Assessment been completed?** | Yes [ ]  No [ ]  Don’t know [ ]  |

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| **OTHER SIGNIFICANT FAMILY MEMBERS/ADULTS/CHILDREN YOU ARE AWARE OF**  |  |
| **Name/s** |       |
| **Relationship/s** |       |
| **Date of Birth / Approx. Age**  |  |
| **Contact Details** |  |

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| **PROFESSIONALS KNOWN TO THE ADULT, FOR EXAMPLE, DISTRICT NURSE, MENTAL HEALTH WORKER**  |  |
| **Name/s** |       |
| **Role** |       |
| **Address/s** |  |
| **Telephone Numbers** |  |

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| **DETAILS OF ANY MEDICAL ATTENTION SOUGHT**  |  |
| **Please state date and time, whether there was a Body Map (Appendix 1) completed or photographs taken and attach where possible.** | *Date & Time:**Further details:* |

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| **PERSON ALLEGED TO BE RESPONSIBLE (if identified)** *For multiple persons, use “Additional Persons Alleged to be Responsible” (Appendix 2) form.*  |  |
| **Name of person or service believed to have caused harm**  | *:* |
| **Date of Birth/** **Approx. Age** |  |
| **Gender** |  |
| **Address****Postcode** |  |
| **Telephone** |  |
| **Email** |  |
| **Ethnic Origin** |  |
| **Is the person alleged to be responsible also considered at risk?**  | Yes [ ]  No [ ]  |
| **Does person have capacity in relation to the allegation(s)?** | Yes [ ]  Don’t Know [ ]  |
| **Is the adult at risk dependent on the person alleged to be responsible to support them?** | Yes [ ]  No [ ]  |
| **Does the person alleged to be responsible care for others?** | Yes [ ]  No [ ]  |
| **If yes is clicked to the question above, please give details:** |  |
| **Occupation or Voluntary Position Title***(If known)* |  |
| **Organisation person works for** *(If known)* |  |
| **Is the person alleged to be responsible aware that you are reporting this?** | Yes [ ]  No [ ]  |
| **If you think there is a risk of violence (such as domestic abuse), provide details of a safe point and/or mode of contact for the adult.** |  |
| **Is there any risk of danger to staff making enquiries?** | Yes [ ]  No [ ]  |
| **If yes is clicked to the question above, please give details** |  |

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| **MAKING SAFEGUARDING PERSONAL****(WHAT DOES THE PERSON WANT TO HAPPEN?)** |  |
| **Please provide details of the views of the person** |  |
| **Please provide details of the views of the representative** |  |
| **Signature of person completing this form** *(Accepted as signed when sent electronically)* | Date: Time: |

Further information on submitting this form and the relevant contact information can be found in the **Kent Adult Safeguarding Concern Form Appendices.** They can be accessed [here.](https://www.kent.gov.uk/social-care-and-health/information-for-professionals/adult-safeguarding/adult-protection-forms)