**Adult Social Care and Health Directorate**

**Safeguarding OperationalPractice Guidance**

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| **Issue Date:** | October 2023 |
| **Review Date:** | October 2024 |
| **Owner:** | Sarah Denson - Assistant Director– Strategic Safeguarding, Policy, Practice & Quality Assurance |

**Document Information**

|  |  |
| --- | --- |
| Working Title: | Safeguarding Operational Practice Guidance |
| Status: | Final |
| Version No: | v1 |
| Date Approved by |  |
| Date Issued | October 2023 |
| Review by: | Vickie Minkiewicz - Principal Social Worker Strategic Safeguarding, Practice, Policy and Quality Assurance Team; and Sarah Denson - Assistant Director– Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Review Date | Sept 2024 |
| Lead Officer/s: | Sarah Denson - Assistant Director– Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Master Location | Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Publication |  |
| Authorised to vary | Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Replaces | - |

**Version Control**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Date re issued** | **Summary changes** | **Reviewed by** |
| v1.0 | Oct 2023 | Original upload to Tri.X | Vickie Minkiewicz & Sarah Denson & Operational Senior Management Team |

Table of Contents

[1. Key Principles 7](#_Toc148699861)

[1.1 The statutory framework (See P.2 Multi agency Policy, Protocols and Guidance) 7](#_Toc148699862)

[1.1.1 Section 42 (1) Care Act 2014 7](#_Toc148699863)

[1.1.2 Section 42 (2) Care Act 2014 8](#_Toc148699864)

[1.1.3 Non-statutory Safeguarding Enquiries 8](#_Toc148699865)

[1.1.4 Duty to Offer a Carers Assessment 10](#_Toc148699866)

[2 Definitions 11](#_Toc148699867)

[3 National Guidance 12](#_Toc148699868)

[3.1 Making Safeguarding Personal (MSP) 12](#_Toc148699869)

[3.2 The Golden Thread 13](#_Toc148699870)

[3.3 Equality, Diversity, and Inclusion 14](#_Toc148699871)

[4 Practice Guidance – What, How, Who and When? 14](#_Toc148699872)

[4.1 Receiving and triaging the referral 14](#_Toc148699873)

[4.1.1 Introducing the role of the Designated Senior Officer (DSO) and Inquiry Officer (IO) 14](#_Toc148699874)

[4.1.2 Receiving the Referral 16](#_Toc148699875)

[4.1.3 Initial Triage of Referral 17](#_Toc148699876)

[4.1.4 Deciding which team is responsible for managing the safeguarding referral 18](#_Toc148699877)

[4.1.5 When referrers wish to remain anonymous 21](#_Toc148699878)

[4.1.6 Informing other departments and agencies 22](#_Toc148699879)

[4.2 Risk Assessment and Strategy Discussion 22](#_Toc148699880)

[4.2.1 Initial Information gathering to inform the risk assessment and strategy discussion 22](#_Toc148699881)

[4.2.2 Completing the initial risk assessment 23](#_Toc148699882)

[4.2.3 What to consider for each category: 23](#_Toc148699883)

[4.2.4 Strategy discussion and decision to progress or close 24](#_Toc148699884)

[4.2.5 Protocol between Area Referral Service and Community Teams 25](#_Toc148699885)

[5. Terms of Reference and Enquiry 25](#_Toc148699886)

[5.1 Planning the Enquiry 25](#_Toc148699887)

[5.2 Terms of reference (TOR) 26](#_Toc148699888)

[5.3 Causing Others to make enquiries 27](#_Toc148699889)

[5.4 Independent Advocates 27](#_Toc148699890)

[5.5 Adult not consenting to a Safeguarding Enquiry 28](#_Toc148699891)

[5.6 The Enquiry 28](#_Toc148699892)

[5.7 Key skills required by the IO 28](#_Toc148699893)

[6. Working with Multi-Agency Partners 29](#_Toc148699894)

[6.1 Information Sharing 29](#_Toc148699895)

[6.2 Criminal Offences 29](#_Toc148699896)

[6.3 Types and patterns of abuse 30](#_Toc148699897)

[6.4 Self-Neglect 31](#_Toc148699898)

[6.5 Domestic Abuse 32](#_Toc148699899)

[6.6 Multi-agency meetings (Case Conferences) 32](#_Toc148699900)

[6.7 Managing disputes with multi-agency partners 33](#_Toc148699901)

[7. Establishments 33](#_Toc148699902)

[7.1 Important factors to consider in establishment safeguarding enquiries 34](#_Toc148699903)

[7.1.2 People in establishments are often the least likely to be able to protect themselves from abuse and neglect 34](#_Toc148699904)

[7.1.3 The danger of normalising abuse within establishments 34](#_Toc148699905)

[7.1.4 Ensuring a proportionate response to apparently minor incidents 34](#_Toc148699906)

[7.2 What do we mean by establishment? 35](#_Toc148699907)

[7.3 Commissioning and Regulatory Bodies 35](#_Toc148699908)

[7.4 Sanctions on KCC commissioned establishments 37](#_Toc148699909)

[7.5 Quality in care or adult safeguarding response 38](#_Toc148699910)

[7.6 Allegations against staff (Allegation Management) 39](#_Toc148699911)

[7.7 People legally detained in an establishment – Deprivation of Liberty Safeguards (DoLS), detention under the Mental health Act 1983 (MHA 1983) 40](#_Toc148699912)

[7.7.1 Independent Mental Health Advocate (IMHA) 41](#_Toc148699913)

[7.7.2 Independent Mental Capacity Advocate (IMCA) 41](#_Toc148699914)

[7.7.3 Mental Health Act (MHA 1983) 41](#_Toc148699915)

[7.7.4 DoLS 42](#_Toc148699916)

[7.8 Reporting a crime when a person is within an establishment 42](#_Toc148699917)

[7.8.1 Reporting to the police 43](#_Toc148699918)

[8. Outcome and Post Enquiry planning 43](#_Toc148699919)

[8.1 The outcome of the enquiry 43](#_Toc148699920)

[8.2 Post Enquiry planning 44](#_Toc148699921)

[8.3 Feedback on the outcome and post enquiry plan 44](#_Toc148699922)

[9. Useful information & Frequently Asked Questions 45](#_Toc148699923)

[9.1 What is the Court of Protection (CoP) and the Office of the Public Guardian? 45](#_Toc148699924)

[9.2 What is Multi-Agency Public Protection Arrangements (MAPPA) and how and when should I refer? 46](#_Toc148699925)

[9.3 What is Violent and Sex Offender Register (ViSOR) 47](#_Toc148699926)

[9.4 What is the Domestic Abuse, Stalking and Honor Based Violence Assessment (DASH) and who should complete it? 47](#_Toc148699927)

[9.5 What is Multi-Agency Risk Assessment Conference (MARAC) and how and when should I refer someone? 47](#_Toc148699928)

[9.6 What legal powers can be utilised to support safeguarding enquiries and help to protect someone from further abuse 48](#_Toc148699929)

[9.7 How do I report to the police when the safeguarding concern appears to be a criminal offence? 48](#_Toc148699930)

[9.8 How do I contact Medway Safeguarding Team? 48](#_Toc148699931)

[9.9 What do I need to consider when uploading 3rd party documents securely 49](#_Toc148699932)

[10. Useful Resources 50](#_Toc148699933)

[10.1 Guidance for people with Dementia on safeguarding enquiries 50](#_Toc148699934)

[10.2 Refusal of a Care Needs Assessment briefing 50](#_Toc148699935)

[10.3 Safeguarding Adult Review (SAR) referral process 50](#_Toc148699936)

[10.4 Inherent Jurisdiction guidance 50](#_Toc148699937)

[10.5 Social Care Institute of Excellence (SCIE) Adult Safeguarding practice questions 50](#_Toc148699938)

[10.6 Guidance on Safeguarding Adults in Care Homes 50](#_Toc148699939)

[11. Monitoring 51](#_Toc148699940)

[12. Appendices 52](#_Toc148699941)

**PRACTICE GUIDANCE**

**Introduction**

The purpose of producing this guidance is to provide clear, practical, and easily accessible guidance to social care practitioners on the specific duties and responsibilities undertaken by adult social care. The guidance is intended to complement and supplement the Multi Agency Safeguarding Policy, Protocols and Guidance (MAPPG) (references are provided throughout to relevant sections of the MAPPG.)

[Multi-agency Safeguarding Adults Policy, Procedures and Practitioner Guidance for Kent and Medway (kmsab.org.uk)](https://kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf)

This document also refers to chapter 14 of the Care Act (2014) statutory guidance, which provides further guidance on the statutory duties relating to adult safeguarding.

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

# Key Principles

## The statutory framework (See P.2 Multi agency Policy, Protocols and Guidance)

### Section 42 (1) Care Act 2014

The criteria for a statutory safeguarding enquiry will be met when the 3 conditions below have been met:

The Local Authority (LA) has reasonable cause to suspect that an adult:

1. has needs for care and support,
2. is experiencing, or at risk of, abuse or neglect,
3. 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.

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| **Important to consider** |
| 1. **We only need reasonable cause to suspect the adult has care and support needs.**     1. It is not relevant whether the adults’ needs are currently being met or whether it has been established that the needs meet the eligibility criteria. 2. **We only need reasonable cause to suspect the adult is experiencing or at risk of abuse or neglect.**     1. We do not need firm evidence of abuse; It is the purpose of the Enquiry to establish this.    2. The statutory criteria can be met in circumstances where the adult is not currently experiencing abuse or neglect but there is clear evidence that the adult is at risk of abuse and neglect. 3. **The third condition will be a matter of professional judgement about how the adults care needs are associated with the abuse/neglect they are experiencing or at risk of experiencing.**    1. This can be how it affects their ability to take action to protect themselves but may also be in circumstances where the adult’s care needs have led to the adult being targeted by abusers (for example scammers).    2. Be careful not to make assumptions when coming to a judgement at this point. A person’s needs may not be obvious initially (for example mental health and depression) If the Designated Senior Officer (DSO) decision is to close on the basis that the adult can take action to protect themselves from the abuse, then they need to clearly record their evidence for this decision. |

### Section 42 (2) Care Act 2014

Where it has been evaluated that the criteria (above) have been met, the LA must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and if so, by who.

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| **Important to consider** |
| It is likely that in most instances the appropriate agency to undertake a safeguarding enquiry will be Adult Social Care, however, there are circumstances when a partner organisation will be the most appropriate. For example, a registered manager can be asked to undertake an enquiry for a resident in their home in situations where the incident is at a low level of seriousness and there is no conflict of interest. A safeguarding lead in a general hospital can also be asked to undertake an enquiry for incidents occurring within the hospital. In this instance the DSO, on behalf of the LA will cause another organisation/agency to undertake aspects of the enquiry. Making Safeguarding Personal (MSP) will remain with a LA appointed Inquiry Officer (IO).  See section 5.2 Setting Terms of Reference (TOR) and 5.3 Causing others to make enquiries. |

### Non-statutory Safeguarding Enquiries

**See P.11 MAPPG**

The statutory criteria set out in S.42(1) is relatively low, so the circumstances in which a decision to undertake a non-statutory enquiry are limited. The main circumstance in which a non-statutory enquiry is indicated, is in circumstances where someone providing care for a person with care needs is experiencing abuse or is at risk of abuse:

“a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with.” Chapter 14.45

[Care and support statutory guidance - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

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| **Case example – Non statutory safeguarding enquiry involving a carer** |
| Mrs C lives with her 19-year-old son G. G is open to adult social care and has a diagnosis of autism and ADHD. Mrs C has cared for G all her life, mostly without any support from others. Mrs C told her worker that “G can become aggressive when he doesn’t get what he wants”, and that he has pushed her and threatened violence towards her on recent occasions. Mrs C disclosed that she feels scared of G and will give in to his demands, usually giving him money. Mrs C thinks that G has become addicted to online gambling. G does not want to move away from his mother and Mrs C has said she won’t ask him to leave and doesn’t believe he will be able to cope on his own or even in a supported setting, she feels he is vulnerable to exploitation and is unable to take care of himself.  Mrs C does not appear to have care and support needs but is a carer to her son and has support needs in her role as carer. Mrs C is experiencing abuse from her son but appears unable to protect herself from the abuse because of her support needs as a carer. |

There may also be circumstances when a non-statutory enquiry might be instigated in circumstances where a young adult may be experiencing or at risk of abuse and may be unable to take action to protect themselves from the abuse due to vulnerability regarding their emotional maturity, history of childhood trauma, being a care leaver and having limited support networks to help protect them. For further information on safeguarding young people see:

**Bridging the gap – Transitional safeguarding and the role of social work with adults**

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf>

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| **Case example – Non statutory safeguarding enquiry involving a care leaver** |
| J has just turned 18 and has transitioned from the Children in Care Team (CIC) to the Care leavers service (18+). J received a transition assessment at 17 ½ but was not found to have eligible care and support needs or be likely to have when he reached 18. J is very vulnerable however, he has been in and out of care since he was 8, he missed a great deal of school so has problems with basic literacy and numeracy, he is described as very emotionally immature and has always struggled to make friends or mix socially. Safeguarding concerns emerged before he became 18 due to J becoming involved with a group of teenagers. J describes them as his friends but there is evidence that they are financially exploiting him and there have also been concerns that he has been physically assaulted on a number of occasions. J moved from foster care into a semi-supported flat when he turned 18 and concerns have been raised that these youths are constantly at the flat and there is evidence that they are dealing and taking drugs there too. J is appearing neglected and often has no money for food or to pay the bills. He continues to insist that the young people are his friends.  The CIC are not able to continue with the safeguarding enquiries now J is 18 and the 18+ team are not resourced or appropriately trained to undertake safeguarding enquiries. The 18+ team have completed an adult safeguarding referral. The referral did not meet the criteria for a statutory enquiry under S.42 as the recent care needs assessment concluded he did not have care and support needs. However, due to J’s young age, history as a care leaver and deficits in his development due to the Adverse Childhood Experiences (ACES), J is unable to protect himself from the abuse and it is agreed that a non-statutory safeguarding enquiry should be commenced. |

### Duty to Offer a Carers Assessment

In addition to our safeguarding duties, the DSO must ensure the local authorities’ duties under S.10 of the Care Act are met. This means that where it has been identified that another adult is providing care for the adult at risk, and it appears that the adult may need support in their caring role, then they must be offered a carers assessment.

**The DSO is to ensure that Carers are identified and record in Mosaic what action has been taken to discuss and provide support.**

# Definitions

The following terms are used in this policy as set out in the appropriate statute regulations and local guidance.

|  |  |
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| **Acronym** | **Expansion** |
| AP | Adult Protection |
| CoP | Court of Protection |
| CQC | Care Quality Commission |
| CTO | Community Treatment Order |
| DASH | Domestic Abuse, Stalking and Honor Based Violence Assessment |
| DBS | Disclosure and Barring Service |
| DoLS | The Deprivation of Liberty Safeguards Team |
| DSO | Designated Senior Officer |
| GMC | General Medical Council |
| HCPC | Health and Care Professions Council |
| IDVA | Independent Domestic Violence Advisors |
| IMCA | Independent Mental Capacity Advocate |
| IMHA | Independent Mental Health Advocate |
| IO | Inquiry Officer |
| KASC | Kent Adult Safeguarding Concern Form |
| KFRS | Kent Fire and Rescue Service |
| KIDAS | Kent Integrated Domestic Abuse Service |
| KMPT | Kent and Medway Partnership Trust |
| KMSAB | Kent and Medway Safeguarding Adults Board |
| LA | Local Authority |
| MAPPG | Multi Agency Safeguarding Policy, Protocols and Guidance |
| MARAC | A Multi Agency Risk Assessment Conference |
| MCA 2005 | Mental Capacity Act |
| MHA 1983 | Mental Health Act 1983 |
| MSP | Making Safeguarding Personal |
| NMC | Nursing and Midwifery Council |
| SAR | Safeguarding Adult Review |
| SCIE | Social Care Institute for Excellence |
| SECAMB | South East Coast Ambulance Service |
| SWE | Social Work England |
| TOR | Terms of Reference |
| UK GDPR | United Kingdom General Data Protection Regulations |
| ViSOR | Violent and Sex Offender Register |
| VIT | Vulnerable Investigation Team |

# National Guidance

## Making Safeguarding Personal (MSP)

MSP was a response to criticisms made by people who had been the subject of an adult safeguarding investigation prior to the enactment of the Care Act. People expressed that they often experienced the safeguarding process as something that was done **to them** not **with them.** The labelling of people as vulnerable adults and the focus on accumulating evidence and establishing facts were also factors which contributed to the process driven disempowering experiences reported by people subject to a safeguarding investigation.

The Care Act subsequently adopted the MSP approach with the values of person centred, outcome focused practice incorporated throughout the statutory guidance (chapter 14). The main tenants of MSP can be expressed as:

* A personalised approach that enables safeguarding to be done with, not to, people
* Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on ‘enquiry' and ‘conclusion'
* An approach that utilises social work skills rather than just ‘putting people through a process'
* An approach that enables practitioners, families, teams, and Safeguarding Adults Boards to know what difference has been made. (P.6 MAPPG)

The statutory guidance also recognises the dilemma’s that can arise when the outcomes people want from the safeguarding process may not be necessarily achieve the level of safety that the professionals involved would prescribe:

“People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved.” Ch.14.8

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| **Note** |
| Please ensure that MSP information is shared with the person where it is safe to do so.  “How to protect yourself from abuse” leaflets are available on the Kent and Medway Safeguarding Adults Board (KMSAB) website in 26  different languages - [Useful Resources for the Public (kmsab.org.uk)](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fkmsab.org.uk%2Fp%2Fworried-about-an-adult%2Fuseful-resources-for-the-public&data=05%7C01%7CKelly.Hagon%40kent.gov.uk%7Ca086ea94f94f4d9080f008dba9569903%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638289964205747779%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=7czjgvovFmJvy7WAEdSMpVAzpKaFOdlT87IYuwxNrnE%3D&reserved=0).  Please also refer to the KCC MSP website [Making safeguarding personal - Kent County Council](https://www.kent.gov.uk/social-care-and-health/adult-social-care/making-safeguarding-personal) where you’ll find useful information to share with the individual and an online feedback form |

## The Golden Thread

It is important that MSP is not reduced to being a discreet part of the process and only evidenced in the box marked “MSP”. It should be a ‘golden thread’ that is evident in all the interactions with the adult and others involved and included within the analysis and decision making. Regular reference to the ‘I statements’ that accompany the 6 statutory principles of safeguarding will support practitioners to ensure that their practice is consistent with MSP throughout the safeguarding process:

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

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| **Principle** | **Definition** | **“I statement”** |
| 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 staff 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.** |

## Equality, Diversity, and Inclusion

Adult safeguarding enquiries by their nature, can be intrusive into the adult and their families’ lives. Everyone involved in the safeguarding enquiry needs to manage their interventions in a sensitive and compassionate way. It will be the responsibility of the DSO that all involved in the enquiry conduct themselves in a way that promotes equality, values diversity and supports the inclusion of the adult and others involved. Due consideration and respect need to be given to the protected characteristics set out in the Equality Act 2010, relating to the adult and their family:

* Age.
* Disability.
* Gender reassignment.
* Race.
* Religion or belief.
* Sex.
* Sexual orientation.
* Marriage and civil partnership.
* Pregnancy and maternity.

An explicit awareness of the influence of unconscious bias, practicing in a culturally competent way, and understanding how intersectionality can impact on people, will support safeguarding enquiries in a way that avoids discriminatory practice.

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| **Note** |
| Please ensure that a person’s protected characteristics are recorded on the Person Summary within Mosaic. |

# Practice Guidance – What, How, Who and When?

## Receiving and triaging the referral

### Introducing the role of the Designated Senior Officer (DSO) and Inquiry Officer (IO)

The specific roles as relevant to each section will be set out throughout this guidance. This brief section will summarise the principal roles and responsibilities over the whole safeguarding process.

**The DSO**

The person in the role of DSO is acting as the representative of the LA in ensuring that the duties under S.42 Care Act are being met, that is: the decision to undertake an enquiry based on the eligibility criteria set out in S.42(1) and ensuring that appropriate actions are being taken to safeguard the adult under S.42(2). The LA is the lead agency for statutory safeguarding enquiries. Therefore, the DSO is the person responsible for ensuring all enquiries completed and appropriate actions taken to safeguard the adult.

The DSO is a role not a job title. The DSO role may be undertaken by different practitioners at different stages of the safeguarding process. The DSO should be at senior practitioner grade (KR11) or above, though in some instances an experienced practitioner (KR10) can act as DSO if they are sufficiently experienced, trained, and confident in safeguarding practice. This will be a decision for the senior practitioner who must ensure the practitioner has appropriate supervision in this role. It is important that the roles and responsibilities are clearly understood. From the point of referral to post enquiry planning and closure the practitioner acting as DSO is:

* Responsible for setting enquiry actions (TOR).
* Responsible for ensuring a suitably trained and experienced professional is allocated to act as IO.
* Responsible for supervising the work of the IO.
* Responsible for ensuring actions are completed in a timely way.
* Responsible for ensuring that the person’s views, wishes, and voice is evident throughout the enquiry and that they are supported by an advocate or suitable representative where required. Refer to advocacy flow chart [here](https://proceduresonline.com/trixcms2/media/20792/advocacy-flowchart.pdf).
* Accountable for all key decision relating to the enquiry.
* Responsible for leading on strategy discussions with police and other agencies.
* Holding all agencies to account and escalating any concerns in accordance with the escalation policy (see S.6.6 below). This is not the IO role.
* Responsible for Causing Others to make Enquiries, setting clear TORs with those agencies and suitable deadline for reports to be returned.

**The IO**

The IO is also a role rather than a job title, therefore any practitioner undertaking tasks at the direction of the DSO will be acting as IO for that part of the safeguarding process. The IO role can also be performed by people working in other agencies/organisation completing parts of the enquiry. In complex multi-agency enquiries, there may be more than one IO undertaking various aspects of the enquiry at the direction of the DSO.

The principal roles and responsibilities of the IO are:

* To engage and form a rapport with the adult at risk of abuse throughout the enquiry process to understand their views, wishes and desired outcomes and reflect any changes to these as the enquiry progresses.
* To work with the adult and others involved to establish the facts about the abuse concerns.
* To analyse information obtained in the enquiry.
* To formulate with the DSO, safeguarding plans/actions to remove or reduce the risk of abuse consistent with the adults’ views and wishes.
* To regularly discuss findings with the DSO and inform of any new information to enable DSO to make further decisions and agree additional TOR’s.

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| **Note** |
| The DSO and IO work very closely together – keeping in regular communication with each other and holding update meetings will ensure any risks are managed in a timely way and prevent drift occurring. |

### Receiving the Referral

A safeguarding referral can be received from many sources and will not always be on the Kent Adult Safeguarding Concern Form (KASC). It would be expected that partner organisations represented on the KMSAB will use the online KASC, except for Police (inc. British Transport Police), Southeast Coast Ambulance Service (SECAMB), Care Quality Commission (CQC) and Kent Fire and Rescue Service (KFRS), who currently complete their own forms.

Once the referral has been received, they will need receive an initial triage from a suitably experienced practitioner who will assess whether the concerns relate to abuse or neglect (including self-neglect), if so, it will need to be transferred onto the Mosaic safeguarding concern workflow and sent to the appropriate virtual worker tray for screening by a DSO.

See Safeguarding Pathway Map Tool for details [Appendix A](#_Appendices)

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| **Important to remember** |
| Initial triage of a referral that is not received on the KASC form is just to determine whether the concerns relate to possible abuse or neglect and should therefore be transferred to the KASC form. Once transferred the from will be triaged by the DSO to decide whether a formal safeguarding enquiry is necessary. |

### Initial Triage of Referral

In most instances the safeguarding referral will be received by the Area Referral Service who will determine the following to decide who will progress the referral:

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| **Not currently open to**  **Adult Social Care** | **Open to adult social care team** |
| Triage undertaken within  Area Referral Service | Passed to appropriate community team to triage |

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| **Important to remember** |
| Triage needs to be completed within 1 working day. This timescale reflects the importance of a DSO having immediate sight of the referral to establish whether any urgent action is needed to safeguard the adult and/or others. |

The DSO will review the information contained in the safeguarding concern in order to make a decision as to whether this will need to progress to a risk assessment and strategy discussion**.**

The DSO must also consider the following questions:

1. Do the safeguarding concerns indicate that the adult or others (including carers) might be at immediate risk of harm and what actions will need to be taken to manage the risks?
2. Are there any children affected by the abuse and if so, what actions need to be taken such as making a referral to Integrated Children’s Services.
3. What is known at this stage about the adult views and wishes regarding the safeguarding concern and whether it is stated if they have consented to the referral being made?
4. Are there indicators that the adult may lack capacity with respect to the safeguarding concerns or that they may have substantial difficulty in engaging with any enquiries?

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| **Important to remember** |
| The only circumstance in which the safeguarding referral will not progress to an Enquiry is if the concerns raised are **clearly not** related to abuse or neglect (including self-neglect).  Therefore, the following circumstances are **not** appropriate reasons to close at the safeguarding concern stage:   * The referral suggests the safeguarding concerns have already been resolved. * The police or other agencies are already investigating – this does not negate the LA duty to carry out enquiries. * The referral indicates that the adult has refused to consent to a safeguarding referral being made.   **Case example 1 - Progress to enquiry:**  Referral received from the registered manager of a care home. Resident A had hit resident B in the arm as they passed in the corridor. Resident B did not receive any obvious injury and did not want any further action taken. Resident B said she understood that Resident A can be aggressive sometimes and said she would avoid him in the future. Resident A has dementia and is thought to lack capacity. The manager has informed the social care and mental health team for older people and is requesting extra support to manage the risks presented by Resident A.  **Case example 2 – Likely can be closed at concern\*:**  Referral received from housing manager at a sheltered housing complex. Mrs B lives alone in a one-bedroom flat and she is becoming increasingly frail with poor mobility. Mrs B has been asking for help with her daily living tasks from the housing manager which go well beyond what she is able to provide. Housing Manager believes Mrs B needs extra support or even to move to a residential care setting.  \*If it does seem legitimate to close at safeguarding concern, then the DSO must demonstrate due diligence by speaking to the referrer and reviewing any other available information from case records, to satisfy themselves that there is not missing information which would indicate possible abuse or neglect. |

The DSO will need to clearly evidence why this decision is being made, why concerns do not meet S.42 criteria and document their decision making.

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| **Note** |
| The DSO is responsible for ensuring feedback is provided to the referrer about the reasons for closing the concern and feedback provided is clearly recorded within Mosaic. |

### Deciding which team is responsible for managing the safeguarding referral

In the majority of concerns the abuse will occur in the area the person lives and therefore the DSO will be allocated from the community team within that area along with the IO.

This is important in terms of ongoing post enquiry support from the practitioner who was acting as IO who can also then be the allocated worker.  Reducing hand offs and enabling relationships to be built.

For teams this also supports building of relationships with their key partners within their own area, (for example, hospitals, care homes, police, community safety networks and primary care services) and will be best placed to coordinate multi agency working.

There are however some exceptions to this rule whereby the abuse occurs in an establishment or service such as a hospital, supported living service or residential care home.

In these instances, the DSO will come from the team covering the locality of the establishment/service as they will have the knowledge and relationships within their area and can continue to gather information about care and health providers where there have been previous safeguarding or quality in care concerns raised, which will help to identify any patterns in relation to abuse and neglect concerns.

Where possible the IO should always be the practitioner best placed with a good relationship with the person and from the team where the person lives. We wish to avoid allocating an IO from a team outside of the area a person lives if they already have an allocated worker or if a person is not open to a team, once the enquiry is concluded, ongoing support may be needed with the IO being the best placed practitioner to provide this due to relationships already being built.

The decision needs to be based on what is best for the person and will reduce the number of times they will need to tell their story.

See below table for guidance on making a decision with regard to DSO and IO allocation.

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| --- | --- | --- |
| **Factors to support the DSO decision on identifying appropriate IO/s** | | |
| **Case example** | **Factors for consideration** | **Likely appropriate person to be IO** |
| P is open to Team B but placed in a care home in Team C. A safeguarding referral has been received from the care home relating to neglect – acts of omission.  (This could also be hospital) | P does not have an allocated worker from Team B but is allocated for annual reviews. The last review was 8 Months ago.  There have been 3 previous safeguarding referrals relating to this home. | The IO will need to come from Team B.  The DSO will come from Team C  The IO can then also complete a review as part of the TORs (if appropriate)  DSO will be able to triangulate information and learning from the previous concerns and understand the systemic issues.  Exceptions made are if Teams B and C Community Team Managers jointly agree in conjunction with the DSO that due to resourcing the IO will be provided by Team C. Team B may wish to ask Team C IO to complete a review on their behalf. |
| P is open to Team B but was the victim of a DA incident while visiting her partner in Team C. | P has an allocated worker from Team B who has built up a good relationship with P which has taken a lot of time and perseverance.  P services struggle to engage with P especially when she feels they are interfering too much in her life. | The IO and DSO will come from Team B which is also where P lives.  DA services and MARAC are always where the person lives not where the perpetrator of the DA lives.  The risk to person will be wherever they are and therefore they remain at risk when in their own home. |
| P is in a supported living placement. P is open to Team B but the placement is in the area covered by Team C. P is among a number of tenants who have been targeted by a local drug gang and financially exploited. P’s mother has said she wants P to move and does not feel he receives the support he needs from the supported living provider. | The enquiry will involve the local police and community safety partnership as well as the supported living service provider.  Local knowledge is an important factor in this enquiry.  P has an allocated worker from Team B who he has a good relationship with  The communication from P’s mother should trigger a review and perhaps a reassessment of his needs. | The IO will be allocated from team B and the DSO will be allocated from Team C.  The DSO holds the wider knowledge of the service and issues and will liaise with agencies and coordinate multi-agency responses. These meetings may involve several IO’s from different enquiries to share their findings.  The IO is from team B as they have the relationship and already built trust. MSP is centre to any enquiry and therefore IO role would sit with the allocated worker. As part of the TORs a request to review/reassess can be undertaken which will assist with decision making as part of the enquiry.  DSO and IO can liaise regardless of not being in the same team and should arrange regular update sessions which can be via teams. |

### When referrers wish to remain anonymous

In common with all other social or health care services, openness, honesty, and trust are central to adult safeguarding practice. This extends to all partners who may be involved in the safeguarding enquiry. It is therefore expected that when a referral is received from a partner agency or health and social care professional, that the referral has already been discussed with the adult and their views and wishes are recorded in the referral.

Partners and professionals making a referral should not have an expectation that their referral will remain anonymous unless there are exceptional circumstances, for example, where disclosure would place the referrer or others at risk of harm. Reasons such as, “it will damage my therapeutic relationship” are not acceptable – all professionals/agencies providing health, social or psychological support to people are required to have safeguarding policies in place and be clear with the people they support about the limits of confidentiality.

Sometimes a referral made by a member of the public will specify that they wish to remain anonymous. This should be discussed with the referrer at the triage stage to clarify their reasons and discuss how their anonymity may adversely affect the success of any safeguarding intervention (this can cause difficulties with engaging with the adult when we hold information about them but cannot tell them where this information came from). There may be very good reasons, however, why the referrer needs to remain anonymous; this could be due to risk of harm from the adult or others or cause the breakdown of a supportive relationship for the adult. In such situations the DSO will need to consider how the safeguarding enquiries can progress while maintain the referrers anonymity.

When considering situations where the referrer wishes to remain anonymous, please refer to the following sections of the safeguarding privacy statement:

“Where you have indicated to remain anonymous when completing the adult safeguarding concern form (as the referrer), we will always do our best to ensure that you remain anonymous. However, we cannot guarantee anonymity as there may be circumstances where the information you provide, may need to be shared. When this happens, your information will only be shared where it is strictly necessary and proportionate and will be shared in accordance with data protection obligations governed by United Kingdom General Data Protection Regulations (UK GDPR) and Data Protection Act 2018.”

### Informing other departments and agencies

In addition to information gathering, the DSO will need to decide at this stage whether the police and/or commissioning, regulatory bodies need to be informed of the alleged abuse. The Deprivation of Liberty Safeguards Team (DoLS) will also need to be informed if the adult is currently subject to DoLS or where it is identified that the adult’s liberty may be restricted and therefore the provider has not completed a DoLS application.

How to inform DoLS team – see [section](#_7.7.__People) 4.5.7 or [Appendix B](#_Appendices)

How to inform CQC, Adult Commissioning (for Accommodation Solutions issues) and Health [see section 4.5.3](#_Strategy_discussion_and)

## Risk Assessment and Strategy Discussion

When the DSO undertaking the initial triage of the safeguarding referral concludes that the concern does relate to an adult with possible care needs who is experiencing or at risk of abuse and neglect (including self-neglect), then they must progress to risk assessment and strategy discussion.

### 4.2.1 Initial Information gathering to inform the risk assessment and strategy discussion

Further information gathering will have begun at the triage stage as stated above. At this point, the DSO will need to decide who needs to be contacted or what other sources of information need to be accessed. This stage of the safeguarding process needs to be completed within **3 working days** so the contacts will be limited to those that will enable the DSO to make the following decisions:

* The level of risk to the adult and others
* Any immediate action needed to safeguard the adult or others at risk.
* Whether there is a need to progress to a full enquiry
* If the enquiry can be closed following the risk assessment and strategy discussion, what actions are needed to support the adult at risk.
* If the enquiry is progressing what is the plan for the enquiry (TOR).

The DSO will also be seeking to identify any information about the adults’ views and wishes in respect to the safeguarding concern and any issues affecting the adult’s ability to make decisions. The DSO will need to consider whether the adult at risk can be contacted at this point or whether it is more appropriate for this to be done when the enquiry progresses. Factors to consider when deciding this are:

* Is the adult contactable by phone and would this be safe?
* Does the adult need someone such as family or an independent advocate to support when talking about the Safeguarding concerns?
* Are there reasons why a face-to-face contact is needed?
* To what extent is the adult aware of the safeguarding referral?

### Completing the initial risk assessment

When the DSO has decided to progress to initial risk assessment, they will need to consider the following:

**Presenting risks**

Summarise the principles concerns, state how the adult and any others might be at risk and how and what the harm or potential harm is to all those at risk.

**Describe any immediate actions needed to safeguard the adult or others**

Consider any necessity for police intervention, medical treatment required, respite placements.

**Mental Capacity Act 2005 (MCA 2005) concerns**

Describe what is known about the adult’s capacity at this stage. Also consider any other factors that might be affecting the adult’s decision making, for example, coercion and control, fear of reprisals, dependence on the person causing the abuse.

**Determining the level of risk**

The main part of the risk assessment is divided into 3 categories:

1. Vulnerability of the adult at risk of harm
2. Overall impact to the adult at risk of harm
3. Likelihood of future harm to the adult and others

The DSO is required to quantify the level of risk for each category and provide their rationale for this decision. The levels are low, moderate, substantial, and critical.

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| **Note** |
| Further guidance on what constitutes the level of risk for each category is provided by clicking on the **?** icon on Mosaic |

### 4.2.3 What to consider for each category:

**Vulnerability**

MSP has led to a change in the way we consider vulnerability in adult safeguarding thus we no longer apply the label ‘vulnerable adult’ to adults experiencing or at risk of abuse and neglect. When we think about vulnerability, we are applying a situational definition rather than stating that the adult is intrinsically vulnerable. This is exemplified in the S.42 Care Act criteria which sets out 3 conditions that need to be met for a statutory enquiry to be instigated in which the presence of care and support needs is only one of those conditions.

When providing their rationale, the DSO needs to set out how the persons care and support needs are impacting their ability to take action to protect themselves from the abuse or neglect. This may be related to the alleged person being in a position of trust or having power over the adult but may be more complex relating to difficult social and family circumstances.

**Overall impact**

Impact can be physical (injuries, pain, distress, potential lifechanging consequences of the injury) and psychological so it is important that the DSO applies a trauma informed approach when providing their rational here and throughout the enquiry process. Consider how the abuse has affected the adult’s mental health, whether there is previous trauma which further exacerbates the psychological impact (consider re-traumatisation).

Although it is stated here that overall impact refers only to the adult at risk, it is strongly suggested that the DSO also uses this section to consider the impact on any other people who may be affected by the abuse concerns (consider other adults, carers within a care setting or family members including any children).

Where this is a crime, this will be assessed as substantial risk. See ‘?’ guidance on the enquiry form on Mosaic.

**Likelihood of future harm**

The DSO will need to provide an analysis of the information available at this time to form a view as to whether the abuse reported in the safeguarding concern is likely to continue and whether others may also be at risk of experiencing this abuse in the future. It is also important to consider whether the abuse is likely to escalate to more serious abuse and/or different patterns and types of abuse.

### Strategy discussion and decision to progress or close

The risk assessment will result in an overall risk evaluation of low, substantial, or critical risk. **When the overall risk assessment identifies a critical level of risk the DSO will need to notify the Community Team Manager and Assistant Director**. The DSO will do this by summarising the concerns raised and risk level alongside the DSO’s plan to address risk. This will include other agencies responses.

The information gathering and risk assessment will enable the DSO to decide on whether the enquiry can be closed or whether further enquiries are needed in order to decide what actions are needed to safeguard the adult, as specified in S.42(2) Care Act. The MAPPG states that:

“This will require a planning discussion that may involve several partners, and this may be carried out virtually or if complex or very serious may well require a strategy/planning meeting.” (Pr. 2)

Strategy discussions may not take place in one meeting but may involve a number of conversations with partners, colleagues, as well as the adult at risk or people in the adults’ network. The strategy discussion might just involve a conversation with a colleague. The purpose of the strategy discussion is to analyse the information gathered so far, hypothesise what might be happening, and form a view as to what the enquiry actions will be needed to inform the TOR.

### Protocol between Area Referral Service and Community Teams

The table below sets out who will be responsible for completing the initial risk assessment where the triage is completed within the Area Referral Service [(see section 4.1.3):](#_Initial_Triage_of)

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| --- | --- | --- |
| **Decision** | **Outcome** | **Action** |
| S.42 criteria is met or decision to proceed with non-statutory enquiry after initial information gathering/triage is complete. | Progress to Risk Assessment | Referral service completes at minimum the following parts of risk assessment:   * Initial contacts to inform the triage decision (pulled through to the risk assessment from concern form) * Presenting risks * Immediate actions * MCA 2005 concerns (where known)   Community team reviews and adds to the above as well as completing:   * Contacts to inform the risk assessment. * Risk evaluation to determine risk level. * Strategy discussion. * MCA 2005 concerns * MSP (this is updated throughout) |

# 5. Terms of Reference and Enquiry

## 5.1 Planning the Enquiry

Having completed the risk assessment and strategy discussion, the DSO will now need to decide how the Enquiry will be conducted, by whom and what actions are required. The Enquiry can be undertaken by one practitioner from within adult social care acting as the IO. Other practitioner or agencies may be undertaking various strands of the enquiry which may be the case in complex enquiries within care settings. The IO may be someone from another agency/organisation such as a safeguarding lead within a health setting. The DSO will need to be satisfied that whoever is identified to undertake part, or all of the enquiry is suitably skilled, experienced, and qualified for the role. The statutory guidance states:

*“Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. It is likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to reach a resolution or recovery.” Ch.14.81*

## 5.2 Terms of reference (TOR)

MSP and the implementation of the Care Act has seen a change from an investigative to an enquiry approach. This represents a change of emphasis from the seeking of evidence, facts as to what happened and establishing culpability of people and organisations at fault. These aims are still important but an enquiry under the Care Act places more emphasis on the views, perspectives, and outcomes that the adult at risk wants to achieve. Central to the TOR, therefore, is a plan as to how the IO will work alongside the person to build a relationship of trust and enable them to decide what they want to happen as a result of the enquiry, including co-producing any post enquiry plans. The TOR will also set out who and what agencies need to be involved, how information will be shared in a proportionate way (need to know) and the specific enquiry tasks to be undertaken.

The MAPPG at Pr.2 state the aims of the enquiry are to:

* establish facts.
* ascertain the adult’s views and wishes.
* assess the needs of the adult for protection, support, and redress and how they might be met.
* protect from the abuse and neglect, in accordance with the wishes of the adult.
* make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect.
* enable the adult to achieve resolution and recovery.

Setting the TOR should be through a discussion with the IO and needs to be more than a list of tasks with timescales to achieve. For example, “speak to the adult to establish their views and wishes” needs to include any contexts or issues which need to be taken into consideration such as what might need to be considered when contacting the adult. This can include the following questions:

* Does the adult need someone to support them?
* Is there evidence to suggest that the adult lacks capacity with respect to the safeguarding concerns?
* Are there concerns about anyone in their networks who are associated with the abuser knowing about the safeguarding enquiry?
* Will the adult need an interpreter?
* What is the safe way to contact the adult and where it is safe to meet them?
* Does there need to be a joint visit with the police?

## 5.3 Causing Others to make enquiries

Where the DSO responsible for a Section 42 Enquiry within the LA identifies that another agency is best placed to undertake that Enquiry, or an element of it,

they must:

* Inform the organisation of this responsibility, firstly verbally and then in writing, clearly setting out the Enquiry’s TOR.
* Explain to the organisation why they are best placed to undertake the Enquiry.
* Be satisfied that the organisation being caused to undertake the Enquiry is competent to do so and that there is no conflict of interest in this organisation (or the person they appoint as IO) fulfilling this role.
* Agree a reasonable timescale for receiving a report of its outcome.
* Ensure the organisation knows how the DSO can be contacted.
* Ensure the organisation knows of the appointment and contact details of any Independent Advocate or other person acting on the adult’s behalf where they have substantial difficulty in taking part in the Enquiry.
* Make any amendments to the TOR necessary as the Enquiry progresses or the adult’s desired outcomes change or develop.
* Ensure the Enquiry report from the agency has addressed the TOR and require rectification to be made where it does not.

The Provider Enquiry Template is to be used in this instance and is available below [(Appendix C)](#_Appendices).

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| **Important to remember** |
| Causing others to make enquiries does not mean the enquiry can then be closed. The DSO needs to analyse the information provided by other agencies and feel assured that enquiries can conclude. MSP also needs undertaking by the KCC IO as someone who is independent from other agencies. |

## 5.4 Independent Advocates

The DSO will need to consider whether the adult may require someone to support them to engage and participate in the enquiry. There may be many reasons why an adult may need support of someone independent of the professionals involved in conducting the enquiry, this could be due to issues such as: anxiety, difficulties in processing the information given to them, ambivalence about taking action about the abuse (**consider where the adult causing concerns is a family member**). Where the adult does not have someone to support them in their networks, or there are reasons why it may not be appropriate for those in their networks to support them, then an independent advocate should be allocated to them to support them through the safeguarding enquiry process.

## 5.5 Adult not consenting to a Safeguarding Enquiry

There can be many reasons why someone might refuse to consent to a safeguarding enquiry and refuse support to protect them from abuse. The MAPPG at Pg.2 highlights the need to exercise concerned (professional) curiosity in the face of a refusal and a non-exhaustive list what needs to be considered when an adult does not consent to a safeguarding enquiry taking place:

* The adult at risk may lack capacity with respect to decisions concerning the abuse or risk of abuse.
* Other vulnerable adults or children may be at risk due to the abuse concerns.
* A crime may have been committed.
* The adult at risk is subject to coercive control or undue influence from the abuse or others which may be affecting their decisions.

The DSO will need to evidence that the above has been considered if a decision is made to close a concern or enquiry due to the person not giving their consent.

## 5.6 The Enquiry

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| **Important to remember** |
| The DSO will need to decide whether they need to cause others to undertake aspects of the enquiry, for example a safeguarding lead in a hospital setting may be best placed to ascertain the facts about an incident that occurs in their setting. ([see section 5.3](#_5.3._Causing_Others)). However, even when a substantial part of the enquiry is undertaken by someone from another agency, the LA is still responsible overall for managing the enquiry and ensuring appropriate actions are taken, and most crucially that the outcomes of the adult are central to the enquiry process. It will be necessary, therefore, from the LA to ensure that MSP has been evident throughout the enquiry process. |

Safeguarding enquiries can be relatively simple or extremely complex depending on the circumstances, risks and actions needed to safeguard the adult and others. The DSO will need to decide whether the IO needs to complete the separate IO report on Mosaic or can complete the summary and analysis. The DSO will make a decision based on what is deemed proportionate in the circumstances.

## 5.7 Key skills required by the IO

Carrying out a safeguarding enquiry can be amongst the most complex work that adult social care practitioners will undertake, therefore the DSO will need to ensure that the practitioner allocated as IO is suitably trained, skilled, and experienced. As discussed in [section 5.2](#_5.2._Terms_of) above, the emphasis has shifted from investigation to enquiry. The skills required, therefore are more grounded in the aims and values of social work. This means the approach is strengths-based, person-centred, and relational. Central to this is being able to build a relationship of trust with the adult at risk while balancing their views and wishes with the need to safeguard the adult and others, the perspectives of multi-agency partners involved, and statutory requirements.

Below are some necessary skills needed by the IO when conducting safeguarding enquiries:

* Hypothesising
* Separating fact from assumption and supposition
* Concerned curiosity (or professional curiosity)
* Compiling chronologies
* Compiling eco maps
* Completing Genograms
* Analysis of complex situations
* Strong communication skills.

# 6. Working with Multi-Agency Partners

This section will provide some guidance on the multi-agency setting of adult safeguarding including proportionate information sharing, co-working and accountability.

## 6.1 Information Sharing

A safeguarding enquiry is a statutory intervention under the Care Act and as such information is able to be shared under UK GDPR on lawful basis without consent as we are undertaking a public task that is in the public interest.

[See P10. of the MAPPG for further information and guidance](https://kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf)

## 6.2 Criminal Offences

The [MAPPG](https://www.kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf) states clearly at P12 that where it is suspected a crime has been committed, then the police must be informed. In the protocols section further clarity with regard to this is provided at Pr.1: sharing information and duty of candour:

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

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

Sharing information with the police at an early stage will ensure that the safeguarding enquiry does not potentially contaminate evidence and jeopardise any police investigation.

See [FAQ’s](#_9._Useful_information) on how to contact Police to share information and/or immediate risks.

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| **Important to remember** |
| The [MAPPG](https://www.kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf) is clear that all criminal offences are reported to the police regardless of how minor the offence may seem or whether the person responsible lacks capacity with regard to the offence. |

## 6.3 Types and patterns of abuse

The DSO will need to have a sound understanding of the patterns and situations in which abuse may occur. This could be within organisations, families, and criminal gangs. Recognising that the abuse concerns relate to a specific pater of abuse (for example, domestic abuse, modern slavery, honour-based abuse, county lines) will enable the DSO to identify the organisations and agencies that need to be involved in the enquiry and support of the adult at risk. It will also provide essential indicators of the likely challenges the IO might face in engaging with the adult at risk who may be reluctant or ambivalent about accepting help due to factors such as: their relationship with the person/s responsible for the abuse, fear of reprisal, dependency on the abuser, social, legal, economic, and cultural factors.

**Types, patterns, and signs of abuse is covered in detail at G.2 in the** [**MAPPG**](https://www.kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf) **including guidance and links to relevant agencies, organisations, and policies in relation to the following:**

* Self-neglect.
* Modern slavery and Human trafficking.
* Radicalisation.
* Gang related abuse and cuckooing (including county lines).
* So called ‘Mate crime’.
* Discrimination and Hate crime.
* Organisational abuse.
* Domestic abuse
* Stalking and Harassment
* Online Safeguarding
* Culturally motivated abuse
  + Female Genital Mutilation.
  + Forced marriage.
  + So called ‘Honour-based’ abuse.

## 6.4 Self-Neglect

The statutory guidance includes self-neglect as a type of abuse though the guidance also recognises it is not always necessary for a self-neglect concern to be managed as a statutory response under S.42 Care Act. The guidance suggests that:

*“A decision on whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.” (Statutory Guidance, Ch.14.17).*

What is of importance in managing self-neglect is that it will normally require a multi-agency response. The DSO will need to ensure that the self-neglect concerns are managed under the Multi-Agency Policy and Procedures are followed, whether the concerns are being managed under S.42 or through case management. The policy can be accessed on the link below:

[Kent and Medway multi-agency self-neglect and hoarding policy and procedures (kmsab.org.uk)](https://www.kmsab.org.uk/assets/1/multi-agency_self-neglect_and_hoarding_policy_and_procedures.pdf)

See [Appendix D](#_12._Appendices) for Self-Neglect Process and Guidance

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| **Important to remember** |
| Where Self Neglect is identified, and the DSO decision is to close with the Community Team following the **Self Neglect Pathway** the DSO MUST ensure that a Self-Neglect hazard is placed on Mosaic and allocated to the receiving team. |

## 6.5 Domestic Abuse

Domestic abuse is a pattern of abuse increasingly identified in safeguarding enquiries. The Office of national Statistics states that over 2.4 million people experienced domestic abuse in the last year (2022). It is important that all practitioners recognise the signs of domestic abuse and know how to support the people accessing specialist services. In addition to the guidance in the MAPPG the DSO will need to refer to the Multi-Agency Protocol for Dealing with Cases of Domestic Abuse to Safeguard Adults with Care and Support Needs:

[KMSAB multi-agency protocol for dealing with cases of domestic abuse to safeguard adults with care and support needs](https://www.kmsab.org.uk/assets/1/kmsab_protocol_for_dealing_with_cases_of_domestic_abuse_to_safeguarding_adults_with_care_and_support_needs.pdf)

Support, guidance, and link to services can also be found on the Kent Academy:

[Course: Safeguarding Resources including the Kent & Medway Safeguarding Adults Board (delta-learning.com)](https://www.delta-learning.com/course/view.php?id=2363)

The **Kent Integrated Domestic Abuse Service (KIDAS)** offer a person-centred, holistic range of support services to victims and their families in Kent, with support available including Safe refuge accommodation, Specialist Independent Domestic Violence Advisors (IDVA) support and Community Outreach Services.

[What is Domestic Abuse? – Domestic Abuse (domesticabuseservices.org.uk)](https://www.domesticabuseservices.org.uk/what-is-domestic-abuse/)

For more information see [FAQ’s](#_9._Useful_information)

## 6.6 Multi-agency meetings (Case Conferences)

When an enquiry involves a number of different strands and there are several agencies undertaking aspects of the enquiry or responsible for completing actions, then a multi-agency meeting, chaired by the DSO is often the best way to bring all those strands together and hold agencies to account. This is especially so where there is evidence of organisational abuse in regulated settings and situations where there may be many people at risk. By necessity, such meeting can be very formal and will require accurate minutes to be taken. The DSO will need to manage differing views and attitudes expressed by those participating in the meeting and ensure that the principles of MSP are at the heart of the discussions and be able to challenge assumptions, biases, and discriminatory language where necessary.

The adult at risk should be able to attend and participate in the meeting (no decision about me without me), and it is the responsibility of the DSO to ensure a safe and supportive environment is created for the adult to feel comfortable and to contribute. This will include ensuring that the adult has the support of an independent advocate or representative where appropriate.

There may be circumstances, however, where a large formal multi-agency meeting is disproportionate and would result in the adult being excluded from the discussions and decision-making process, for example the adult may suffer with mental health difficulties that would mean attending the meeting would be detrimental to their mental wellbeing. DSO’s will need to apply a trauma informed approach to consider whether attending a formal multidisciplinary meeting might re-traumatise the adult at risk (see link to trauma informed practice at 4.3 above). The DSO in such instances should consider alternatives ways to share information and hold agencies to account.

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| **Important to remember** |
| Reference to the 6 principles and “I” statements will support this decision.  The MAPPG at G6 provides detailed guidance on when a formal meeting is indicated and how these should be conducted. |

The MAPPG at G6 provides detailed guidance on when a formal meeting is indicated and how these should be conducted.

## 6.7 Managing disputes with multi-agency partners

On occasions there will be situations where the DSO may be concerned that a partner agency is not fulfilling its commitments in timely manner or there may be concerns about the conduct of a partner agency with respect to their involvement in the safeguarding enquiry. The DSO should try to resolve any issues with the worker or agency in question, but if this is not successful the DSO will need to refer to the Escalation policy (see link below). Further guidance is provided at P.15 in the MAPPG.

[Kent-and-Medway-Multi-Agency-escalation-policy-for-adult-safeguarding-resolving-practitioner-differences.pdf](https://www.kent.gov.uk/__data/assets/pdf_file/0019/56107/Kent-and-Medway-Multi-Agency-escalation-policy-for-adult-safeguarding-resolving-practitioner-differences.pdf)

# 7. Establishments

Abuse and neglect occurring in establishments has always formed a large proportion of adult safeguarding work, both in respect of volume of referrals and, at times, the complexity of the response required. Arguably it constitutes the highest profile of adult safeguarding contexts due to well publicised reports into serious incidents that have occurred in establishments (Winterbourne View, Mid-Staffordshire NHS Foundation Trust, Orchid View).

The possibility of there being a serious, high-profile incident within an establishment in their area can be anxiety provoking for adult safeguarding practitioners, though, on the other hand, the high volume of what appear to be minor safeguarding incidents can perhaps contribute to a degree of desensitisation to potential risks and impacts on people residing in those establishments.

This Section, therefore, is intended to support DSOs and IOs to navigate their way through establishment safeguarding inquiries in order to provide a robust but proportionate response to the concerns.

## 7.1 Important factors to consider in establishment safeguarding enquiries

### 7.1.2 People in establishments are often the least likely to be able to protect themselves from abuse and neglect

The people who are living, or for the time being placed within establishments are often those with the greatest level of need and are therefore least likely to be in a position to protect themselves from abuse. The LA has an absolute duty in such circumstances to take action to safeguard people.

### 7.1.3 The danger of normalising abuse within establishments

It can perhaps be easy to normalise minor incidences of abuse within an establishment, for example a patient in a mental health inpatient unit hitting another patient, though no injuries result, or a resident being left in soiled clothing for longer than is normal due to staff shortages. Safeguarding practitioners need to remember that, however seemingly minor they are, such incidents can be very distressing for the people who have experienced the abuse and their families.

### 7.1.4 Ensuring a proportionate response to apparently minor incidents

As above, normalising minor incidents of abuse can contribute to accepting the most cursory actions taken by a service provider are sufficient to be able to close the safeguarding referral. For example, an altercation between two patients on a Mental Health inpatient unit might lead to the person responsible being placed on 1:1 supervision. DSO’s need to demonstrate professional curiosity, showing due diligence to ensure the incident and any actions taken are properly interrogated, including:

* What are the circumstances of the incident (what led up to the incident, have there been previous incidents involving the same people)?
* What is the impact on the victim?
* What are the views and wishes of the person and what is the outcome the want?
* What are the impacts on other vulnerable people in the establishment (including how it might have affected anyone witnessing the incident)?
* Are there any risks to other vulnerable people in the establishment (the measure in place might protect the victim but will they also protect others at?)?
* Have there been similar incidents involving the same people or others in the establishment that might indicate systemic/organisational factors contributing to the abuse (consider ‘near misses’ - incidents that did not result in harm, but may be indicative of systemic issues in the establishment)?
* Does this constitute a crime?

## 7.2 What do we mean by establishment?

An establishment in this context is any social care or health provision that will generally include residential stays, either on a temporary or long-term basis. Typically, these are hospitals, nursing homes, residential care homes and heath or social care provisions providing respite or step down from hospital care. It will also include intensive 24 hour supported accommodation. Other provisions that will constitute an establishment can be day services for social care or health provision.

All these services are likely to be, but not in all circumstances, regulated by CQC. Services will often be commissioned by the NHS or LA to provide services (see 7.3 below). Regulated and commissioned services will be required to have safeguarding polices in place and will often (always in the case in the case of hospitals) have a safeguarding lead within their setting or wider organisation. They will also likely have representatives on the Safeguarding Adults Board.

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| **Important to consider** |
| It may be helpful for community teams to scope out their area to identify the main establishments, their regulatory and commissioning status, and key contacts, such as registered managers and safeguarding leads. |

## 7.3 Commissioning and Regulatory Bodies

Where the alleged abuse or neglect has occurred in a setting regulated by CQC or any other regulatory body, then they must be informed. Regulatory bodies have a responsibility to ensure that the service they regulate meets certain standards with regard to quality and safety.

Commissioning agencies will also have a responsibility in respect to ensuring that the services they commission provide good quality and safe service to people. It is therefore important to inform them of abuse concerns that occur within a service that they commission. Services that provide care, support or treatment to adults include:

**Integrated Care Boards (ICBs) – Local health commissioned services**

[KMICB.Safeguarding@nhs.net](mailto:KMICB.Safeguarding@nhs.net)

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| **Important to remember** |
| Unlike CQC and Adult Commissioning, ICB do not need to be informed about safeguarding concerns raised within services that they commission. Communication should always be directed to the Safeguarding lead at the relevant NHS Trust or All Age Continuing Healthcare in the ICB. The only circumstances where the ICB safeguarding lead will need to be informed is:   * The DSO has experienced difficulties engaging with the health provider or there is a dispute that it has not been possible to resolve and requires further escalation (please refer to KMSAB escalation policy). * Multiple concerns in a particular health provider that require further discussion and possibly a larger / wider enquiry needs to be instigated. |

**NHS England – Nationally commissioned health care services***(Regional semi-secure Mental Health Units)*

Please send to both:

[england.sesafeguarding@nhs.net](mailto:england.sesafeguarding@nhs.net) & [victoria.gray3@nhs.net](mailto:victoria.gray3@nhs.net)

If the establishment is an NHSE commissioned service, then please also include:

[deborah.perriment2@nhs.net](mailto:deborah.perriment2@nhs.net)

**Kent Community NHS Foundation trust – East and West Kent Community based health care services**

[kcht.SGA@nhs.net](mailto:kcht.SGA@nhs.net)

**HCRG – North Kent community-based health care**

[vcl.safeguardingteam.northkent@nhs.net](mailto:vcl.safeguardingteam.northkent@nhs.net)

**KCC Adults Commissioning – LA commissioned adult social care**

[Adultscommissioning@kent.gov.uk](mailto:Adultscommissioning@kent.gov.uk)

[safeguarding@cqc.org.uk](mailto:safeguarding@cqc.org.uk)

The referral form for CQC and Adults Commissioning is located in the ‘Forms and letter’ icon in the menu bar when in the safeguarding workstream in Mosaic. The form needs to be emailed to the respective addresses as above. The form must be resent to Adults Commissioning and CQC at the conclusion of the safeguarding enquiry with the outcome section completed. Please ensure that this is anonymised.

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| **Important to remember** |
| Please ensure that the above form sent to CQC is anonymised |

## 7.4 Sanctions on KCC commissioned establishments

Adults Commissioning are able to place commissioned services under a sanction in circumstances where it has been identified that the care and support provided by the service has not been to an acceptable standard. There are three types of sanction, two of which (Poor Practice and Contract Compliance) are decided by commissioners and relate to quality in care concerns (see 7.7 below). Once a sanction is placed on the service this information will be available to adult social care practitioners for consideration when considering service provision for the people they support. The service provider will need to agree a plan to address the concerns in a given time scale in order for the sanction to be lifted and failure to address the concerns could lead to an increase in the sanction level and potentially, to the termination of their contract with KCC.

The most serious sanction is the Adult Protection (AP) sanction, and this is placed on the service when there are serious safeguarding concerns. The decision to place an AP sanction and at what level will be decided by the DSO. AP along with the quality in care sanctions have three levels, 1,2,3. As stated above the sanctions can have serious consequences for the provider, most seriously at level 3 the provider will not be able to take any further placements from KCC and there may be advice to all placing authorities to review their people placed in the setting.

Complete template [Appendix E](#_Appendices) on an email [adultscommissioning@kent.gov.uk](mailto:adultscommissioning@kent.gov.uk) to add a sanction.

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| **Important to remember** |
| Placing an AP sanction onto a service provider is an important and necessary measure to ensure that the people in the services care are safeguarded and ensuring actions are taken to address the safeguarding concerns. Sanctions can have serious consequences for the provider so the DSO will need to ensure their decisions are supported by a clear evidence-based rationale and that the sanction is accompanied by a robust action plan to address the safeguarding concerns. AP level 3 requires Assistant Director approval. |

## 7.5 Quality in care or adult safeguarding response

DSO’s will need to consider whether the concern meets the criteria for a safeguarding response or whether it is a minor incident that can be managed through Adults Commissioning sanction options for poor practice and contract compliance. It is inevitable within establishments that mistakes will occur at times that may have the potential to cause harm to residents, for example medication errors. It is also inevitable at times that a resident may come to some harm where it is clear that care staff were not at fault, for example a resident who is usually fully mobile falling over. Below is a non-exhaustive list of consideration for DSO when deciding whether an incident within an establishment requires a safeguarding or quality in care response:

|  |  |  |
| --- | --- | --- |
| **Consideration** | **Yes**  ***(Indicative of a safeguarding response)*** | **No**  ***(Indicative of a quality in care response)*** |
| **Has anyone experienced harm as a result of this incident?** |  |  |
| **If no, was there the potential for serious harm to occur?** |  |  |
| **Is there evidence that there were systemic factors that led to the incident?**  *(Consider staffing, training, management and supervision, appropriate policies, and protocols in place, care plans and risk assessments updated, appropriate and contemporaneous record keeping)* |  |  |
| **Is there evidence of a pattern of such incidents occurring in this establishment?**  *(Have there been similar concerns identified, either through informal channels or through previous safeguarding referrals?)* |  |  |
| **Is there evidence that the worker responsible for the incident has acted negligently?** *(Is this a simple mistake or indicative of poor practice, have there been previous concerns about this worker?)* |  |  |
| **Is there evidence that this incident could and should have been prevented?**  *(Were the risks known, were risk assessments and care plans adequate to manage the risks, was there adequate and contemporaneous record keeping?)* |  |  |

This table is for guidance to support decision-making and there may well be other factors that need to be taken into consideration, ultimately decisions will be made based on the DSO’s judgement.

The response will need to be managed through liaison and co-working with the commissioning team and the responsible community team. Here is the link to the protocol section in the MAPPG. [Multi-agency Safeguarding Adults Policy, Procedures and Practitioner Guidance for Kent and Medway (kmsab.org.uk)](https://kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf)

## 7.6 Allegations against staff (Allegation Management)

[Managing-Concerns-around-People-in-Positions-of-Trust.pdf (kent.gov.uk)](https://www.kent.gov.uk/__data/assets/pdf_file/0019/111169/Managing-Concerns-around-People-in-Positions-of-Trust.pdf)

The above guidance is supplementary to the [MAPPG](https://kmsab.org.uk/assets/1/multi-agency_safeguarding_adults_policy_procedures_and_practitioner_guidance_for_kent_and_medway.pdf) and relates specifically to situations where the person responsible for the abuse is someone who works with adults either in a paid or voluntary position. People in Positions of Trust states:

A person can be considered to be in a ‘position of trust’ where they are likely to have contact with adults with care and support needs as part of their employment or voluntary work, and

• Where the role carries an expectation of trust and

• The person is in a position to exercise authority, power, or control over an adult(s) with care and support needs (as perceived by the adult themselves).

This guidance provides a framework for how concerns and allegations against people working with adults with care and support needs should be notified and responded to, so DSO’s will need to follow this guidance when managing safeguarding enquiries in these circumstances.

This will include consideration whether a body that regulates the conduct of certain people in professional roles need to be informed if there is evidence that the abuse or neglect has been perpetrated by a professional or professionals, involved in the adult’s care and support. This may occur at any stage in the enquiry when it is identified that a regulated professional has breached their professional standards and code of conduct. The principle regulatory bodies for professionals are:

**General Medical Council (GMC) – Doctors**

<https://www.gmc-uk.org/>

**Nursing and Midwifery Council (NMC) -nurses and midwifes.**

<https://www.nmc.org.uk/>

**Social Work England (SWE) – Social workers**

<https://www.socialworkengland.org.uk/>

**Health and Care Professions Council (HCPC) – Psychologists, Occupational Therapist, Physiotherapists, and other ancillary health professionals.**

<https://www.hcpc-uk.org/>

**Disclosure and Barring Service (DBS)**

The DBS is a public body that provides criminal records checks on any person working either in a paid or voluntary position with children and adults (with care and/or health needs). The DBS will also make decision on barring people from working with children and adults. Where a safeguarding enquiry finds that a person working in a position of trust with children or adults either paid or voluntary, a decision will need to be made as to whether a referral needs to be made to DBS with respect to barring that person or persons from working with vulnerable people.

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| **Important to remember** |
| The LA along with other public authorities are able to make DBS referrals but there is a legal duty place on employers providing regulated activity and agencies suppling workers to regulated providers to make a referral to DBS where:   * The employer has withdrawn permission for a person to engage in regulated activity with children and/or vulnerable adults. Or you move the person to another area of work that is not regulated activity. * The person’s conduct has endangered or caused harm children adults. This can be physical, sexual, psychological/emotional, and financial.   For further guidance on how and when to make a DBS referral visit the DBS website:  <https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs#who-has-a-legal-duty-to-refer>  Kent’s Regional Outreach Advisor for DBS: Kelly Matthews.  Email: [Kelly.Matthews@DBS.gov.uk](mailto:Kelly.Matthews@DBS.gov.uk) Tel: 03001046630 |

## 7.7 People legally detained in an establishment – Deprivation of Liberty Safeguards (DoLS), detention under the Mental health Act 1983 (MHA 1983)

Some of the people who reside in establishments will have conditions which mean they are unable to make decisions about their need for care, support, and treatment due to their lacking the mental capacity to do so or that they are suffering from a mental disorder which is of a nature or degree which necessitates their detention under the MHA 1983.

Where a safeguarding enquiry relates to people who have been detained (this may also include the person responsible for the abuse) then it is likely that they will require the support of an advocate (see S.5.4). In addition to the role of the Care Act advocate to support the person who has substantial difficulty to engage with the enquiry, the person may also require the support of other specialist advocates:

### 7.7.1 Independent Mental Health Advocate (IMHA)

Anyone detained under the MHA 1983 will have the right to be allocated an IMHA who can support them with issues relating to their mental health care and treatment. They also help people understand their rights under the Mental Health Act. Further information on the role of the IMHA is provided by the Social Care Institute for Excellence (SCIE):

<https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/>

### 7.7.2 Independent Mental Capacity Advocate (IMCA)

An IMCA is an advocate appointed to act on the person’s behalf if they lack capacity to make certain decisions. Further information on the role of the IMCA can be found on SCIE:

<https://www.scie.org.uk/mca/imca>

### 7.7.3 Mental Health Act (MHA 1983)

There are a number of sections under the MHA 1983 under which people can be detained in a hospital, most commonly:

S.2 – Up to 28-day detention order for the purpose of assessment followed by treatment

S.3 – Up to 6 Months detention for the purpose of treatment for a mental disorder. Renewable for periods of 24 Months.

The MHA 1983 also includes sections which place conditions on the person subject to the order:

S.7 - Guardianship order places a requirement on where the person lives, to allow access to health and social care professionals and to attend appointments and other relevant services. As with S.3 Guardianship is initially for 6 Months and then renewed yearly.

S.17(A) – Community Treatment Order (CTO), can be applied to a person being discharged from a treatment order. The main purpose of the CTO is to require that the person abides by their treatment plan, but also can contain other requirements such as place of residence, attending health and social are appointments and allowing access to professionals.

The above sections are civil orders and are applied without recourse to the courts. There are also a number of sections not included here which related to mentally disordered offender which are applied by the criminal courts and may include further condition applied by the Ministry of Justice.

### 7.7.4 DoLS

It is important to establish whether the adult at risk is subject to a DoLS. If this is the case, then the DoLS office will need to be notified of the open safeguarding inquiry. The DoLS team should be notified by the clipboard on Mosaic, see [Appendix B](#_Appendices) for Mosaic guidance on how to do this.

Where the adult is potentially experiencing a deprivation of their liberty and it is likely that they lack capacity with respect to decisions about their care arrangements, but there is no DoLS in place, the DSO will need to escalate this concern to the responsible team and ensure arrangements are in place for an interim authorisation to be put in place by the registered care setting. If the adult is not in a registered setting (e.g., Supported Living), the responsible team will need to make an urgent application to the Court of Protection (CoP) for an interim order.

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| **Important to Remember** |
| DoLS will only be applicable if the adult lacks capacity with respect to their care arrangements and the acid test has been met: “the person is subject to continuous supervision and control and are not free to leave i.e., staff would try to bring the person back.” (MAPPG, G.8) |

## 7.8 Reporting a crime when a person is within an establishment

As is the case with all safeguarding concerns that appear to involve a criminal offence, the MAPPG is clear that these must be reported to the police (see S.6.2). A very common theme of referrals from establishments is incidents of altercations between residents and patients. Frequently these incidents are at the minor end, for example pushes and shoves. As should be expected the service provider will usually include actions taken to manage the risk, often measure such as the person responsible being placed on 1:1 supervision, or one of the parties being moved to another ward. These incidents will still need to be reported to the police regardless of perceived level of seriousness, the mental capacity of the parties involved, or whether the victim has agreed to police involvement.

DSO’s will also need to consider whether the report of abuse involving the provider and members specific workers in the establishment might constitute a criminal offence and require discussion with the police’s Vulnerable Investigation Team (VIT). Circumstances such as unlawful use of physical restraint, criminal negligence, fraud and theft, wilful neglect under the MCA 2005 and MHA 1983.

### 7.8.1 Reporting to the police

The service provider should notify the police by phone on 101 when an offence occurs in their establishment. This will ensure that the offence is reported in a timely manner and a Crime Number is generated. The DSO needs to send a copy of the concern to the local VIT team who will then decide who is the most appropriate policing team to investigate the concerns.

Do remind providers that they should not commence investigations around allegations against staff members until liaising with Police as provider investigations can impact gathering of evidence within criminal investigations. Providers should focus on ensuring adults are safeguarded whilst investigations are completed.

Kent and Medway Partnership Team (KMPT), Oxleas and some Private Mental Health Hospitals have their own specialist Mental Health Police Liaison Team – Kent Police.

The ward needs to report the incident via 101 or online. Once this team have received the report, they will become involved. There is a police officer attached to each Mental Health hospital who will be the investigating officer in charge for the police investigation.

The Mental Health Police Liaison Team can be contacted on [mental.health.liaison.team@Kent.police.uk](mailto:mental.health.liaison.team@Kent.police.uk)

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| **Important to remember** |
| If an emergency police response is required, then the provider must call 999. |

# 8. Outcome and Post Enquiry planning

## 8.1 The outcome of the enquiry

When the enquiries have been completed the DSO will need to decide that sufficient information has been provided in order to fulfil the LA’s duty under S.42(1):

*“To enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.”*

The statutory guidance at Ch.14.11, sets out the aims of the enquiry:

* Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
* Stop abuse or neglect wherever possible.
* Safeguard adults in a way that supports them in making choices and having control about how they want to live.
* Promote an approach that concentrates on improving life for the adults concerned.
* Raise public awareness so that communities, alongside professionals, play their part in preventing, identifying, and responding to abuse and neglect.
* Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.
* Address what has caused the abuse or neglect.

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| **Important to remember** |
| Revisiting the “I” statements will support the DSO when reviewing how well the enquiry has adhered to the principle of MSP |

## 8.2 Post Enquiry planning

DSO’s will need to consider what actions are needed to support the adult to be safe from harm. Actions can be both with respect to the adult at risk and the person found to be responsible for the abuse. These can include (not an exhaustive list):

* A care needs assessment (S.9 Care Act 2014)
* A carers assessment (S.10 Care Act 2014)
* MCA 2005 assessment and best interest decision
* DoLS application
* MHA 1983 intervention, e.g., compulsory admission, Guardianship application.
* Criminal prosecution
* Civil or criminal injunctions
* Support regarding re-housing
* Application to client financial affairs
* Application to CoP to appoint a deputy.

The DSO is responsible for recording the post enquiry plan within the enquiry form, ensuring this is shared with the person (where appropriate) and evidence that the DSO has assurance from other agencies that they are aware of the agreed plan and their actions within that.

## 8.3 Feedback on the outcome and post enquiry plan

The DSO will also be responsible for ensuring that feedback is provided to the adult and others involved in the enquiry as appropriate and proportionate.

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| **Note** |
| Consider the statutory principles and accompanying “I” statements: proportionality, partnership, and accountability) – Feedback provided is on a ‘need to know’ basis. |

In addition to providing feedback to the adult at risk, it is essential that feedback is provided to the following agencies where they are involved (not exhaustive):

* CQC and any other regulatory body.
* Adult Commissioning (for Accommodation Solutions issues) and any other commissioning body.
* Health service providers.
* Police

**Guidance on providing feedback is provided at Pr.5 in the MAPPG.**

For templates for feeding back to the referrer please click the relevant one below:

Does meet Section 42 Criteria Feedback – [Appendix F](#_Appendices)

Does **not** meet Section 42 Criteria Feedback – [Appendix G](#_Appendices)

Closure following Section 42 Enquiry Feedback – [Appendix H](#_Appendices)

Closure Aide Memoire – [Appendix I](#_Appendices)

# 9. Useful information & Frequently Asked Questions

## 9.1 What is the Court of Protection (CoP) and the Office of the Public Guardian?

The CoP make decisions on financial or welfare matters for people who cannot make decisions at the time they need to be made (they ‘lack mental capacity’).

They are responsible for:

* deciding whether someone has the mental capacity to make a particular decision for themselves.
* appointing deputies to make ongoing decisions for people who lack mental capacity.
* giving people permission to make one-off decisions on behalf of someone else who lacks mental capacity.
* handling urgent or emergency applications where a decision must be made on behalf of someone else without delay.
* making decisions about a lasting power of attorney or enduring power of attorney and considering any objections to their registration.
* considering applications to make statutory wills or gifts.
* making decisions about when someone can be deprived of their liberty under the MCA 2005.

If there are concerns as to how someone with lasting power of attorney or enduring power of attorney are making decisions that are not in a person’s best interests and/or managing affairs the CoP should be contacted using the Office of Public Guardian email address [opg.safeguardingunit@publicguardian.gov.uk](mailto:opg.safeguardingunit@publicguardian.gov.uk)

Office of Public Guardian is responsible for registering lasting and enduring powers of attorney, so that people can choose who they want to make decisions for them.

We maintain the public register of deputies and people who have been given lasting and enduring powers of attorney.

We also supervise and support deputies appointed by the CoP and look into reports of abuse against registered attorneys or deputies.

## 9.2 What is Multi-Agency Public Protection Arrangements (MAPPA) and how and when should I refer?

Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders. This guidance sets out the responsibilities of the police, probation trusts and prison service. It also touches on how other agencies may become involved, for example the Youth Justice Board will be responsible for the care of young offenders.

The guidance includes information on the following:

* identification and notification of MAPPA offenders
* Violent and Sex Offender Register (ViSOR), the secure database that holds details of MAPPA offenders.
* information sharing
* disclosure and risk assessment
* risk management plans
* multi-agency public protection meetings
* MAPPA documents set.
* custody, recall and transfer of MAPPA cases.
* critical public protection cases
* mentally disordered offenders and MAPPA

Information on MAPPA can be found at [www.mappa.justice.gov.uk](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.mappa.justice.gov.uk%2F&data=05%7C01%7CKelly.Hagon%40kent.gov.uk%7Ca086ea94f94f4d9080f008dba9569903%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638289964205747779%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ySOIc6nvDewAHeaU4cGVdbwGovb0fAxHVBiNUENmxlU%3D&reserved=0)

[MAPPA guidance Appendix J](#_Appendices)

## 9.3 What is Violent and Sex Offender Register (ViSOR)

ViSOR provides a secure database, graded as CONFIDENTIAL, enabling the prompt sharing of risk assessment and risk management information on individual offenders who are deemed to pose a risk of serious harm to the public. This sits under MAPPA. There will be a ViSOR officer appointed to an individual who can be contacted as part of S.42 enquiries to obtain and share information. This is usually via local VIT team who can provide contact details.

## 9.4 What is the Domestic Abuse, Stalking and Honor Based Violence Assessment (DASH) and who should complete it?

The purpose of the DASH risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made. The DASH should be completed by practitioners who have undertaken the Domestic Abuse Training. Further information can be found here:

<https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf>

[MARAC referral with DASH Appendix K](#_Appendices)

## 9.5 What is Multi-Agency Risk Assessment Conference (MARAC) and how and when should I refer someone?

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, IDVAs, probation and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other fora to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

More information can be found here:

<https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf>

## 9.6 What legal powers can be utilised to support safeguarding enquiries and help to protect someone from further abuse

* S.115 MHA 1983
* S.135 MHA 1983
* S.1 Principles, S.2 People who lack capacity, S.3 Inability to make decisions and S.4 Best interests of the Mental Capacity Act 2005
* Civil and criminal injunctions (e.g., restraining order, non-molestation order)
* Restrictions imposed by police (e.g., bail conditions, Domestic Violence Protection Notice)
* Inherent Jurisdiction of the high court

## 9.7 How do I report to the police when the safeguarding concern appears to be a criminal offence?

When concerns are received, and the information suggests that a crime has been committed you need to send a copy of the concern to your local Kent Police VIT. You can provide information within the email as to whether the person is consenting and what action they wish to be taken. This will support Police to make a decision as to level of response and any further action required. It is also the opportunity to request that Police share information under S.42 that is relevant to the concerns raised. For example, history of reports of Domestic Violence. This will assist with assessing the level of risk. Email addresses for each team are held locally.

If concerns need a more immediate response, you can send a copy of the concern form to Force Control Kent [force.control@kent.police.uk](mailto:force.control@kent.police.uk) or of course dial 999 where appropriate.

## 9.8 How do I contact Medway Safeguarding Team?

[Locality1safs@medway.gov.uk](mailto:Locality1safs@medway.gov.uk)

## 9.9 What do I need to consider when uploading 3rd party documents securely

At times DSO / IO will be sent information that will be password protected and may also hold information about other people. An example of this is MARAC minutes. Please ensure that all information pertaining to other people (excluding the person causing concerns) is removed and documents are saved within Mosaic with the password removed.

If minutes are being saved from an establishment conference where several people are discussed, please ensure information pertaining to others is anonymised.

# 10. Useful Resources

## 10.1 Guidance for people with Dementia on safeguarding enquiries

[See Appendix L](#_Appendices)

## 10.2 Refusal of a Care Needs Assessment briefing

[See Appendix M](#_Appendices)

## 10.3 Safeguarding Adult Review (SAR) referral process

<https://proceduresonline.com/trixcms2/media/11619/safeguarding-adults-review-sar-internal-process.docx>

## 10.4 Inherent Jurisdiction guidance

The below link refers to the legal powers which includes Inherent Jurisdiction. Inherent Jurisdiction is used when person has capacity, but we are concerned about their decision making due to e.g., coercion and control:

[Gaining access to an adult suspected to be at risk of neglect or abuse | SCIE](https://www.scie.org.uk/safeguarding/adults/practice/gaining-access)

This guidance note provides for social workers and those working in front-line settings an overview of the inherent jurisdiction of the High Court as it applies to adults.

It sets out (a) when it is appropriate to seek to obtain orders from the High Court; and (b) key procedural matters relating to such applications.

[Mental Capacity Guidance Note - Inherent Jurisdiction | 39 Essex Chambers](https://www.39essex.com/information-hub/insight/mental-capacity-guidance-note-inherent-jurisdiction)

## 10.5 Social Care Institute of Excellence (SCIE) Adult Safeguarding practice questions

[Adult safeguarding practice questions | SCIE](https://www.scie.org.uk/safeguarding/adults/practice/questions)

## 10.6 Guidance on Safeguarding Adults in Care Homes

[See Appendix N](#_Appendices)

# 11. Monitoring

|  |  |  |
| --- | --- | --- |
| **Role** | **Name** | **Job Title** |
| Responsible Assistant Director | Sarah Denson | Assistant Director– Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Responsible Senior Manager | Vickie Minkiewicz | Principal Social Worker - Strategic Safeguarding, Policy, Practice & Quality Assurance |
| Person responsible for monitoring day-to-day compliance | * Alyson Wagget; * Akua Agyepong * Janice Grant; * Sarah Denson; * Sue Ashmore; and * Sydney Hill. | * Assistant Director Thanet South Kent Coastal; * Assistant Director Countywide Services; * Assistant Director West Kent; * Strategic Safeguarding, Policy, Practice & Quality Assurance Team; * Assistant Director Ashford & Canterbury; and * Assistant Director North Kent. |

# 12. Appendices

|  |  |  |
| --- | --- | --- |
| **Appendix Reference** | **Title** | **Document** |
| Appendix A | Safeguarding Pathway Map Tool |  |
| Appendix B | DoLS Mosaic Guidance |  |
| Appendix C | Provider Enquiry Template |  |
| Appendix D | Self-Neglect Process and Guidance |  |
| Appendix E | Sanctions Template |  |
| Appendix F | Does meet Section 42 Criteria Feedback template |  |
| Appendix G | Does **not** meet Section 42 Criteria Feedback template |  |
| Appendix H | Closure following Section 42 Enquiry Feedback |  |
| Appendix I | Closure Aide Memoire |  |
| Appendix J | MAPPA guidance |  |
| Appendix K | MARAC guidance with DASH |  |
| Appendix L | Guidance for people with Dementia on Safeguarding enquires |  |
| Appendix M | Refusal of a Care Needs Assessment briefing |  |
| Appendix N | Guidance on Safeguarding Adults in Care Homes |  |