London Multi-Agency Adult Safeguarding Policy, Practice Guidance and Procedures

Foreword

This document is intended to provide guidance for all workers who have responsibilities related to adult safeguarding. It sets out the principles, values and how organisations and individuals should be working together to respond to abuse or neglect of adults with care and support needs in London. Individual Safeguarding Adults Boards have agreed to and adopted this policy, practice guidance and procedures.

Organisationally, London is a complex place, and this document represents the commitment to working in partnership. Ensuring there is a single overarching approach to adult safeguarding across the capital, and that people with care and support needs can live safely within their communities and can access services and support.

There have been several updates of this document since the first version was published in 2011. This version captures developments and learning following 10 years of implementation of the Care Act 2014. It has been worked on collaboratively by a multi-agency partnership who represent members of the London Safeguarding Adults Board's Network. It consolidates experience of adult safeguarding, promotes best practice across London and provides updated resources and practice examples.

The merger of NHS England and the Department of Health and Social Care functions will be fully integrated by 2027 alongside the restructure of the Integrated Care Boards (ICBs), which includes the amalgamation of two ICBs in London.

The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and the National Safeguarding Adults Board (SAB) Network will also be publishing national toolkits and guidance. This update supports those initiatives by including emerging themes from Safeguarding Adults Reviews (SARs), Working with Providers, Cultural Competency, Online Harm, the Use of Digital Tools and an update to Safeguarding and Homelessness. The Glossary, Acronyms and Further Information has also been significantly extended.

We want to ensure the document is kept updated and reflects good practice and developments. Going forward, the London SAB Network intend to work with colleagues across other partnerships including the London Criminal Justice Board and national bodies. We also want this to be a living document with case examples and links to new good practice tools as these are developed.

The document is for all workers and organisations, and we have used the generic term of 'worker' unless there is the need to specify a role e.g. Nurse, Police Officer, General Practitioner, Social Worker etc. It is separated into sections - Context, Principles, and Values; Policy, Practice Guidance, Procedures and Appendices, including Organisational Abuse and Glossary; Acronyms and Further Information. At the end of the document there are lists that provide links to research, practice guidance and resources.

Workers will have access to their own procedures and should be accessing the primary legislation, regulations, and practice guidance. Since the statutory guidance is regularly updated paragraph numbers will change, so we have used the chapter numbers. Workers will need to ensure that they check the current guidance and where necessary, legal advice should be sought.

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Part One: Context, Principles, and Values

Context

The Care Act 2014 sections 42 to 45 and the Care Act 2014 Care and Support Statutory Guidance - GOV.UK (updated February 2025), Chapter 14 gives the legal framework provides for adult safeguarding work. Adult Safeguarding is defined as "*protecting an adult's right to live in safety, free from abuse and neglect".* Organisations and workers should work together in partnership with adults to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives.
- Promote an outcomes approach in safeguarding that works for people resulting in the best experience possible.
- Raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

The adult safeguarding duty co-exists and runs parallel with duties to assess and meet social care needs and/or provide treatment.

1.1 The Care Act 2014 Care and Support Statutory Guidance[1]

This states that adult safeguarding:

- Is person led.
- Engages the person from the start, throughout and at the end to address their needs and report on whether risk was reduced or removed and if the outcomes that matter to them were achieved.
- Is outcome focused.
- Is based upon a community approach from all partners and providers.

Paragraph 14.9 of the Care Act Guidance states adult *"Safeguarding is not a substitute for":*

- Providers' responsibilities to provide safe and high-quality care and support.
- Commissioners regularly assuring themselves of the safety and effectiveness of commissioned services.
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action.
- The core duties of the police to prevent and detect crime and protect life and property.

1.2 Duty to Make Enquiries

Section 42 of the Care Act 2014 states that:
S42(1) - where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and
(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

[1] To be referred to as Care Act Guidance throughout.

S42(2) - the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
See**:** Making decisions on the duty to carry out Adult safeguarding enquiries | Local Government Association on the duty to carry out safeguarding enquiries.

1.3 Safeguarding Adults Boards

Section 43 of the Care Act 2014 requires each Local Authority to set up a Safeguarding Adults Board (SAB) with core membership from the Local Authority, the Police and the NHS (specifically ICBs). It has the power to include other relevant bodies. Each organisation involved in adult safeguarding also has obligations under data protection legislation. The SAB must develop clear policies and processes that have been agreed with other interested parties, and that reflect the local service arrangements, roles and responsibilities. Policies will state what organisations and individuals are expected to do where they suspect abuse or neglect.

1.4 Cooperation and Taking a Partnership Approach

London SABs have adopted this updated document to ensure that there is consistent response across London. It is built on strong multi-agency partnerships and all organisations involved in adult safeguarding are asked to adopt it. This entails joint accountability for the management of risk, timely information sharing, co-operation and a collegiate approach that respects boundaries and confidentiality within legal frameworks. They should also be used in conjunction with partnerships and individual organisations' procedures on related issues such as fraud, disciplinary procedures and health and safety. Organisations may wish to add local practice guidance, protocols, organisational and operational guidance.

Partnership working depends on all partners being open and honest. This document provides a framework, but individual workers and organisations should feel able to challenge decision making and resolve difficulties between themselves where there are any disagreements. Good partnership working, adherence to professional codes of conduct, organisations values and behaviours will further support working together across London.

Principles

1.5 The Six Principles of Adult Safeguarding

The document is based on the Six Principles of Adult Safeguarding, outlined in the Care Act Guidance, which underpin all adult safeguarding work:

Empowerment	People being supported and encouraged to make their own 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.***
Proportionate	The least intrusive response appropriate to the risk presented.	***I am sure that the professionals will work in my interest, as I see them, and they will only get involved as much as needed.***
Protection	Support and representation for those in greatest need.	***I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.***
Partnerships	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 and with me to get the best result for me.***
Accountability	Accountability and transparency in delivering safeguarding.	***I understand the role of everyone involved in my life and so do they.***

The Care and Support Guidance states:

14.14. In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and lifestyles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised; and the case study below helps illustrate this.

14.15. Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

These are supported by Making Safeguarding Personal (a person centred, outcome focused approach and a strength-based approach) recognising the person as the expert in their own life, identifying what the person wants to happen, utilising their skills, abilities and family/friends and

community networks/supports to achieve their desired outcome(s), where appropriate. While there are times when the persons' outcome(s) cannot be achieved due to the level of risk or resource restrictions, Making Safeguarding Personal should improve wellbeing, outcomes, promote Human Rights, increase empowerment and independence.

1.6 Wellbeing (Also known as the Wellbeing Principle)
It is a guiding principle and should apply to all agencies involved in safeguarding adults. Section 1 of the Care Act 2014 puts wellbeing at the heart of care and support. For safeguarding, this would include adult safeguarding activities in the widest community sense and is not confined to adult safeguarding enquiries under section 42 of the Care Act. These should apply to all agencies involved in adult safeguarding.

'Wellbeing' is a broad concept and in relation to an individual means any of the following:
1. Personal dignity (including treatment of the individual with respect).
2. Physical and mental health and emotional wellbeing.
3. Protection from abuse and neglect.
4. Control by the individual over day-to-day life (including over the care and support provided and the way it is provided).
5. Participation in work, education, training or recreation.
6. Social and economic wellbeing.
7. Domestic, family and personal.
8. Suitability of accommodation.
9. The individual's contribution to society

All organisations working with adults who may be at risk of abuse and neglect, must aim to:
- Ensure that they are supporting people to make their own informed and safe decisions.
- Take prompt action to protect people who are not able to protect themselves.

These should underpin every activity through consistent adult safeguarding work. This includes any adult safeguarding activity that is outside the scope of a Section 42 Care Act 2014 Enquiry.

Section 1 of the Care Act states that Local Authorities must promote wellbeing when conducting any of their care and support functions. Wellbeing is also central to NHS strategies encompassed within the10 Year Health Plan for England: fit for the future (2025), and within the Code of Practice for the Victims of Crime, statutory guidance published by the Ministry of Justice - The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK

1.7 Risk Management
Adult safeguarding is fundamentally about promoting the safety and wellbeing of an adult in line with the above six principles. This involves a holistic risk management and is used to:
- Promote, and thereby support, inclusive decision making. This should be a collaborative and empowering process, which takes full account of the individual's perspective and views of primary carers.
- Enable and support the positive management of risks. Where endorsed by multi-agency partners.
- Promote the adoption by all staff of 'defensible decisions' rather than 'defensive actions.

Not all risks can be eliminated, and part of risk management is accepting that risk elimination is not possible if adopting a person-centred - Making Safeguarding Personal approach. Effective risk management strategies should identify risks and provide an action or means of mitigation

against each identified risk and have a mechanism in place for early escalation if the mitigation is no longer viable.

Contingency arrangements should always be part of risk management. Risk assessments and risk management should take a holistic approach and partners should ensure they have systems in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention.

Where an individual is not able to protect themselves without support, the aim should be to support them to make their own informed decisions which preserve their safety. People involved in adult safeguarding work need to acknowledge that there is a balance to be struck between risk and an individual's right to make their own informed decisions, even if others consider the decision to be unwise or puts the individual at risk. Staff should be alert to issues that might impact on a person's ability to keep themselves safe, such as coercion, duress, or trauma, which can impact on their executive functioning. Acting under coercion, duress or undue influence is not the basis for concluding that that the person lacks mental capacity to make the decision.

1.8 Co-Operation and Information Sharing

The Care Act Guidance highlights the need for organisations to work together to prevent and reduce abuse and neglect of adults. Co-operation to deliver effective adult safeguarding practice should take place across the whole organisation including corporate and strategic leadership, operational practice. For local authorities, this includes (but not exclusive to) adult social care, children's services, public health, housing and environmental health.

All organisations (Police, NHS bodies e.g. Pharmacists, NHS Trusts) have legal duties and responsibilities in relation to safeguarding adults with Local Authorities retaining the lead for co-ordinating activity.

Organisations contributing to effective inter-agency working can achieve this through creative joint working partnerships that focus on positive outcomes for the individual(s).

The five aims of co-operation set out in the Care Act 2014 and relevant to care and support, are:

- Promoting the wellbeing of adults needing care and support, and of carers.
- Improving the quality of care and support for adults and support for carers (Including the outcomes from such provision).
- Smoothing the transition from children to adults' services.
- Protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect.
- Identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

The importance of effective multi-agency working is a common feature in Safeguarding Adults Reviews (SARs) and co-operation between organisations is key. This includes taking a broad community approach, establishing adult safeguarding arrangements, working together on prevention strategies, and awareness raising. These aims also support the objectives of Health and Wellbeing Boards, Children's Safeguarding Partnerships and Community Safety Partnerships. It also includes co-operation between local authorities.

Information sharing, where this is lawful and proportionate is supported by all data protection legislation, and partners must respond to requests to cooperate under s6-7 of the Care Act, but also in line with wider public law duties.

No delay - sharing the right information, at the right time, with the right people, is fundamental to good practice in adult safeguarding. Responses should be carried out in a timely fashion and workers should consider the presenting risk. Where there is risk of abuse or neglect, quick action must be taken and an effective response made.

Organisational policies should be clear about how confidential information should be shared, including between departments within the same organisation. Workers or volunteers should always report safeguarding concerns in line with their organisation's policy. SABs needs to be assured that any shared learning identifies where cooperation has strengthened adult safeguarding and where improvements may be needed, promoting the effectiveness in its annual report.

If an organisation is refusing to share information, the organisation conducting an enquiry can escalate to the SAB under local escalation or dispute resolution processes. The SAB can then consider whether the concern warrants a request, under Section 45 of the Care Act, for the 'supply of information'. Then the reluctant party would only have grounds for refusal if it would be 'incompatible with their own duties or have an adverse effect on the exercise of their duties.

Sharing information between organisations, not part of s45 but as part of day-to-day operational safeguarding practice is covered by the common law duty of confidentiality, the General Data Protection Regulation. See: The UK GDPR | ICO; Data protection: The Data Protection Act - GOV.UK; Human Rights Act 1998 and the Crime and Disorder Act 1998

The Data Protection Act 2018/GDPR provides public interest exceptions to share patient data for safeguarding purposes. All information sharing for safeguarding purposes must comply with the relevant legislation i.e. Data Protection 2018 (DPA 2018) and Human Rights Act 1998 and the Common-law Duty of Confidentiality etc. Helpful guidance to ensure that information sharing is justified and proportionate is set out in The Caldicott Principles - GOV.UK for Health and Social Care organisations.

A London Data Sharing Agreement was agreed in 2019, but it is recognised that this no longer reflect new issues such as use of artificial intelligence and automation for data analysis.

Several SABs across the region e.g. Lewisham and Hillingdon have developed their own agreements or provided operational guidance for workers across partner organisations:
- Lewisham SAB Information Sharing Agreement
- Hillingdon SAB Information Sharing Agreement

1.9 Confidentiality

A duty of confidence arises when sensitive personal information is obtained and/or recorded in circumstances where it is reasonable for the subject of the information to expect that the information will be held in confidence.

Adults at risk provide sensitive information and have a right to expect that the information directly provided by themselves, obtained from others will be treated respectfully and only shared if necessary and proportionate to protect them or others from harm.

The challenges of working within the boundaries of confidentiality should not impede taking appropriate action and whenever possible, informed consent to the sharing of information should be obtained.

However:

- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.
- The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding adult concern, sharing it may be justified.
- The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

Whether information is shared with or without the adults' consent, the information sharing process must abide by the principles of the General Data Protection Regulation (GDPR). The GDPR provides a framework to ensure that personal information about living persons is shared appropriately and should not be a barrier to sharing information.

In those instances where the person lacks the mental capacity to give informed consent, requirements of the Mental Capacity Act 2005 and whether sharing it will be in the person's best interest should always be born in mind.

1.10 Duty of Candour (Whistleblowing)

Referring an adult safeguarding concern to a local authority is not whistleblowing and will not give people protections under the Public Interest Disclosure Act 1998.

Sometimes it may be necessary to go outside the immediate work environment or immediate organisation. A whistle blower is an employee, a former employee or member of an organisation who reports misconduct to people or organisations that have the power and presumed willingness to take corrective action.

It is good practice, and all workers have a duty of care, to draw attention to bad/poor practice in the workplace, this includes practice that may cause harm, be abusive and/or neglectful. Failure to report amounts to collusion with the person alleged to have caused harm or the abuse. Staff registered the Nursing and Midwifery Council, General Medical Council, Health and Care Professionals Council; Social Work England who work with adults at risk have an individual responsibility to raise concerns with someone who has the responsibility to act.

All health and social care organisations must comply with the statutory duty of candour set out in Whistleblowing for employees: What is a whistleblower - GOV.UK and Duty of candour - GOV.UK to promote a culture which values good practice and encourages whistleblowing.

Each organisation should have its own policy/guidance about whistleblowing that is easily available for staff to read; staff must be made aware of these policies. If workers have concerns and are not sure how to raise them or want advice about good practice, please refer to local agencies. They can advise on the whistleblowing process, but they are not a disclosure line.

Since 2022 all NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to have a Freedom to Speak Up Policy. This is to promote speaking up for the benefit of patients and workers; to support the process organisations have in place Freedom to Speak Up Guardians. Freedom to Speak Up Guardians are a point of contact to report a concern, to listen and work to identify the most appropriate way of responding to the issues raised.

If employed by an organisation regulated by the Care Quality Commission, whistleblowing concerns can be reported through the Care Quality Commission's whistleblowing procedures:
- CQC Contact us to Report a Concern
- Whistleblowing Guidance for providers who are registered with the Care Quality Commission
- Whistleblowing Guidance for providers who are registered with the Care Quality Commission

1.11 Safeguarding Adult Concerns and People in Positions of Trust
The People in Positions of Trust (PiPoT) process does not replace adult safeguarding duties.

Where there is an allegation of abuse or neglect of an adult with care and support needs by a person in a position of trust in the course of their duties 'in work', and this amounts to a safeguarding adult concern, this must be explored under Section 42 of the Care Act 2014.

There may also be occasions when incidents are reported that do not directly involve an adult with care and support needs, but indicate, nevertheless, that a risk may still be posed to this group of adults by a person in a position of trust.

Paragraph 14.123 of the Care Act Guidance states: Examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who has:
- Behaved in a way that has harmed or may have harmed an adult or child.
- Possibly committed a criminal offence against, or related to, an adult or child.
- Behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

All SABs should have clear multi-agency policies for dealing with allegations that fall under PiPoT, including clear information sharing procedures. Those overseeing a PiPoT process should ensure they consider if the individual works, volunteers or is undertaking charitable activities with children, or has done so, and they should liaise with the Local Authority Designated Officer (LADO) immediately and with the Adult LADO (if there is one). This is also covered in sections 14.120 to 14.132 of the Care Act Guidance. Several London SABs have developed their own frameworks, for example:
- Allegations Against People in Positions of Trust: Adult Local Authority Designated Officer - Hillingdon SAB
- Lewisham Safeguarding Adults Board PiPOT Framework

Values

There is a shared value of placing adult safeguarding within the highest of corporate priorities.

Organisations are measured on their values towards adults who, because of their care and support needs, are reliant on workers and organisations to protect them from abuse or neglect.
Values include:
- People can access support and protection to live independently and have control over their lives.
- Appropriate adult safeguarding options should be discussed with the adult at risk according to their wishes and preferences. They should take proper account of any additional factors associated with the individual's disability, age, sex, sexual orientation, race, faith, culture or lifestyle.
- All action should begin with the assumption that the adult at risk is best placed to judge their own situation and knows best the outcomes, goals and wellbeing they want to achieve and should be supported to make decisions, determining what safeguards they want in place and provided with options so that they maintain choice and control.

- The individual's views, wishes, feelings and beliefs are critical to a personalised way of working with them (Making Safeguarding Personal).
- If someone has been assessed as not having mental capacity, to make decisions about their safety (and the adult safeguarding concern), decision making will be made in their best interests as set out in the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice.
- People will have access to supported decision making.
- All decisions should be made with the adult at risk and promote their wellbeing and be reasonable, justified, proportionate and ethical.
- Timeliness should be determined by the personal circumstances of the adult at risk.
- Every effort should be made to ensure that adults at risk are afforded appropriate protection under the law and have full access to the criminal justice system when a crime has been committed.
- Where technologies are used, they should enhance the care and support offered and there are clear policies and procedures in place to collect and use data.

1.12 Cultural Capabilities

London is very diverse, with individuals from a wide range of cultural, ethnic, and socio-economic backgrounds. Cultural capability refers to our ability to understand, communicate, and interact effectively with people across cultures. It involves developing an awareness of cultural differences and integrating this understanding into safeguarding practice. To enable equitable and effective safeguarding, these are important considerations when preventing and responding to adult safeguarding matters given that cultural, ethnic, and faith factors may influence the person's understanding of and approach to adult safeguarding and willingness to engage.

Key elements:

- **Understanding cultural differences:** be aware of how culture influences behaviour, values, beliefs, and expectations. Cultural competence involves understanding the norms, practices, and values of different cultural groups and how they may affect an individual's experience of abuse or neglect.
- **Effective communication:** develop skills in communicating across cultural boundaries, including language barriers, different communication styles, and the use of interpreters or culturally relevant resources.
- **Recognising cultural biases:** reflect on your own cultural biases and how these might impact the assessment of risk or their engagement with individuals from different cultural backgrounds. It is important to challenge stereotypes and ensure that decisions are based on individual needs rather than assumptions or cultural misunderstandings.
- **Adapting adult safeguarding practices:** flexibility in applying adult safeguarding policies and procedures, ensuring that they are sensitive to the cultural context of the individuals involved. This may include adapting interview techniques, risk assessment processes, or the types of support provided.
- **Learning and development:** SAB partners can support learning and development by identifying ongoing resources to develop and maintain their cultural competency. This includes learning about the cultural backgrounds of the communities they work with and understanding the impact of cultural factors on safeguarding.

Actions to support good practice:

- Build your knowledge base about different cultural backgrounds, especially before you contact an individual.
- Share your knowledge with others and model best practice within multi-agency settings.

- Ensure care and support plans/ adult safeguarding plans reflect cultural preferences, including for example family dynamics, gender roles, and spirituality.
- Ensure that interventions are respectful and do not unintentionally marginalise or invalidate cultural practices. See:

- Cultural competence - Definition and Explanation - The Oxford Review - OR Briefings
- Appendix 4: Cultural Competency, Cultural Humility and Cultural Safety

1.13 Victim Blaming Language

How we write about incidents and speak about adults to colleagues and partners has the power to alter our understanding of events and our role/responsibilities in relation to the people involved. The London SAB Network and partners are committed to recognising and calling out problematic and victim blaming language, supporting partners to make the right choices around language, and to understand the impact this can have whether this is done deliberately or inadvertently. Victim blaming is "any language or action that implies (whether intentionally or unintentionally) that a person is partially or wholly responsible for the abuse that has happened to them". It is often used unconsciously and does not automatically indicate victim-blaming ideologies. It can occur because people are used to writing or saying things in a certain way without being aware of the impact this can have on others.

The use of victim blaming language can mean further distress and trauma to victims, who can then lose trust and confidence in the worker or organisation they represent. It can also influence how partners carry out an enquiry or investigation - minimising the risk to the adult, limiting support offered or unconsciously impacting on pace or progress, perhaps leading to a belief that the adult has agency in a situation where they are afraid, being exploited and manipulated by perpetrators.

Adult safeguarding partners are interconnected and the language used can affect others, for example an adult safeguarding concern from the Local Authority containing victim blaming language could influence the police to minimise the risk to the individual in any subsequent investigation, a report written by the police to the Crown Prosecution Service (CPS) for charging advice containing language that blames the victim can influence the CPS to more lenient outcomes for any perpetrators.

1.14 Skills and Experience

All individuals working or volunteering with adults who draw on care and support, or carers, should be able to identify and raise safeguarding adult concerns and know how to respond to someone who discloses abuse to them.

Depending on the role, there is a requirement for individuals to have a more in-depth knowledge of types of abuse and neglect; and self-neglect; to make decisions and carry out actions in relation to adult safeguarding concerns or enquiries; or undertake a strategic or governance role. Please see link to examples of an adult safeguarding competency framework. See: Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing and Concise-National-Competency-Safeguarding-Framework

Local Authorities, or where agreed, Safeguarding Adults Boards, should have policies in place to define who should undertake the role of Enquiry Officer, any supporting Enquiry Officer roles, the role of Safeguarding Adults Manager, and provide appropriate training, and refreshers. SABs should have arrangements in place for partners to report compliance with the training and competency of workers. Multi agency training coordinated and monitored by the Safeguarding Adults Board can enable a consistent approach to professional development, and greater

oversight of compliance with training. Safeguarding leads provide advice, guidance and leadership to staff in their organisation and refer to members of staff responsible in their organisation to provide:

- Managerial support and direction to staff in that organisation.
- Decision making for concerns raised by members of staff and/or members of the public.

Skills and actions to support good practice:

- Be trauma informed and aware how trauma can impact victims, how they behave and affect areas such as memory recall.
- Be aware of survival strategies whereby some victims can seem to co-operate with abusers or minimise abuse done to them. This can occur for a variety of reasons including fear, preventing further abuse, to regain some control over themselves after abuse. Another form of survival strategy can take the form of substance abuse, self-harm or not engaging with authorities.
- Maintain concerned curiosity and proactively explore reasons for disengagement and record the reasons. The adult's response could reveal further abuse, such as coercive controlling behaviour or fear of repercussions from the abuser if they found out they are working with authorities.
- Be aware of the need to convey fact – it is important for professionals to describe what has happened, what the adult said etc rather than using generalisations or subjective terms that can minimise the risk, such as an 'adult refused to open the door', 'they refused to engage'. What exactly was said/happened and were the reasons for this explored with the adult to break down barriers to engagement.
- Be aware of the need to avoid using minimising language – avoid using terms such as it was a 'low level assault', 'it was just an argument' – this can belittle the experience of the victims so try to avoid their use and accurately describe, in detail, what has occurred.
- Be aware of the need to identify the power holder - an imbalance of power can be created by vulnerability so always consider whether any such unevenness exits in a relationship and whether, and in what ways, it may have impacted on the victim's agency in relation to any actions taken by them or the perpetrator.
- Be aware of the need to use neutral language – this will avoid casting doubt on the account of the adult, unless there is incontrovertible evidence to the contrary e.g. avoiding terms such as 'the victim alleged they were raped', and using terms like 'reported'. Also, by correctly giving agency (in grammatical terms – the person who carries out the action) we can ensure the focus remains on the actions of the perpetrator.

There are consequences in terms of the individual case (further trauma for the vulnerable), and consequences in terms of how it shapes our practices. It is incumbent upon us all to challenge victim blaming language where we see or hear it, within our own organisations and acting as critical friends across the safeguarding partnership.

Part Two: Policy

2.1 Prevention

Section 2 of the Care Act requires local authorities to ensure the provision of preventative services (i.e. a health care system that prevents, reduces and delays the development of care and support needs). Organisations should take a broad community approach to establishing adult safeguarding arrangements, working together on prevention strategies. In addition, s44(5) of the Care Act requires organisations to act on recommendations to improve practice from Safeguarding Adults Reviews locally as the primary purpose of those reviews is to prevent against future harm.

A core responsibility of a SAB is to have an overview of prevention strategies and ensure that they are linked to e.g. the Health and Wellbeing Boards, Children's Safeguarding Partnerships, Rapid Quality Review Meetings and Quality Improvement Groups, Violence Against Women and Girls Groups, Health and Social Care Place Based Partnerships, Community Safety Partnerships, prevention strategies etc.

Actions to support good practice:

- Early intervention and early help.
- Identifying adults at risk of abuse.
- Public awareness raising.
- Information, advice and advocacy.
- Inter-agency cooperation.
- Training and education.
- Integrated policies and procedures.
- Integrated quality and adult safeguarding strategies.
- Community links and community support.
- Regulation and legislation.
- Proactive approach to Prevent.
- Suicide prevention.

Partners should embrace strategies that support action before harm can occur. Where abuse or neglect has occurred, steps should be taken to prevent it from reoccurring wherever possible, doing so within relevant parameters and sharing information in ways which are proportionate and lawful to support a holistic partnership approach to prevention. For example, visiting workers might identify an adult with a combination of characteristics that may render them more vulnerable to a fire risk and take direct action by referring the adult to Home Fire Safety | London Fire Brigade

They may also become aware of housing conditions that suggest an adult with care and support needs is at risk of exploitation, including cuckooing/ hijacked tenancy (home invasion).

Organisations should implement robust risk management processes that identify adults at risk of abuse or neglect and take timely appropriate action. Adult safeguarding functions should be integrated into quality management and assurance structures, and these should be able to evidence the effectiveness of safe systems to prevent abuse directly to the SAB.

Prevention should be discussed at every stage of the adult safeguarding process and is especially important at the closure stage when working with adults on resilience and recovery.

Discussions between staff and adults, their personal network and the wider community (if appropriate) help build resilience as part of the recovery process. Where support is needed to prevent abuse, this needs to be identified and put into planning.

2.2 Raising Awareness

Public awareness campaigns can make a significant contribution to the prevention of abuse.

They are more effective if backed up by information and advice about where to get help, and where there is effective training for staff and services to respond. Joint initiatives to raise awareness can be very effective. SABs should actively engage with the voluntary and community sectors so that public awareness campaigns reach all communities, and that consideration is given to engaging with experts by experience and underrepresented groups.

2.3 Information and Advice

The term 'information' means the communication of knowledge and facts regarding care.

'Advice' means helping a person to identify choices and/or providing an opinion or recommendation regarding a course of action in relation to care and support.

Local authorities are required to establish and maintain an information and advice service relating to all residents within its area, not just adults with care and support needs.

Information and advice are critical to preventing or delaying the need for services and, in relation to adult safeguarding, can be the first step to responding to a concern. Section 4 of the Care Act states that local authorities must: "*establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers*."

This includes information and advice about adult safeguarding and should include:

- How to raise concerns about the safety or wellbeing of an adult who has care and support needs.
- Awareness of different types of abuse (including neglect and self-neglect) and harm, and indicators to look out for.
- How people can keep safe, and how to support people to keep safe.
- The safeguarding adult's process.
- How SABs work.

All organisations should ensure that they are able to provide this service and can signpost adults to receive the right kind of help by the right organisation.

Information and advice should be tailored to the person needs seeking them, recognising people may need different mediums through which to communicate. Information and advice should, where possible, be provided in the manner and language preferred by the person and in a way to help them understand the information being conveyed. This should be carried out with an awareness of the Equality Act 2010

Culture, ethnicity, and faith need to be considered in relation to our prevention and response to safeguarding adult concerns, as these may influence an individual's understanding of and approach to the adult safeguarding process as well as their willingness to engage.

‘Reasonable adjustments’ should be made to ensure that people have equal access to information and advice services. Reasonable adjustments could include the provision of information in accessible formats or with communication support.

2.4 Adult Safeguarding Duties
Safeguarding duties apply regardless of whether a person’s care and support needs are being met, whether by the local authority or anyone else. They also apply to people who pay for their own care and support services. An adult with care and support needs may be:

- An older person.
- A person with a physical disability, a learning difficulty or a sensory impairment.
- Someone with mental health needs, including dementia or a personality disorder.
- A person with a long-term health condition.
- Someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living. (Adult Safeguarding Practice Questions, SCIE, July 2018).

Consideration of this need for care and support must be person-centred (for example, not all older people will need care and support but those who are frail due to ill health, physical disability or cognitive impairment’ may be). See:

- Understanding what constitutes a safeguarding concern and how to support effective outcomes
- Understanding what constitutes a safeguarding concern: FAQs | Local Government Association

N.B: Homelessness and rough sleepers - there are a range of risks experienced by people living on the streets that expose them to a higher level of vulnerability to harm and abuse. Some of these risk factors may be more prevalent amongst people who sleep rough. See:

- Adult safeguarding and homelessness: experience informed practice | Local Government Association
- Appendix 3: Adult Safeguarding and Homelessness

If an adult does not fully meet the criteria set out in Section 42ii of the Care Act 2014, the Local Authority may choose to carry out proportionate enquiries, to promote the adult’s wellbeing and to support preventative action. The Care Act 2014 provides powers to support adults to reduce risks and harms in these circumstances.

Outside the Scope:

- **Adults in Custodial Settings** i.e. prisons and approved premises National Offender Management Service - GOV.UK The Safeguarding Adults Board does however have a duty to assist prison governors on adult safeguarding matters. Local Authorities are required to assess for care and support needs Care Act 2014 which take account of their wellbeing. Equally NHS England has a responsibility to commission health services delivered through offender health teams which contributes towards safeguarding adult offenders. For more information How is Social Care Provided in Adult Prisons in England and Wales? | Nuffield Trust
- **Babies, Children and Young People** London Safeguarding Children Procedures provides details of how partners across London work together.

2.5 Who Abuses and Neglects Adults?
Anyone can carry out abuse or neglect, including spouses/partners; children; other family members; neighbours; friends; acquaintances; other residents; paid staff; volunteers; strangers.

Abuse can happen anywhere. for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can take place when an adult lives alone or with others.

2.6 Types and Indicators of Abuse and Neglect
It is important to recognise that exploitation is a common theme in nearly all types of abuse and neglect. The Care Act Guidance (para 14.17) states that:

"Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms, and the circumstances of the individual case should always be considered; although the criteria (at paragraph 14.2) will need to be met before the issue is considered as a safeguarding concern".

The 10 categories of abuse as described in Chapter 14 of the Care and Support Statutory Guidance - GOV.UK are set out below; although we have also included new and emerging areas of abuse as highlighted in local adult safeguarding activity and in the Second National Analysis of Safeguarding Adults Reviews: April 2019 - March 2023 | Local Government Association

Physical Abuse:
Including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Restraint covers a wide range of actions and includes the use of active or passive means to ensure that the person concerned complies.

Restrictive interventions are defined as: deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and /or freedom to act independently in order to:

1. Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
2. End or reduce significantly the danger to the person and others; and
3. Contain or limit the persons freedom for longer than is necessary.

If restrictive interventions are carried out for any other purpose than those listed above, concerns should always be escalated. See: Positive and Proactive Care: reducing the need for restrictive interventions

Domestic Abuse:
The Domestic Abuse Act 2021 - GOV.UK and the Domestic Abuse: Statutory Guidance provides information on what domestic abuse is; it also provides and signposts support for those organisations who need to respond, and conveys standards and best practice for single agency and multi-agency responses. It creates a statutory definition of domestic abuse, defining 'abusive behaviour' as any of the following:

- Physical or sexual abuse (including non-fatal strangulation and non-fatal suffocation in England and Wales under the Domestic Abuse Act 2021.
- Violent or threatening behaviour.
- Controlling or coercive behaviour.
- Economic abuse See: Economic abuse and the Domestic Abuse Act - Surviving Economic Abuse
- Psychological, emotional or other abuse.

For the definition to apply, both parties must be aged 16 or over and 'personally connected'.

‘Personally connected’ is defined in the act as parties who:

- Are or have been married to each other.
- Are or have been civil partners of each other.
- Have agreed to marry one another (whether the agreement has been terminated).
- Have entered into a civil partnership agreement (whether the agreement has been terminated).
- Are or have been in an intimate personal relationship with each other.
- Have, or there has been a time when they each have had, a parental relationship in relation to the same child.
- Are relatives.

The Domestic Abuse Statutory Guidance includes behaviours such as harassment and stalking, technology-facilitated abuse, abuse relating to faith and some examples of ‘Honour’-based abuse are covered by the definition of domestic abuse defined in the 2021 Act.

See: Home - Domestic Abuse Commissioner

Specific sub-types of domestic abuse may include but are not limited to stalking, coercive reproduction, faith-based abuse, and child to parent abuse and the legislation has made some types of abuse criminal offences. They may include all other forms of abuse, harm and neglect.
See: Information on Psychological Abuse - Safe Lives

The offence of coercive and controlling behaviour in intimate and familial relationships was introduced in section 76 of into the Serious Crime Act (2015). The offence of Forced marriage was introduced by section 121 of the Anti-social Behaviour, Crime and Policing Act 2014. The Marriage and Civil Partnership (Minimum Age) Act 2022 amended section 121 by establishing the offence of carrying out any steps that permits someone under aged 18 to enter into a marriage. The offence occurs whether or not there is parental consent, violence, threats or any other form of coercion or deception and whether or not it is carried out in England and Wales if the child is habitually resident in England and Wales. The 2022 Act also amended the Civil Partnership Act 2004 by making any civil partnership void if one of the two people was under 18.

This means that in England and Wales 16- and 17-year-olds are no longer be allowed to marry or enter a civil partnership.
Virginity Testing and Hymenoplasty are offences under Part 5 of the Health and Care Act 2022.

See: Information on Psychological abuse - Safe Lives
See: Hackney Intergenerational Domestic Abuse Protocol

Honour Based Abuse (HBA)
Honour-based abuse is a crime or incident which has or may have been committed to protect or defend the perceived honour of the family and/or community, or in response to individuals trying to break away from constraining ‘norms’ of behaviour that their family or community is trying to impose. Domestic Abuse Statutory Guidance

The abuse is motivated by the perpetrator’s perception that an individual has shamed, or may shame, the perpetrator, the family, or community, or has otherwise broken, or may break, the perceived norms of the community’s accepted behaviours, including by speaking out about the abuse and where the perception of shame may also prevent a victim from accessing support or help: Sector Partners Agree and Push for Statutory Definition – Karma Nirvana

Honour-based abuse can include physical, emotional or psychological abuse and occur in specific contexts.

Some examples of Honour-based abuse are Domestic Abuse, Child Marriage (It is illegal in England and Wales to get married under the age of 18), Forced Marriage, Virginity Testing and or Hymenoplasty, and Female Genital Mutilation (FGM).

In all suspected cases, use of official interpreters is required. Co Action Hub Factsheet 'Honour' Based Abuse - provides further information on 'do & don'ts'.

All professionals working with suspected or actual victims of honour-based abuse need to be aware of the "one chance" rule. That is, they may only have one opportunity to speak to a victim or potential victim and may possibly only have one chance to save a life. See:
- What is honour-based abuse? | Metropolitan Police
- Multi-agency statutory guidance for dealing with forced marriage and multi-agency practice guidelines: Handling cases of forced marriage (accessible version) - GOV.UK)

Sexual Abuse:
Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, sexual assault and sexual acts to which the adult has not consented or was pressured into consenting.

Sexual Exploitation (not specifically included in the statutory guidance) involves situations, including online sexual exploitation contexts, and instances where adults at risk receive something (e.g. food, accommodation, drugs, alcohol, cigarettes, gifts, money, affection) in return for conducting sexual acts (and/or another/others conducting such acts on them).

Sexual exploitation affects men as well as women. People who are being exploited may not always perceive such behaviours as exploitation. In all cases those exploiting the adult at risk have power over them by virtue of their position, gender, age, physical strength, intellect, economic situation or other resources. There is a distinct inequality in the relationship.

See: Adult Online Hate, Harassment and Abuse: A rapid evidence assessment - GOV.UK

Psychological Abuse:
Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, unreasonable and unjustified withdrawal of services or supportive networks. See:
- Practical advice for handling psychological abuse and impact on wellbeing | Local Government Association
- Psychological Abuse | Hourglass

Financial or Material Abuse:
Including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements including in connection with wills, property, inheritance or financial transactions and the misuse or misappropriation of property, possessions or benefit. An adult at risk may be persuaded to part with large sums of money/life savings. Such concern should always be reported to the Police and if relevant, local Trading Standards for further investigation. Where this abuse is perpetrated by someone with authority to manage the adult at risks finances, the Office of the

Public Guardian should be informed (in relation to Deputies/Attorneys) or the Department for Work and Pensions (for Appointees). See:
- Protect yourself from scams | FCA
- Investment scams and fraud | Age UK

Modern Slavery:
The Modern Slavery Act 2015 is the main U.K. legislation linked to this subject which sits alongside other domestic legislation and international conventions.

Modern Slavery is an overarching term covering slavery, servitude, forced or compulsory labour and human trafficking. Human trafficking occurs when someone is moved, within a country or to another country, and forced into exploitation.

There are different types of exploitation that victims of modern slavery can be subjected to:
- Sexual exploitation.
- Labour exploitation.
- Forced criminality (including County Lines).
- Domestic servitude.
- Debt bondage.
- Organ harvesting.

Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. They exploit the social, cultural and financial vulnerabilities of the victim. They control almost all aspects of the victim's life with little regard for their welfare and health. Adults who are enslaved are not always subject to trafficking. Someone is in slavery if they are forced to work through physical or mental threat, owned or controlled by an 'employer' (usually through abuse or threat of abuse), dehumanised and treated as a commodity (bought & sold as 'property'), physically constrained or has restrictions placed on his/her freedom of movement.

Key points to be aware of:
- People can be victims of modern slavery even if on face value they indicate they have consented to the circumstances they find themselves in, as this may have happened under duress or through coercion.
- Some people may not recognise themselves as victims of modern slavery. This can be because they feel their current circumstances are better than before.
- U.K. nationals can be victims of modern slavery in the U.K. as well as people trafficked into the U.K.
- Someone is a victim of human trafficking if they have not yet been exploited but have been moved for the purposes of exploitation.
- Modern slavery victims can be related to or in a relationship with their abusers.
- Modern slavery victims can be scared to come forward as they fear repercussions for themselves or their family, if they have been involved in criminal activity, due to their immigration status, or because of misplaced loyalty to the perpetrators, or due to fear of authorities.

National Referral Mechanism (NRM) and Duty to Notify (DtN):
The NRM is a framework to identify and refer victims/ potential victims of modern slavery, and to ensure they receive appropriate support. Adults must consent to a NRM referral. If an adult does not consent to an NRM, a DtN should be submitted.

Specified public authorities are required to notify the Home Office about potential victims of modern slavery in England and Wales - this is a DtN referral. The NRM and DtN form is responsive and will help you determine if it is a NRM or DtN.

Children do not need to give consent and must be referred into the NRM (a DtN is not completed for children because all cases should be referred via the NRM).

Only First Responders can submit NRM or DtN referrals. First Responder organisations also have a range of responsibilities related to modern slavery.

A potential victim of modern slavery is also a potential victim of crime. All NRM referrals should be referred to the police by the First Responder - either on the victim's behalf if they give consent, or as a third-party referral if they don't give consent:
- Report modern slavery – GOV.UK
- National referral mechanism guidance: adult (England and Wales) - GOV.UK

Also see:
- Publish an annual modern slavery statement - GOV.UK
- LGA resources on modern slavery | Local Government Association
- Tackling modern slavery in NHS procurement (draft guidance) - GOV.UK
- Modern Slavery Act 2015
- Modern slavery | Metropolitan Police
- Types of Modern Slavery - Unseen

Discriminatory Abuse:
Section 14.17 of the Care Act Guidance defines discriminatory abuse as: *"…forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation, religion."*

Examples of discriminatory abuse may include:
- Denying access to communication aids, not allowing access to an interpreter, signer or lipreader.
- Harassment or deliberate exclusion on the grounds of a protected characteristic.
- Denying basic rights to healthcare, education, employment and criminal justice relating to a protected characteristic.
- Substandard service provision relating to a protected characteristic (SCIE 2015).

Some forms of discriminatory abuse may also constitute a Hate Crime – defined by the Crown Prosecution Service as: *"Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability or perceived disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation or transgender identity or perceived transgender identity."*

See: Discriminatory abuse: a briefing for practitioners | Local Government Association

Organisational or Institutional Abuse:
The Care Act Guidance section 14.7 states the following related to Organisational Abuse:
"Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor

professional practice because of the structure, policies, processes and practices within an organisation."

Assessment, information-sharing and professional judgement is required to determine whether poor practice has become organisational abuse. Several individual safeguarding enquiries at the same place/within the same organisation may indicate wider organisational concerns about poor quality care or indicate the need for further review.

Examples of causes for concern and further investigation can include a series of medication errors; an increase in calls to London Ambulance Service; an increase in the number of visits to the Emergency Department, and especially if the same injuries occur more than once; an increase in the number of agency staff or high turnover of permanent staff; a pattern of missed dental, GP or other medical appointments; an unusually high or unusually low number of safeguarding concerns or enquiries. See: Appendix 1: Organisational Abuse Including Provider Support Procedure

Neglect and Acts of Omission:
This includes whenever an individual (including informal carers, care homes, domiciliary services, day services, hospitals etc) with responsibility for meeting the needs of an adult at risk ignores medical, emotional or physical care needs, fails to provide access to appropriate health, care and support or educational services and/or withholds the necessities of life, such as medication, adequate nutrition and heating.

Neglect also includes a failure to intervene in situations that are dangerous to the person concerned, or to others, particularly where the adult at risk lacks the mental capacity to assess risk for themselves.

Indicators can include where the adult is not supported to present themselves the way they would like (hair, nails), or have poor hygiene; are given other people's clothes to wear and/or these are unclean; denied communication and independence aids e.g. hearing aids; not kept safe from everyday hazards etc. See: London SAB Conference 2024: Neglect and Acts of Omission - Karen Rees

Section 44 of the Mental Capacity Act 2005, any act of ill treatment or wilful neglect is subject to criminal prosecution when the adult lacks capacity to make decisions about their care or treatment and the act is carried out by:

- A carer (paid or unpaid).
- A Deputy; or
- The donee of a Lasting Power of Attorney.

Where it is suspected that the neglect or act of omission meets these criteria, the police must be notified. See: Policy guidance on the prosecution of crimes against older people | The Crown Prosecution Service

Self-Neglect:
The term 'self-neglect' is commonly used by workers to describe widely differing behaviour or lifestyle. Paragraph 14.17 of the Care Act Guidance describes it as 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'. It should be noted that self-neglect may not always prompt a section 42 enquiry, and advice, guidance and/or a Care Act assessment may be most appropriate course of action.

The following areas have been identified as emerging issues through the analyses of National Safeguarding Adults Reviews:

Artificial Intelligence (AI) and the use of AI tools in Adult Safeguarding Meetings
AI tools such as Magic Notes are being used extensively across London to transcribe SAB meetings, other formal Adult Safeguarding meetings, and meetings with people who have care and support needs. This can free up resources of workers and can analyse vast amounts of data.
However, there are ethical concerns and risks about using these tools and caution is needed when using them.
All organisations will need to develop and agree how these tools are used, and the following will need to be considered:

- People with lived experience and partners will need to know and understand when and how AI tools are being used.
- Robust data security is essential, and all involved will need to understand and agree to how this information will be handled.
- AI tools will not always be accurate, and human oversight will be needed to ensure that they are a true reflection of any meeting.

See: Oxford Statement on the responsible use of generative AI in Adult Social Care | Ethics in AI

Cuckooing (also known as home take over or invasion):
This is where the home of a vulnerable person is taken over by a criminal(s) to use the home as a place to deal, store, take drugs; for sex work; financially abuse the tenant or owner of the home.
Indicators include:

- The presence of unfamiliar individuals regularly coming and going from the property at all hours.
- An increase in foot traffic or loitering in the area around the property or takeaway deliveries at unusual hours.
- An increase in noise and disturbance levels, including late-night parties or arguments or other signs of anti-social behaviour such as littering around the property.
- Damage to the property, such as broken windows or doors; and
- Threats or intimidation towards other residents or neighbours.

Multi-agency response to suspected cuckooing:

- The multi-agency workforce needs to have a good understanding of the signs of, and the risks arising from, exploitation.
- Complex case / multi agency risk management arrangements need to be in place that can be enacted rapidly.
- There needs to be a strong relationship between Police, Adult Social Care, Children's Services, Community Safety and housing providers.
- Transitional arrangements should be in place which encourage a joint approach between Safeguarding Children Partnerships and Safeguarding Adults Boards. This is crucial due to the links between cuckooing and county lines.
- It is important that agencies work to prevent victims from becoming homeless due to antisocial behaviour, and prevention of adults being at risk of repeated cuckooing. This can be supported through good data sharing arrangements between ASC and housing.
- The multi-agency approach to tackle cuckooing should be aligned with local contextual safeguarding frameworks. See:

- Preventing and Disrupting County Lines 'Cuckooing' Victimisation | School of Law | University of Leeds
- Cuckooing | Islington Council

Exploitation:
This is when an individual or group unfairly takes advantage of a person to coerce, manipulate or deceive for personal gain, there is generally a clear inequality in the relationship between the person perpetrating the exploitation and the adult at risk. Situations include where those who are exploiting the adult at risk can do so using a power imbalance through gender, age, physical strength, economic situation or position. It is a complex area of adult safeguarding and is a common theme in nearly all types of abuse and neglect. In many circumstances, a person may not fit into just one of the below definitions and there may be crossovers**.** This can also include Mate Crime where a person with care and support needs can be befriended with the intention of exploiting them. This often centres on people's isolation and lack of social contacts.

When there are indicators of exploitation, even where the individual seems to be consenting to the activity, there should a risk assessment undertaken to ensure that the person is free to stop the activity. Anyone can be exploited, particularly young people and adults at risk. It can affect any person regardless of age, gender, social or ethnic background.

Exploitation does not present consistently across the nation. For London, it is likely to look very different to rural areas, and between inner and outer London boroughs. Therefore, it is important to know your local area and consider are their cohorts of people who could be more vulnerable to exploitation e.g., rough sleepers, those living in hostels, or hotspots, such as railway stations and parks. In what ways might perpetrators try to exploit these individuals?

There needs to be local arrangements in place to address exploitation. These should be agreed through the strategic partnerships: community safety, safeguarding children's partnerships and SABs.

Ways in which perpetrators exploit victims include:
- Physical abuse - intimidating victims through actual violence, or threats to self and family.
- Emotional abuse through coercive control, manipulation or controlling victim's movements.
- Sexual abuse or exploitation.
- Financial abuse or exploitation, for the purposes of money laundering.
- Offering exchanges to the victim in return for them carrying drugs, e.g., money, drugs, clothes, protection.
- Blackmailing a victim into committing a crime, with threats to report the crime if they do not cooperate with the perpetrator.
- Forcibly moving the victim away from their home and holding them in another location.
- Online grooming, entrapment or coercion.
- Cuckooing, also known as forced home invasion, is when perpetrators take over the home of a vulnerable person and use the premises to conduct criminal activity (see above).
- Coercion of a person to conceal drugs internally within their body.
- Debt bondage, which is a form of entrapment of the victim through being made to pay back a debt.

Professional Responsibilities:
Being curious about potential exploitation (concerned curiosity) is a key responsibility. The national guidance suggests that there are factors that may heighten a person's vulnerability. For those working with adults with care and support needs, it is important to consider these factors within any assessment and planning with the person. Perpetrators manipulate those with existing vulnerabilities, to promote their power over the person at risk. If the person denies that

they are being exploited, workers need to consider whether they can make their own decisions and should not assume they consent to the activity**.** Examples include:

- Contact with the criminal justice system.
- Experience of neglect, physical abuse, sexual abuse/exploitation, lack of a stable home environment, trauma.
- Social isolation or social difficulties.
- Economic vulnerability.
- Homelessness or insecure accommodation status.
- Gang connections.
- Physical or learning disability, being neurodivergent.
- Mental ill-health.
- Substance misuse - victims are sometimes given substances in lieu of payment.
- Care experienced.
- Insecure immigration status, Asylum Seekers, people with No Recourse to Public Funds.

Disrupting Exploitation:
Alongside the safeguarding of the victim, there needs to be action taken to disrupt the perpetrators. This requires good knowledge of the exploitation presentation in the local area.

There are a range of orders which can be used to disrupt perpetrators, depending on the type of exploitation e.g., Slavery and Trafficking Risk Orders, Anti-Social Behaviour Civil Injunctions, Community Protection Notices. However, it is essential that safeguarding adult procedures are also enacted to support the victim throughout the disruption phase.

Sexual Exploitation:
The following are signs to look out for:

- Missing for periods of time.
- Unexplained increased money available, or property.
- Keeping away from family, friends, trusted support networks.
- Changes in behaviour or emotional wellbeing, e.g., self-harming, increased use of drugs.
- Increase in sex work activity or use of sexual health services.

Multi-Agency Response

- As with other types of exploitation, it is important to recognise that the victim will not always ask for help. They may appear to be consenting to the activity. Therefore, it is crucial for professionals to work on developing trusting relationships with those adults they believe are at risk of sexual exploitation. A multi-agency approach is needed.
- Consider appropriate referrals in respect of the information known:
  - Multi-Agency Risk Management /High Risk Panel.
  - Multi-Agency Risk Assessment Conference (MARAC).
  - Adult safeguarding referral – if the adult has care and support needs and is unable to protect themselves from the sexual exploitation.

Fire Safety:
Fire deaths have been on the increase in London, and the approach is multifaceted with a key focus on preventing fires and ensuring that adults with care and support needs are protected from harm, especially those people who may have difficulties escaping or are not able to call for help. The focus should be on enhanced fire risk assessments, increased awareness among care providers and communication and cooperation between all partners. This includes:

- Increasing awareness and minimising the risk of a fire occurring.

- Undertaking Fire Risk Assessments - The London Fire Brigade offer free home fire safety visits and advice to anyone with care and support needs and ensuring that fire safety equipment is available and working.
- Collaboration between all partners and ensuring that care plans include fire safety considerations.
- Training and support for carers and support workers.
- Learning from SARs.

- Fire safety for carers, social workers and support workers | London Fire Brigade
- Fire Prevention and Safeguarding Toolkit (Merton SAB)

Homelessness:
People experiencing homelessness, including rough sleeping, are exposed to all forms of abuse and neglect as well as facing heightened and discrete risks because of their circumstances.

This results in significantly reduced life expectancies and increases in acute health crises.

Learning from SAR's, the Museum of Homelessness Dying Homeless Project, and the evidence-base from the inclusion health sector indicates, that adults with care and support needs who are homeless require flexible and creative support to prevent harm and mitigate the impact of stigma, trauma and social exclusion. This can result in their needs being overlooked, downplayed or normalised in decision-making and when considering the interplay of mental capacity and self-neglect.

Adult safeguarding activity must engage with the complex risks facing adults with care and support needs that arise from drug and alcohol dependency, and dual diagnosis, which typically manifest as self-neglect and multiple unplanned hospital admissions. See: Appendix 3: Adult Safeguarding and Homelessness

Emphasis should be placed on:

Multi-agency collaboration: the Care Act's intentionally low thresholds for assessment and safeguarding intervention create an opportunity for agencies to work together to assess need and engage in coordinated support planning that prioritises information sharing, joint action-planning and Lead Professional arrangements.

Creative solutions: gaps in law and policy can result in people experiencing homelessness 'falling through the net' of housing, health and adult social care duties and entitlements. Making good use of local Multi-agency Risk Management panels or forums and having clear escalation routes for professional differences, is key to avoiding delays in securing accommodation and support as well enabling agencies to make coordinated use of what they individually have to offer.

Ensuring smooth transitions: the risk of serious harm and premature death increase when accommodation is not in place following a period in hospital or prison or following unplanned departures from hostel/supported housing settings. Transition/discharge planning should start at the earliest possible moment, and interim housing and support solutions should be prioritised for adults at risk, using powers under the Care Act and Housing Act to prevent rough sleeping, especially for those living with chronic health and care needs.

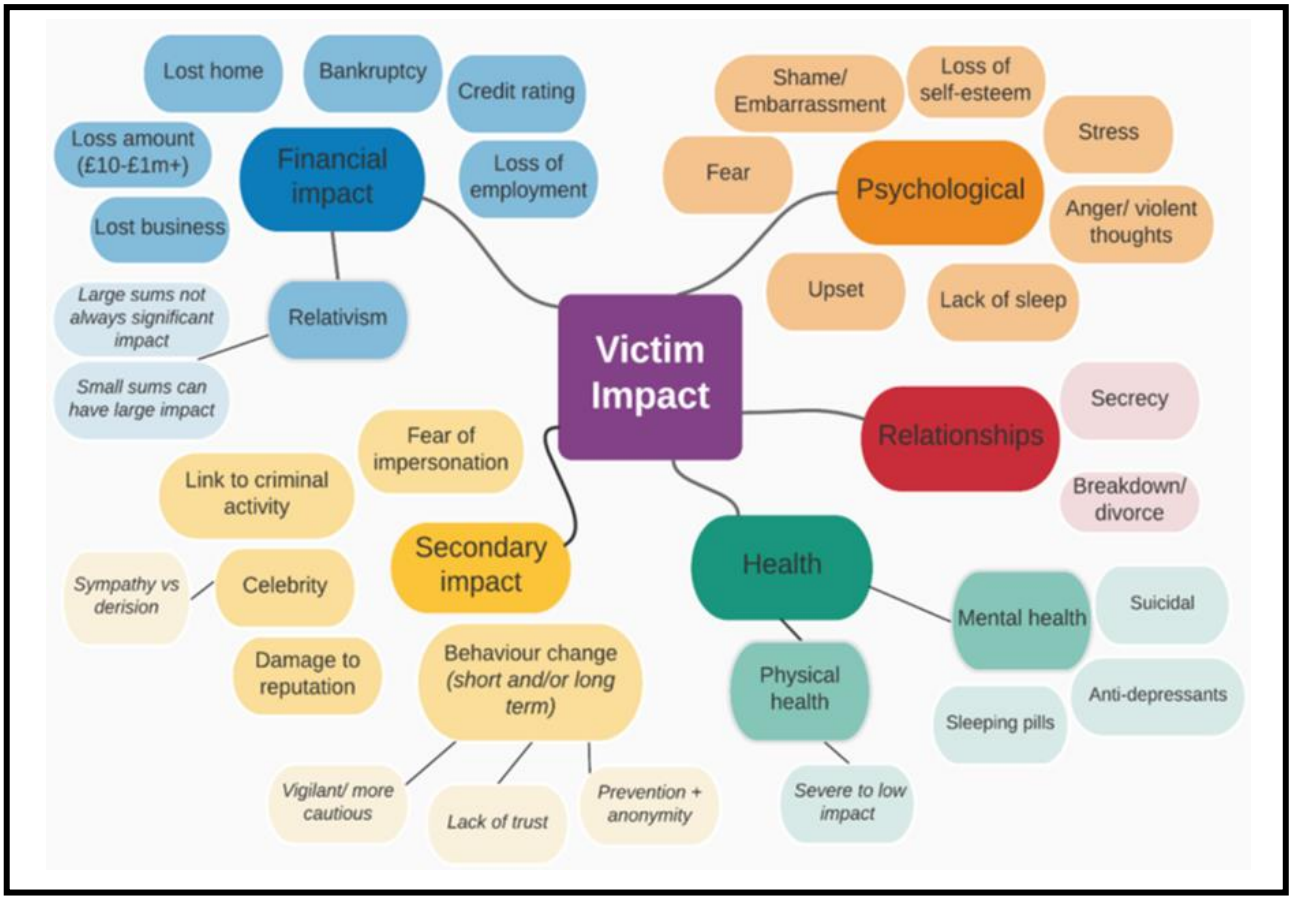
Mental capacity assessment: issues with decision-making and executive functioning may be more easily overlooked in people experiencing homelessness who live with drug and alcohol dependency or where self-neglect is a feature. The impacts of learning disabilities, neurodivergence, brain injury and other cognitive impairments that are common but under-diagnosed in people experiencing homelessness may be mistaken for intoxication, 'lifestyle choice' or 'non-engagement'. Capacity assessments should consider how the individuals living conditions are likely to influence decision-making, especially if assessments are carried out in significantly different environments, such as hospitals. See Appendix 3 for more detailed engagement with the policy and practice concerns around adult safeguarding and homelessness and Capacity Guide

Online Harm:
The Online Safety Act (2023) is the most important piece of legislation in relation to Online Harm. Online spaces continue to provide predators with the opportunity to initiate contact with adults that can often lead to grooming, manipulation, extortion for both financial gains, extorting indecent images and to facilitate acts of contact abuse, fraud and scams

Online risks include:
- Phishing deliveries, postal or courier services.
- Impersonation of Police, HMRC, DVLA, Banks.
- Fake investment or 'get rich quick' schemes.
- Banking - Push Payment and Courier Fraud.
- Social media, forums, bots, fake profiles.
- Fake websites, anonymous chat websites.
- Energy scams - rebates and refunds.
- Online marketplaces and adverts.
- Romance fraud.
- Copycat fraud.
- Subscription trap.
- Ticket fraud.
- Gaming with video / chat functions.
- Recruitment fraud.
- Unsafe goods.
- Fake competitions.
- Recovery fraud.
- Copycat websites.

See: Types of fraud and cyber crime | Action Fraud

The impact of online abuse:



Research by the Alan Turing Institute has previously estimated that 10-20% of people in the U.K. have been personally targeted by abusive content online. A wide range of organisations that campaign on behalf of specific groups have reported on this:

- **Antisemitism Policy Trust**: antisemitism online is “widespread and pervasive”.
- **Stonewall:** 78% of LGBTQ+ people had experienced hate speech online in previous 5 years.
- **Women’s Aid:** research consistently shows that women are subjected to more bullying, abuse, hateful language, and threats online than men, and highlighted the increasing use of the online world to perpetrate Violence Against Women and Girls.
- **Amnesty International:** black women are 84% more likely to be abused online than white women.

The behaviour can also disproportionately impact disabled people, and the effects can include stress, depression, and anxiety, which can in turn contribute to a worsening of any pre-existing or long-term health conditions. The National Crime Agency estimate that 38% of all crime is now fraud.

The National Trading Standards Scams Team data suggests that 73% of UK adults (equivalent to 40 million people) have been targeted by scams, with 35% of UK adults (equivalent to 19 million people) having lost money.

Abuse may also lead to people abandoning online profiles or having to change their contact details, contributing to social isolation and increased difficulty in taking on professional or other opportunities.

Despite this, fraud and scams are massively underreported. The National Crime Agency estimate that 86% of fraud instances go unreported.

See: Online Safety Act: explainer - GOV.UK

Mate Crime:
This is when a vulnerable person is falsely befriended with the intention of exploiting them. This could include financial, physical or sexual exploitation.

Pressure Ulcers:
This protocol should be used in determining if a pressure ulcer should be reported as an adult safeguarding concern: Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK

This protocol provides a framework for health and care organisations to draw on when developing local guidance for staff in all sectors and agencies that may see a pressure ulcer. If the staff member is concerned that the pressure ulcer may have arisen because of poor practice, neglect or an act of omission, local guidance should be clear about what steps they need to take and whether the local authority adult safeguarding duties are triggered.

Radicalisation:
Radicalisation can happen when a person develops extreme views or beliefs that support terrorist groups or activities.

Prevent is a national programme that aims to stop people from becoming terrorists or supporting terrorism. It works to ensure that people who are susceptible to radicalisation are offered appropriate interventions, and communities are protected against radicalising influences. There are different types of terrorism and **Prevent** deals with all of them.

The most common types of terrorism in the UK are Extreme Right-Wing terrorism and Islamist terrorism. Find out more about what terrorism means.

Radicalisation can happen both in person or online. Everyone is different, and there is no checklist that can tell us if someone is being radicalised or becoming involved in terrorism. But these signs may mean someone is being radicalised:
- Accessing extremist content online or downloading propaganda material.
- Justifying the use of violence to solve societal issues.
- Altering their style of dress or appearance to accord with an extremist group.
- Being unwilling to engage with people who they see as different.
- Using certain symbols associated with terrorist organisations.

If there is a concern about potential radicalisation into terrorism or reason to believe that someone is susceptible to radicalisation, specified authorities should use the National Prevent referral form to make a referral to the police: Get help for radicalisation concerns - GOV.UK

Channel focuses on providing support at an early stage to people who are at risk of radicalisation, supporting terrorism or committing terrorist acts. Channel uses a multi-agency approach to:
- Identify people at risk.
- Assess the nature and extent of that risk.
- Develop the most appropriate support plan for the person concerned.

See: Channel and Prevent Multi-Agency Panel (PMAP) guidance - GOV.UK

2.7 Safeguarding Adults Reviews (SARs)

The following section summarises key points of the national guidance and the SABs duties in relation to SARs under Section 44 of the Care Act 2014.

Mandatory Duty: Section 44 of the Care Act 2014 mandates Safeguarding Adults Boards (SABs) must arrange for there to be a Safeguarding Adult Review of a case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of these needs) if:

- There is reasonable concern about how the SAB, partner agencies or other persons with relevant functions worked together to safeguard the adult AND
- The adult dies because of abuse or neglect (or suspected abuse or neglect) OR
- The adult experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) because of the abuse or neglect.

Discretionary Duty: Section 44(4) of the Care Act 2014 permits SABs discretion to arrange for a SAR in any other situations involving an adult in its area with needs for care and support where there are valuable lessons to be learnt with the aim of improving how agencies work together, to promote the wellbeing of adults and their families and to prevent abuse and neglect in the future. Local arrangements to make a SAR referral are in place for each SAB and should be followed.

The findings of any SAR should be reported within the SAB's annual report. Whilst there is no legal duty to publish the full report, consideration should be given to the wider public benefit of doing so. It may prove necessary to redact information and, to protect the adult and family members, anonymise personal information.

When SAR criteria are not met: Where the SAB agrees that a situation does not meet the criteria, but agencies will benefit from a review of actions other methodologies can be considered.

These include:

- **NHS Patient Safety Incident Response Framework (PSIRF):** PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. See: NHS England » Patient Safety Incident Response Framework
- **LeDeR Review:** Integrated care systems are responsible for ensuring that LeDeR (Learning for Lives and Deaths) reviews are completed based on the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process. See: NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
- **Single Agency Review:** A review by an individual organisation in relation to their understanding and management of a particular adult safeguarding issue.
- **Reflective Practice Session:** The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the adult safeguarding lead or other such suitable person, including an independent facilitator.

- **Learning Together:** A collaborative scrutiny approach Learning Together to safeguard adults and children: a multi-agency systems approach - SCIE
- **Homelessness Mortality Reviews (HMRs):** The joint ministerial letter of May 2024, sent to all local authorities and SAB's, advises the recording and reviewing of deaths affecting people who died whilst homeless. These may be implemented in parallel to other relevant reviews, and as a standalone process, to ensure relevant multi-agency learning is captured to inform commissioning and service delivery that prioritises the prevention of future deaths.
- **Individual Management Reviews (IMRs):** These examine how agencies and individuals responded to an individual issue. This includes developing a chronology of events, reviewing and analysing decisions, interviews with key people. Reports will be considered by SABs to review learning and recommendations made to individual organisations.
- **Safeguarding Adult Reviews in Rapid Time (SARiRT):** This is a methodology and set of tools developed by the Social Care Institute for Excellence (SCIE) which aims to facilitate a quicker and more efficient SAR. See: Safeguarding Adult Reviews (SARs) In Rapid Time - SCIE
- **Maternity Reviews:** NHS England » National Maternity Review

Nature and Scope of a SAR:
The s44 duty provides SABs with flexibility to choose a proportionate methodology to complete reviews. As set out within Paragraph 14.167 of the Care Act Guidance, SARs should be based on the following principles:

- A culture of continuous learning and improvement across organisations who work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works well and promote good practice.
- Adults at risk and families should be invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively.
- The approach to reviews should be fair and proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. See:

- List of 15 Safeguarding Adult Reviews Quality Markers - SCIE
- Safeguarding Adults Reviews (SARs) under the Care Act - SCIE
- Safeguarding adults: sharing information - SCIE

Cross Authority Cooperation/ Out of Area Care Placements:
Where the subject of a SAR was placed out of area into another borough to receive health or care services, the home locality/ SAB where the adult was ordinarily resident should be notified, and they should cooperate across borders with requests for information. See:

- Advice Note - Commissioning Out-of-Area Care and Support Services
- ADASS Out-of-Area Safeguarding Adults Arrangements Protocol - ADASS (October 2025).

Learning and Recommendations from SARs:
The SAB will have a local process to monitor progress on all recommendations and may request periodic progress update reports from partner agencies and relevant organisations (in line with statutory duties under s44(5) and s45 of the Care Act) until all actions are completed. Reports on the implementation of action plans across the partnership will also be presented to Board meetings and published within the SAB's annual report.

SAB members who are responsible for learning and development issues and organisational development will lead on ensuring that learning from SARs is acted upon and reflected in local training programmes. The SAB will ensure that there is an effective approach across local networks, including the Local Safeguarding Children Partnership and the Safer Communities Partnership, to sharing learning emerging from reviews. Whenever there is an issue of national importance or commonality across SARs of importance to central government departments and regulatory bodies, the SAB should initiate discussions in line with the National Escalation Protocol for Issues from Safeguarding Adults Reviews from Safeguarding Adult Boards (2021) | Local Government Association

SAR Good Practice Guidance:
The London SAR Guidance and the national SAR analyses have highlighted Priority Improvements:

- It is important that Safeguarding Adults Boards ensure that all decision making is timely, beginning with consideration of SAR referrals. SARs should clearly outline the timeline from referral through to completion.
- The agency referring the case for consideration as a SAR should be recorded.
- It is important that the reasons for a chosen methodology and approach to reviewing the case are clearly recorded.
- It is important that race, ethnicity, and other protected characteristics are routinely addressed in reports and their significance considered.
- It is important that the reasons for a chosen methodology and approach to reviewing the case are clearly recorded.
- It is important that SAR reports comment on whether reasons for delay were positive, such as waiting for the conclusion of criminal proceedings, or a negative, such as agencies failing to cooperate.
- Section 44(5) requires agencies to cooperate and contribute, to ensure that lessons are identified and then applied to future cases.
- Section 45 of the Care Act 2014 can be used to secure compliance where cooperation has not been forthcoming.
- It is important that individuals, where still alive, and family members are involved, and that this is recorded, including the offer and provision of advocacy to support their engagement. The reasons for any non-involvement should be clearly stated.

How to Access Previous SARS, Understand Themes and Key Areas of Learning:
The National SAR Library is hosted by the National Network for Chairs of Safeguarding Adults Boards on their website: nationalnetwork.org.uk/search.html

The SAR Library contains SAR reports from 2015-2018 which were originally held by SCIE, and from 1st April 2019 to date, including a section of historical SARs of importance.

NHS England Safeguarding Case Review Tracker (S-CRT) is a secure web-based tool, which enables Integrated Care Boards (ICB) and designated safeguarding professionals to update the status of statutory reviews and download review summaries for their ICB area. It is also accessible to national and regional NHS England safeguarding leads, for the purposes of regional monitoring and analysis. The Case Review Tracker produces live data including the number of cases open and closed, themes of incidents and learning from any recommendations, that can be shared across the systems.

The Case Review Tracker enables consistent oversight and reporting for ICBs across their localities and is linked to the NHS repository of Domestic Abuse Related Death Reviews

(DARDR), Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adults Reviews and Rapid Reviews to support reporting for National and Regional Safeguarding meetings. The Case Review Tracker also supports the delivery of safeguarding statutory duties across all agencies involved in safeguarding. See:

- Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association
- Second National Analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association

2.8 Parallel Processes

A SAR is not designed to hold any individual or organisation to account, establish how someone died or was harmed, or undertake human resources duties, as other processes exist to address those concerns. The SAR process is also not intended to duplicate or replace other agencies' own internal or statutory review procedures to investigate serious incidents, or their own mechanisms for quality assuring safe practice or for providing workers opportunities for reflective practice and de-briefing.

Alongside the core principles of adult safeguarding, the London SAB network believe that the following core principles should apply to any decision making:

- Process should be carried out on a case-by-case basis.
- Choosing the type of review should be dependent on perceived outcomes and where any learning will be of most value.
- Reviews should be proportionate.
- No duplication – sharing information and findings; joint meeting/ interviews with friends and family.

See: Paragraphs s14.174 – s17.176 Care Act Guidance.

There is no requirement that any parallel process is completed before a SAR can commence and SARs sit within a range of regulatory reviews that can often overlap or duplicate actions e.g. Local Child Safeguarding Practice Reviews, Homeless Fatality Reviews (also known as Mortality Reviews), Domestic Abuse Related Death Reviews etc. This can lead to extended discussions about how best to resolve and agree a way forward.

Several processes can run in parallel to a SAR, including but not limited to:

- Employment and regulatory investigations and disciplinary proceedings, including Making barring referrals to DBS - GOV.UK
- Coroner Inquests. Also see: NHS England » The national medical examiner system
- Criminal investigations.
- NHS England » Patient Safety Incident Response Framework
- Learning From Lives and Deaths LeDeR - Home
- Child Safeguarding Practice Review Panel - GOV.UK
- Domestic Abuse Related Death Reviews (previously Domestic Homicide Reviews)
- Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK
- NHS England » Independent patient safety investigations
- Homelessness or Public Health Mortality Reviews.

Where there are parallel processes, the SAB should address within the SAR Terms of Reference how the review will dovetail with other relevant processes to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay, and confusion to all

parties, including the person, their family and staff. It will be the responsibility of the SAB Board Manager, in consultation with the SAB Chair, to contact the lead partnership or agency to ensure there is effective co-ordination. Regard should be made to:

- Where the adult has died, notification to the coroner and the medical examiner.
- Where there are parallel criminal investigations, with the Police Senior Investigation Officer.

Coroners:
Any SAR may need to take account of a Coroner's inquest, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay. Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations.
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home).
- Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries/actions are identified by the coroner or his or her officers.

In the above situations the local SAB should give serious consideration to instigating a SAR:

- National-SAB-Guidance-on-the-Interface-between-SARs-and-Coronial-Processes-22nd-July-2024-FINAL
- Safeguarding Adults Reviews 4b: Parallel Processes

Fatality Reviews also known as Mortality Reviews:
Although not all deaths and serious incidents affecting adults who are homeless may meet the threshold for Safeguarding Adult review, learning from deaths is crucial to preventing future harm for this population. See: Appendix 3 on homelessness for more information
See: Preventing drug related deaths - GOV.UK

Rapid Quality Review Meetings and Quality Improvement Groups:
The National Guidance on Quality Risk Response and Escalation in Integrated Care Systems sets out the approach to managing system-level concerns and risks – including categorising concerns, reporting, escalating, de-escalating and monitoring.

The expected role of Integrated Care Boards (ICBs) and local authorities, working with NHS England (NHSE)/Department of Health and Social Care (DHSC) and wider partners in managing quality concerns and risks will change, but this currently includes expected roles when there are multiple commissioners (e.g. ICBs and local authorities). What should happen when there are quality concerns that justify escalation to a regional or national response due to the consequences or potential for learning, including complex, significant or recurrent concerns that may require regulatory action and service closures.

Examples: significant quality failings across a pathway, material concerns about the leadership or culture within a provider or ICB, lack of timely and sustained traction to address regulatory non-compliance: NHS England » National Guidance on Quality Risk Response and Escalation in Integrated Care Systems

2.9 Mechanisms to Support Adult Safeguarding

It is important to have local mechanisms in place to enable effective information sharing and to have established escalation processes in place where there are risks that cannot be managed, i.e. escalation to high-risk panels and the Safeguard Adults Board as required.

Multi-Agency Risk Assessment Conference (MARAC):

MARAC meetings take place in each local area, usually chaired by the police, where statutory and voluntary sector partners share information on identified 'high risk' cases using the Domestic Abuse Risk Assessment tool (DARA) – and develop a coordinated, multi-agency safety plan to protect each victim. This might include agreeing actions for any children, adults, and for perpetrators.

The four aims of a MARAC are as follows:

1. To safeguard adult victims who are at high risk of future domestic violence.
2. To make links with other public protection arrangements in relation to children, people causing harm and vulnerable adults.
3. To safeguard agency staff.
4. To work towards addressing and managing the behaviour of the person causing harm.

At the heart of a MARAC is information sharing and a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, all may have insights that are crucial to their safety, as part of the coordinated community response to domestic abuse. Adult safeguarding staff can refer to the MARAC if the risk of domestic abuse is found to be high. The MARAC may also make a referral to adult safeguarding services if someone has care and support needs. Referrals should be made to specialist domestic abuse services regardless of the level of risk and thresholds for the MARAC.

Community MARAC (CMARAC):

This is a multi-agency meeting where information is shared on complex/high risk cases involving vulnerable victims/perpetrators of anti-social behaviour. The primary focus is to safeguard the victims and witnesses and prevent further victimisation. All relevant information is shared to inform a collective assessment of risks. The conference will develop an action plan to address problematic behaviour and agree on an effective safety planning strategy to manage the overall risk to the victim, perpetrator or community.

Multi-Agency Public Protection Arrangements (MAPPA):

The purpose of the MAPPA framework is to reduce the risks posed by sexual and violent offenders to protect the public, including previous victims, from serious harm.

MAPPA brings together the Police, Probation and Prison Service into what is known as the MAPPA Responsible Authority. The Responsible Authority has a statutory duty to ensure that MAPPA is established in its geographic areas and to undertake the risk assessment and management of all identified MAPPA offenders.

Several other agencies are under a 'Duty to Co-operate' with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities. The Duty to Co-operate agencies are represented on the London Strategic Management Board (SMB), which is how the Responsible Authority fulfils its duties under the relevant legislation.

The London SMB has determined that Adult Social Care Services should be a 'core member' of MAPPA. Where, in exceptional circumstances, attendance is not possible and where, by agreement with MAPPA, Adult Services are represented by Children's Services or Mental Health Services, that representative must also be able to obtain any relevant information from Adult Services where this is necessary.

Community Multi-Agency Risk Assessment Panels (or High-Risk Panels):
Community Multi-Agency Risk Panels consider complex and high-risk cases, often where agencies spend significant amounts of time responding to difficult, high-risk situations where it can be challenging to engage with the adult, and their behaviour or lifestyle can place the person and possibly others, at significant risk. Local panels can be created with all the necessary partners, both statutory and third party, and will vary depending on local need of the case in question. Any situation calling for multi-agency action could be discussed at panel meetings. The panel will support agencies in their work to lower and manage risk for both individuals and the wider community. These have a variety of names; look on the local SAB website for reference to local multi-agency panels.

Community Multi-Agency Risk Panels are based on the belief that shared decision making is the most effective, transparent and safe way to reach a decision, where there is challenge with the adult at risk and professionals working with them to mitigate the risk; or where there is a highly complex case, and the risk needs to be escalated for consideration by such a panel. The purpose of the panel is to agree a risk reduction plan that is owned and progressed by the most relevant agency with the support of necessary partners. See: Newham High Risk Panel – Safeguarding and prevention – Newham Council

Multi- Agency Safeguarding Reflective Practice Forums:
This is for all SAB partners to share safeguarding learning, to ensure open communication and collaboration, share learning, and improve outcomes.

2.10 Historic Allegations of Abuse or Neglect
A historic allegation of abuse or neglect should be responded to in the same way as current adult safeguarding concerns. There is a need to establish if a statutory adult safeguarding enquiry should commence because an adult **is now experiencing**, or, **is now at risk of** abuse or neglect.

The following actions may be considered or also required to prevent or minimise the risk of harm in addition to an adult safeguarding enquiry (if one is required):

- A care and support assessment and subsequent care and support plan.
- Counselling for the adult at risk or others.
- A Child Protection referral.
- Police Investigation.
- Professional Regulatory Investigation.
- HR action.
- Person in a Position of Trust referral.
- Complaints process.
- Coroner Inquest.
- Safeguarding Adults Review.
- LeDeR.
- Health and Safety legislation investigation.
- Patient Safety Incident Response Framework.

- Any single agency internal investigation, or commissioning action.

Not an exhaustive list.

2.11 Safeguarding Concerns When the Adult is Deceased

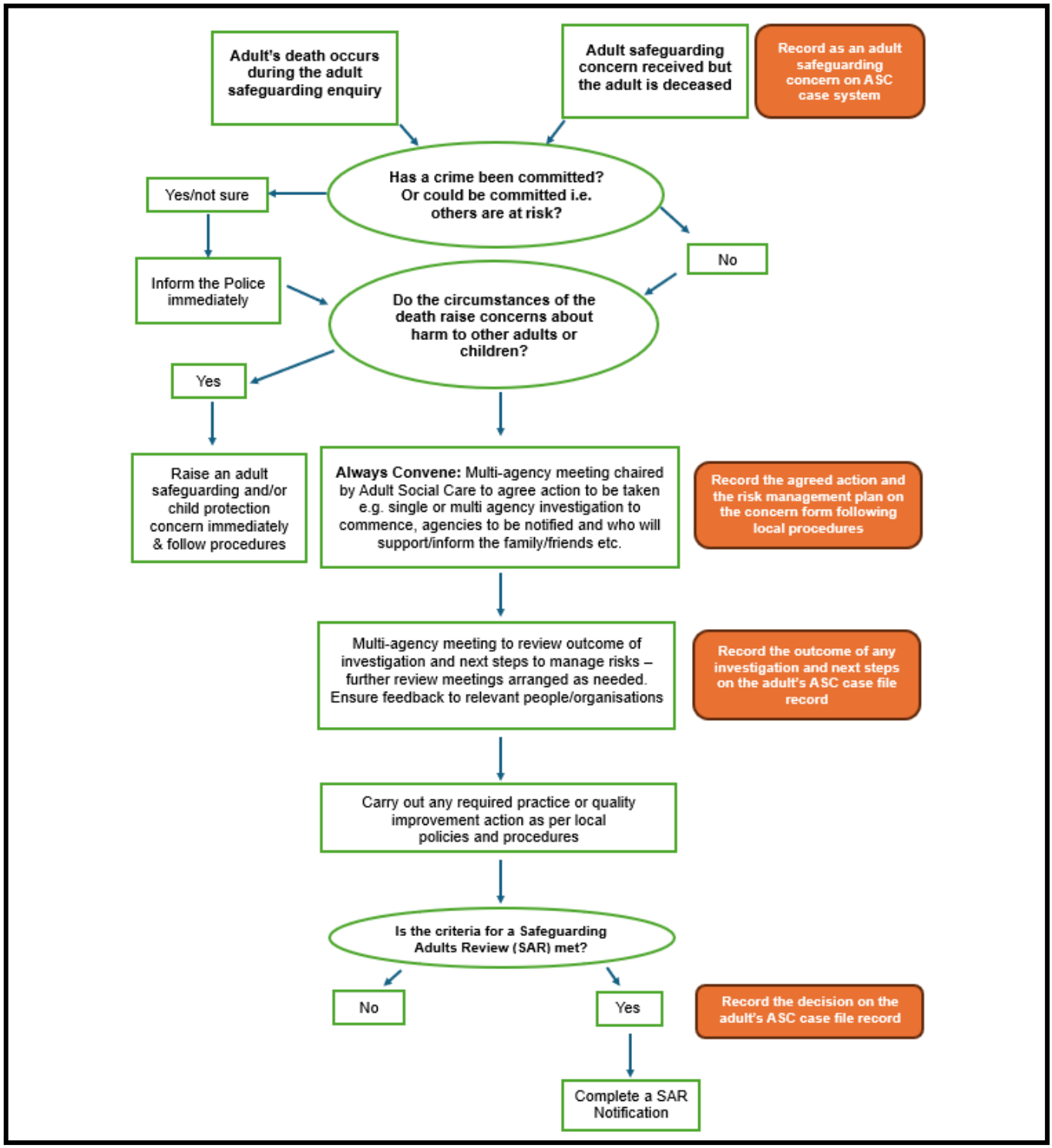
The conditions for undertaking a section 42 enquiry apply to a living person but there are actions that must be taken if an adult safeguarding concern is received about an adult who is already deceased, or the adult's death occurs during an adult safeguarding enquiry. Please see the flowchart for an overview of the actions required.

As the overall purpose of an enquiry is to protect an adult at risk from experiencing harm, it may be, after considering the circumstances of their death, that a different process or type of enquiry would need to be undertaken.

In accordance with local policies and procedures consideration should be given to:

- Notifying the police as a matter of priority if:
  - The death of the adult is suspected to have been potentially attributed to abuse or neglect; and/or
  - There is reason to suspect that a crime is likely to be committed i.e., other people are at risk.
  - Securing documentation.
  - Raising a concern(s) for others at risk if the circumstances of the death mean that there are reasons to be concerned about risks to other adults or children. Enquiries may need to be made to decide whether action needs to be taken to protect them.
- Partnership discussion/safeguarding meeting to consider issues and agree a plan as to how an enquiry should proceed.
- Adult Social Care should chair/lead this meeting as the lead agency for adult safeguarding.
- Single agency/organisation investigation (the relevant agency/organisation e.g. the local authority, hospital, mental health trust, community health, London Fire Brigade, commissioning/quality assurance or care provider etc. Not an exhaustive list).
- Where the action being taken will be recorded if either an adult safeguarding concern has been received, and the adult is deceased, or the adult's death occurs during an adult safeguarding enquiry – who will be responsible for this.
- Who will liaise with/support the adult's family/friends etc and let them know the outcome/ action taken.
- Notification to CQC. If there are concerns about how a provider has cared for the adult prior to their death.
- Notification to the appropriate commissioning/contracting team if there are concerns about the quality of care delivered by the provider. This should be done in line with local processes and requirements.
- Notification to Ofsted. The Working Together to Safeguard Children 2023 statutory guidance requires that local authorities should notify Ofsted of the death of any care leaver under the age of 25, where it is aware of their care leaver status. This is regardless of the circumstances of their death.
- Notification to the Coroner and Medical Examiner (see above).
- Safeguarding Adults Review. If the criteria for a Section 44 SAR is met, a referral must be made. A referral should also be made where the Section 44 mandatory criteria is not met, but the discretionary criteria may have been reached. See section 2.7.

Flowchart: Safeguarding Concerns When the Adult is Deceased



Also see: [Concerns related to an adult who is deceased]

Part Three Practice Guidance

This section sets out the essential work that must be considered throughout adult safeguarding processes. In every case there must be evidence of due diligence and attention to mental capacity and consent regarding the person at the centre of the process.

3.1 Working Across the Life Course: Children, Young People and Adult Services
When undertaking safeguarding adult processes, we should all adopt a **"Think Family"** approach, i.e. who else may be at risk? What is the impact on others? We should also adopt a trauma informed approach. Children and young people (young carers) may be at greater risk of harm or need additional help in families where the adults have mental health problems, misuse substances or have alcohol dependencies, or are in a violent relationship, have complex needs or live with a learning disability. For further information see: Working together to safeguard children - GOV.UK Lewisham Safeguarding Adults Board - Think Family

Abuse within families reflects a diverse range of relationships and power dynamics, which may affect the causes and impact of abuse. These can challenge professionals to work across multi-disciplinary boundaries to protect all those at risk. In particular staff may be assisted by using domestic abuse risk management tools such as the Dash risk assessment resources for professionals - SafeLives. Staff providing services to adults, children and families should have appropriate training whereby they are able to identify abuse in relations to children and adults at risk.

In all adult safeguarding work, staff working with the person at risk should establish whether there are children in the family, and whether checks should be made on children and young people who are part of the same household. This should be irrespective of whether they are dependent on care either from the adult at risk, or the person alleged to have caused harm.

Transitional Safeguarding - Moving to Adulthood:
Transitional Safeguarding means *"safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives".*
Transitional safeguarding - adolescence to adulthood: Strategic Briefing
Research in Practice (Holmes & Smale, 2018).

It is a concept for whole-system change, underpinned by six key principles (Holmes, 2018 Transitional Safeguarding) in order to support and safeguard young people at risk of or experiencing abuse in transition to adulthood. Transitional Safeguarding refers to activity that has often fallen outside of the traditional notions of both transitions and safeguarding, where these have sometimes been interpreted through a lens of eligibility, rather than in the wider sense of human experiences and needs. See: Contextual Safeguarding and Child Protection (Carlene Firmin 2020).

The Care Act Guidance (Paragraph 16.75) says that: ***"****where someone is over 18 but still receiving children's services and a safeguarding issue is raised the matter should be dealt with as a matter of course by the adult safeguarding team. Where appropriate, they should involve the local authority's children's safeguarding colleagues as well as any relevant partners (for example, police or NHS) or other persons relevant to the case. The same approach should apply for complaints or appeals, as well as where someone is moving to a different local authority area after receiving a transition assessment but before moving to adult care and support".*

Usually, a young person's Educational Health Care Plan (EHCP) will continue until the academic year after their 19th birthday, but young people continue to have rights to additional support until they are twenty-five. For those who continue in further education, the ECHP support should continue until they are 25.

Chapter 16 of the statutory guidance outlines responsibilities to assess and support young people in transition to adulthood, including safeguarding risks. See:
- Care and support statutory guidance - GOV.UK
- Bridging the Gap: transitional safeguarding and the role of social work with adults – Knowledge Briefing.

There are also several other examples of evidence-based policy and practice resources:
- Transition from children's to adults' services for young people using health or social care services
- Adolescent Safeguarding Handbook – LIIA

There are regional policies and procedures for children and families' services that apply to young people and should be referred to when relevant, e.g. London Safeguarding Children Procedures and Practice Guidance: London Safeguarding Children Procedures and London Adolescent Safeguarding Handbook: Adolescent Safeguarding Handbook – LIIA

The Mental Capacity Act 2005 and its principles, which complement the Making Safeguarding Personal principles, come into effect as soon as a young person is 16, and is relevant when considering safeguarding risks for young people.

Children and Young People who Abuse:
If a child or children pose a risk of abuse or neglect to an adult who meets the s42 Care Act criteria, action should be taken under safeguarding adult procedures, and a referral and close liaison with children's services should take place. The developmental age of a child may impact on the process and needs to be child centred. This is especially of importance for people at an earlier age, 14 years which aligns with SEND cohort, this should be done in partnership with organisations, the child and family to ensure a seamless transition.

Physical and sexual abuse towards parents and other relatives (for example, grandparents, aunts, uncles) some of whom, may be adults with care and support needs can be carried out by adults and by young people and children, some of which can cause serious harm or death. The National Elder Abuse Prevalence Study Final Report – Compass on elder abuse identified younger adults (rather than the person's partner) as the main perpetrators of financial abuse.

Transitional arrangements are also key to ensuring that when Young Carers reach adulthood, they continue to be offered support and preventative, proactive approaches to safeguarding.
Some SABs and CPS have joint policies on intergenerational or family domestic abuse.
See: Hackney Intergenerational Domestic Abuse Protocol

3.2 Carers

Young Carers:
Section 1 (3) of the Care Act Guidance states that in exercising its Part 1 functions the local authority must have regard to several factors including (f) the importance of achieving a balance between the individual's well-being and that of any friends or relatives who are involved in caring for the individual.

Sections 63-65 covers transition arrangement that includes assessment and support to child carers. Alongside sections 96 and 97 of the Children and Families Act 2014, they offer a joined up legal framework to identify young carers and parent carers and their support needs. Both Acts have a strong emphasis on outcomes and wellbeing. Within any s42 enquiry, careful consideration should be given to young people taking on caring responsibilities to ensure the expectations under the 2014 Acts are met to avoid unintentional harm to the young person or the person cared for. See: Merton SAB: Lorel's Story

Adult Carers:
Unpaid carers are often under considerable pressure and there may be a background of complex dynamics. They may unintentionally or intentionally harm or neglect the adult they support on their own or with others. For example, if they have unmet or unrecognised needs of their own; have unwillingly had to change their lifestyle including no personal time of their own; are not receiving practical or emotional support; have other caring or work responsibilities or are being abused by the cared for person.

Unpaid carers are not regulated or inspected against the quality-of-care standards, so it is often challenging to know how to monitor their ability to meet specific care needs, or when and how to intervene. It is crucial that all unpaid carers are offered a Carer's Assessment, and that as part of any care or treatment plan, the relevant clinician, prescriber, occupational therapist or social care professional ensures carers have sufficient information to understand their caring responsibilities and can deliver these safely (carers can refuse a carers assessment).

See: Care Act 2014 Section 11.

The key question is whether the person cared for is at risk of abuse or neglect, and if they are, safeguarding duties under Section 42 of the Care Act should always be considered.

In some cases, the person being cared for can be abusing the person caring for them, due to their condition or an ongoing part of their relationship. It is important to develop an approach that considers the needs of both the person being cared for, and the unpaid carer. Any response should be proportionate and include honest conversations about the consequences of any abuse by the cared for or the unpaid carer.

It is important that unpaid carers are encouraged to have a contingency plan that can be put into place if they are unable to continue in their caring role for whatever the reason, for example having to go into hospital in an emergency. Safety plans may also be required, setting out what practical arrangements can be made in advance if the unpaid carer feels at risk from the person they are caring for. Further guidance is available through work developed by ADASS/LGA Carers and safeguarding: a briefing for people who work with carers | Local Government Association

3.3 Consent in Relation to Adult Safeguarding
Local authorities do not require a person's consent to undertake the enquiry, but must take steps to facilitate the person's involvement at the beginning of the enquiry and throughout the adult safeguarding process (Care Act Guidance, Paragraph 14.80).
Making Safeguarding Personal is a person-centred approach which means that adults are encouraged to make their own decisions and are provided with support and information to empower them to do so. This approach recognises that adults have a general right to independence, choice and self-determination including control over information about themselves. Staff should strive to deliver effective adult safeguarding consistently with the

above. They should ensure that the adult has accessible information so that the adult can make informed choices about safeguarding: what it means, risks and benefits, and possible consequences. Staff will need to clearly define the various options to help support them to decide about their safety.

Considering different ways to communicate and support the person with understanding the options, and making decisions, will need to be considered throughout all stages of the enquiry.

Adults may not give their consent to the sharing of safeguarding information for several reasons.

For example, they may be unduly influenced, coerced or intimidated by another person, they may be frightened of reprisals, they may fear losing control, they may not trust social services or other partners, or they may fear that their relationship with the abuser will be damaged.

Reassurance and appropriate support may help to change their view on whether it is best to share information. Staff should consider the following and:

- Explore the reasons for the adult's objections - what are they worried about?
- Explain the concern and why you think it is important to share the information.
- Tell the adult with whom you may be sharing the information with and why.
- Explain the benefits, to them or others, of sharing information - could they access better help and support?
- Discuss the consequences of not sharing the information - could someone come to harm?
- Reassure them that the information will not be shared with anyone who does not need to know.
- Reassure them that they are not alone, and that support is available to them.

Mental Capacity and Consent:
The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with this Act.

Learning from Safeguarding Adults Reviews continues to show that those working with adults who lack mental capacity are not fully complying with principle 5 - that before a decision is made, regard must be given to whether the purpose for which it is needed can be effectively achieved in a way that is the least restrictive option in relation to the person's rights and freedoms. This includes:

- Making decisions about their care and support needs.
- Planned interventions and decisions about their safety.
- Their safeguarding plan and how risks are to be managed to prevent future harm.

If an adult is subject to coercion or undue influence by another person, this may impair their judgement and could impact on their ability to make decisions about their safety.

Workers must satisfy themselves that the adult has the mental ability to make the decision themselves, if not, it is best to be cautious, identify the risks and consider support or services that will mitigate the risk. Preventing isolation can be a protective factor. Involving an advocate could assist in such circumstances. Section 68 of the Care Act 2014 requires that a local authority, where appropriate must arrange for an advocate to represent and support an adult who is the subject of an adult safeguarding enquiry where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate individual to help them. (Also see page 26).

3.4 Advocacy and Support

Advocacy:
An Advocate is someone who can help a person to be involved in conversations and decisions.

They will not be deemed appropriate if they are already involved and paid to support that person (e.g. Social Worker; Community Nurse, GP) or the person doesn't want them to be involved, or their circumstances would mean that it would be problematic for them to be involved (e.g. due to distance, capacity).

Section 68 of the Care Act 2014 places: *"a duty on Local Authorities to arrange that an independent advocate to be available to represent and support an adult who is the subject of an adult safeguarding enquiry or a safeguarding adults review where appropriate, if that local authority considers that the adult would experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes, or feelings".*

The condition for the appointment of an independent advocate is that the local authority considers that there is no appropriate person to represent and support the adult and where an advocate is not available, the person would experience 'substantial difficulty' in being involved in the process. The purpose of the appointment of an independent advocate is to facilitate the adult's involvement in a relevant process, enquiry or review.

Advocacy support can be invaluable and may be provided by an Independent Mental Capacity Advocate (IMCA) or another appropriate advocate.

If a Lasting Power of Attorney - Health and Welfare (or Enduring Power of Attorney) has been made and registered, or a deputy - Health and Welfare has been appointed under a court order, the attorney or deputy may be the appropriate person.

There are distinct differences between an IMCA introduced under the Mental Capacity Act and an Independent Advocate introduced under the Care Act 2014. Independent advocates cannot undertake advocacy services under the Mental Capacity Act 2005, however where there is an appointed IMCA they may also take on the role of Independent Advocate under the Care Act 2014. Where the adult does not want support from family or friends an independent advocate should be provided.

Local authorities need to monitor how advocates are involved in supporting people experiencing safeguarding concerns, and SABs should be assured that local authorities have auditing processes in place to monitor how people and their advocates are included in safeguarding processes.
Other types of advocates include:

- **Community Advocates**, or General Advocates which can include advocates for specific situations.
- **Peer Advocates** who have 'lived experience'.

- **Citizen Advocates** is a partnership between the advocate and the person involved and can support people for a much longer time than other advocates. See:
- Briefing Note: Independent Advocacy under the Care Act 2014 - Care and support providers
- Overview | Advocacy services for adults with health and social care needs | Guidance | NICE

Support to Adults:
A requirement under the Equality Act 2010 is for the provision and adjustments to people living with disabilities, so people have equal access to information and advice. This applies to all 9 protected characteristics under the Equality Act 2010. Ensuring equality may reduce or remove substantial difficulty. Access to other services, for example translators, should always be considered to ensure that the adults are afforded every opportunity to participate and be involved.

Support for Vulnerable Witnesses in the Criminal Justice Process:
The London Mayors Office of the Police and Crime Commissioner (MOPAC) data and research demonstrate there are negative experiences for victims and witnesses with additional needs, which reduces our collective ability to hold perpetrators to account through the criminal justice system. Duties to adjust and put in place special measures for vulnerable witnesses, including for children, adults with mental illness, cognitive impairments or those living with learning disabilities, should be actively considered as part of a protection plan to ensure the adult at risk's evidence is not discounted.

It is crucial that reasonable adjustments are made, and appropriate support given, so people can get equal access to justice.

Guidance should include reference to support relating to criminal justice matters which is available locally from such organisations as Victim Support and court preparation schemes:
- The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK
- Home - Victims Commissioner

3.5 Managing Risk

Involving the Adult:
Making Safeguarding Personal (MSP) stresses the importance of keeping the adult at the centre of positive approaches to managing risks to their safety. Under MSP the adult is best placed to identify risks, provide details of its impact and whether they find the mitigation acceptable. See: Making Safeguarding Personal | Local Government Association

Working with the adult to lead and manage the level of risk that they identify as acceptable creates a culture where:
- Adults feel more in control.
- Adults are empowered and have ownership of the risk.
- There is improved effectiveness and resilience in dealing with a situation.
- There are better relationships with professionals.
- Good information sharing to manage risk, involving all the key stakeholders
  See: Adult safeguarding: sharing information - SCIE
- Key elements of the person's quality of life and wellbeing can be safeguarded.

Identifying Risk:
Not every situation or activity will entail a risk that needs to be assessed or managed. The risk may be minimal and no greater for the adult, than it would be for any other person.

- Risks can be real or potential.
- Risks can be positive or negative.
- Assessments should consider all aspects of an individual's wellbeing and personal circumstances.

Sources of risk might fall into one of the categories below:

- Private and family life: The source of risk might be someone like an intimate partner or a family member.
- Community based risks: This includes issues like 'mate crime', anti-social behaviour, and gang-related issues.
- Risks associated with service provision: This might be concerns about poor care which could be neglect or organisational abuse, or where a person in a position of trust because of the job they do financially or sexually exploits someone.
- Self-neglect: Where the source of risk is the person themselves.
- Location of risk.

Risk Assessment:
Risk assessment involves collecting and sharing information through observation, communication and investigation. It is an on-going process that involves persistence and skill to assemble and manage relevant information in ways that are meaningful to all concerned. Risk assessment that includes the assessment of risks of abuse, neglect and exploitation of people should be integral in all assessment and planning processes, including assessments for self-directed support and the setting up of personal budget arrangements. Assessment of risk is dynamic and on-going and a flexible approach to changing circumstances is needed. The primary aim of a safeguarding adult's risk assessments is to assess current risks that people face and potential risks that they and other adults may face. Specific to adult safeguarding, risk assessments should encompass:

- The views and wishes of the adult.
- The person's ability to protect themselves.
- Factors that contribute to the risk, for example, personal and environmental.
- The risk of future harm from the same source.
- Identification of the person causing the harm and establishing if the person causing the harm is also someone who needs care and support.
- Deciding if domestic abuse is indicated and the need for a referral to a MARAC.
- Deciding if a community multi-agency risk assessment (high risk panel) is needed.
- People in Positions of Trust and other policies identify people causing harm who should be referred to MAPPA.
- The increased risks if information is not shared.
- Risk to others.

See: DASH Risk Checklist

Risk Management:
Information sharing should not be a hindrance or a barrier to report a safeguarding concern.

The focus must be on the management of risks not just a description of risks. Employers need to take responsibility for the management of risk within their own organisation and share information responsibly where others may be at risk from the same source. All agencies and

organisations involved need to have their own policies and procedures and the ability to set up multi agency meetings.

The local authority may be ultimately accountable for the quality of section 42 enquiries, but all organisations are responsible for supporting holistic risk management, with the adult and in partnership with other agencies.

It is the collective responsibility of all organisations to share relevant information, make decisions and plan intervention with the adult. A plan to manage the identified risk and put in place measures includes:

- What immediate action must be taken to safeguard the adult and/others.
- Who else needs to contribute and support decisions and actions.
- What the adult sees as proportionate and acceptable.
- What options there are to address risks.
- When action needs to be taken and by whom.
- What the strengths, resilience and resources of the adult are.
- What needs to be put in place to meet the on-going support needs of the adult.
- What the contingency arrangements are.
- How will the plan be monitored?
- What escalation processes will be used if risk isn't reduced or removed.

Positive risk management needs to be underpinned by widely shared and updated contingency planning for any anticipated adverse eventualities. This includes warning signs that indicate risks are increasing and the point at which they become unacceptable and therefore trigger a review.

Effective risk management requires exploration with the adult using a person-centred approach, asking the right questions to build up a full picture. Not all risks will be immediately apparent; therefore, risk assessments need to be regularly updated as part of the adult safeguarding process and possibly beyond.

Reviewing Risk:
Individual need will determine how frequently risk assessments are reviewed and wherever possible there should be multi-agency input. These should always be in consultation with the adult at risk. Within s42 enquiry process, ultimately this will be a decision for the enquiry officer, but any professional disagreement should be resolved through local SAB dispute or escalation processes.

Risk Disputes:
Risk assessment and risk management is carried out in partnership with the adult, wider support network and others. The decision to involve others or not is a decision which may give rise to risk, and the individual may need support to make this decision.

The professional views of risk may differ from the views of the adult. Perceived risks have implications for the safety and the independence of the individual, but they also have implications for the accountability of professionals. This highlights the importance of training and/or regular practice in making independent decisions by adults. Accessible knowledge through information and advice, assertiveness through the right kind of advocacy and support may be appropriate.

Professionals need to embrace and support positive risk taking by finding out why the person wishes to make a particular choice, what this will bring to their life, and how their life may be adversely affected if they are not supported in their choice.

The promotion of choice and control, of more creative and positive risk-taking, implies greater responsibility on the part of the adult and greater emphasis on keeping them at the centre of decision making.

It may not be possible to reach agreement, but professionals need to evidence that all attempts to reach agreement were taken. Where there are concerns about people making unwise decisions, or there is high risk that requires wider collaboration; Community Multi-Agency Risk Panels, sometimes referred to as High-Risk Panels or Risk Enablement Panels, are models used to support the adult safeguarding process. This emphasises shared responsibilities, including the adult and any advocate. If there is a dispute, local escalation processes should be followed.

Legal advice should be sought if the adult has mental capacity in relation to the safeguarding concern, and there is concern the adult is being coerced or unduly influenced into making decisions. In specific circumstances an application can be made the High Court for Inherent Jurisdiction – an order or declaration to protect the adult. See:
- Mental Capacity Guidance Note - Inherent Jurisdiction | 39 Essex Chambers
- Bexley-7-minute-Briefing Inherent Jurisdiction

Consider the Mental Capacity Act 2005 in all instances.

3.6 Recording Actions and Decisions in Adult Safeguarding Work

A record of all actions and decisions must be made as record keeping is a vital component of professional practice and is an essential element in documenting the legal justification for decisions. When abuse or neglect is raised, managers need to look for past incidents, concerns, risks and patterns. In many situations, abuse and neglect arises from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action. At a minimum there should be an audit trail of:

- Date and circumstances of concerns and subsequent action.
- Decision making processes and rationales.
- Risk assessments and risk management plans.
- Consultations and correspondence with key people.
- Advocacy and support arrangements.
- Adult safeguarding plans.
- Outcomes.
- Feedback from the adult and their personal support network.
- Differences of professional opinion.
- Referrals to professional bodies.

As records may be disclosed in courts in relation to criminal or civil actions, and to individuals under data protection legislation, all organisations should audit adult safeguarding related records and outcomes as part of their quality assurance processes. Supervisors should ensure that record keeping is addressed during supervision and that staff are clear about their responsibilities. SABs should regularly review the quality of recording as part of their scrutiny arrangements.

Learning lessons from practice shortfalls highlighted in Safeguarding Adults Reviews, Child Safeguarding Practice Reviews, single agency reviews and other reports emphasise the need for quality recording, and especially when managing abuse, neglect and risk. This includes providing a rationale (working's out) for actions and decisions, including not to take any action.

Quality recording of adult safeguarding work not only safeguards adults but also protects workers by evidencing decision making based on the information available at the time.

3.7 Use of Digital Tools

SAB partners are at different stages in their digital transformation journeys. As digital tools become more integrated into adult social care, the NHS etc, their use in formal settings such as Safeguarding Adults Board (SAB) meetings and other safeguarding-related discussions is increasing. Tools like digital transcription and summarisation platforms (e.g., Magic Notes, Otter.AI, Co-pilot, Teams premium etc) can support efficiency by capturing and condensing large volumes of information, freeing up time for frontline professionals, and positively changing the interactions for the person with lived experience.

The use of digital tools in safeguarding contexts requires careful, separate consideration due to the sensitive nature of the discussions and the vulnerability of the individuals involved. This holds true no matter what tool is being used. We have outlined principles for SAB partners to consider when implementing digital tools in an ASC context.

To ensure ethical and responsible use, organisations should consider the following:

Transparency and Inclusion:

- Clearly inform all meeting participants, including people with care and support needs, when digital tools are being used.
- Ensure communication is accessible and inclusive, using formats such as Easy Read or translated materials where needed.
- Involve people with lived experience in shaping how digital tools are introduced and explained.
- If the activity involves participants from partner organisations, ensure they contribute to the development and implementation of the digital tool in each use case. SAB partners as sovereign organisations may wish to utilise the expertise in their existing structures e.g. Performance and Quality Groups.

Data Security and Information Governance:

- Align with existing data protection legislation (e.g., U.K. GDPR) and local information governance frameworks.
- Establish clear protocols for how data is captured, stored, shared, and deleted.
- Ensure robust access controls and audit trails are in place.
- These should be included and documented in project plans or specific Data Protection Impact Assessments (DPIAs).

Human Oversight and Accountability:

- Safeguarding meetings often involve complex, nuanced issues - professional judgment remains essential.
- Digital outputs (e.g., meeting summaries) must be reviewed by a human to ensure they accurately reflect the discussion.
- There should be a clear process for correcting inaccuracies or omissions in digital records. See:

- Oxford Statement on the responsible use of generative AI in Adult Social Care | Ethics in AI
- Principles and priorities for the responsible use of Generative AI in care and support - TLAP
- Research, guidance and templates - Socitm
- AI-in-Social-Care-White-Paper-April-2025-Institute-for-Ethics-in-AI
- BASW Statement on Social Work and Generative Artificial Intelligence | BASW
- Generative AI & Social Work Practice Guidance | BASW

3.8 Organisational Learning
It is essential that all aspects of adult safeguarding practice are monitored and scrutinised on a regular basis. All staff have a responsibility to audit their work, and establish a set of local outcome focused standards, to help support staff.

In local authorities, Principal Social Workers have the lead for professional development, learning from best practice including disseminating learning from SARs.

Each NHS region operates a bespoke safeguarding assurance function and structure, and ICBs and Safeguarding Leads within NHSE will ensure that learning is shared across all NHS organisations.

All agencies however need to take responsibility for organisational learning and implement changes to their practice because of audits, complaints, SARs, and most importantly feedback from adults at risk. Organisations need to understand what works well and what needs to improve to provide opportunities for learning based on the themes and patterns of practice.

SABs should receive regular quality assurance reports from partners and coordinate any joint learning.

3.9 Missing Adults
in the most recently available data, the Metropolitan Police reported over 12,000 missing adults in a year in London.

There is a connection between the subject of missing adults and safeguarding as many of those who go missing may meet the duty for adult safeguarding under the Care Act 2014:
- 3:4 adults experience some form of harm whilst missing.
- 40% of returned missing adults disclosed trying to take their own life. This is the most common reason for death for missing adults.
- 40% of people living with dementia go missing at some point, and 1:10 of current missing cases involves dementia.
- 80% of adults are experiencing diagnosed/ undiagnosed mental illness whilst missing.

All SABs are encouraged to have multi-agency procedures for missing adults. See:
- APPG: Inquiry into Support for Missing Adults - Missing People
- Home - Missing People
- Herbert Protocol | MedicAlert (national scheme and support)
- Report a Missing Person | Metropolitan Police

Part Four Procedures

4.1 Context

The main objective of adult safeguarding procedures is to provide guidance to mitigate against the risks to adults from abuse or neglect, ensuring that any outcomes from any enquiry are focused on the adult, are achievable, and identify immediate action to be taken where required.

Guidance is often criticised for over-standardising practice and undervaluing the skills required when applying policies in diverse circumstances. The procedures are a means for staff to combine principles of protection and prevention with an individuals' right to self-determination.

Our approach should be in accordance with the six adult safeguarding principles and Making Safeguarding Personal, ensuring the outcomes and goals are led by the adult whilst being realistic and attainable.

They are a framework for managing adult safeguarding interventions through strong multi-agency partnerships that provide timely and effective prevention of, and responses to, abuse and neglect. All organisations who work with or support adults experiencing, or who are at risk of abuse and neglect, may be called upon to lead or contribute to a safeguarding adult concern and need to be prepared to take on this responsibility.

4.2 Responsibilities

Safeguarding adult referral points:
Each organisation must have its own operational policy on how it manages adult safeguarding concerns, including a list of referral points with up-to-date contact details, so that staff and the public know how to report abuse and neglect. Referral points may be through a contact centre, specific access team or through a Multi-Agency Safeguarding Hub (MASH) or other locally agreed arrangements. The local authority is the main referral point even if others have their own, and all local authorities should provide referral points that are accessible outside of normal working hours to enable them to respond to urgent concerns.

Safeguarding leads in all organisations:
Safeguarding leads provide advice, guidance and leadership to staff and refer to members of staff responsible in their organisation to provide:

- Managerial support and direction to staff in that organisation.
- Decision making for concerns raised by members of staff and/or members of the public.

Safeguarding Adults Manager (SAM):
A Safeguarding Adults Manager is the local authority member of staff who manages, makes decisions, provides guidance and has oversight of adult safeguarding concerns that are referred to the local authority, or through the mental health trust where those agreements are in place.

Enquiry Officer:
An Enquiry Officer is responsible for undertaking actions under statutory adult safeguarding procedures. In some instances, there is a lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional skills, and expertise is required. The lead Enquiry Officer will retain responsibility for undertaking and co-ordinating actions under Section 42 Enquiries.

The role of Enquiry Officer is usually held by an individual in an adult social care frontline operations team, or in a mental health trust (section 75 arrangement – see below).

The following are examples of key roles that could be allocated or utilised in a supporting role to the lead Enquiry Officer:

- Housing Officers.
- Ward staff in an acute hospital, mental health hospital or private hospital.
- Care staff in care homes, supported living, extra care sheltered housing, day centres and domiciliary care providers.
- District Nurses.

Local authority and NHS partnerships:
Local authorities can continue to enter partnership arrangements for the NHS to carry out a local authority's 'health-related functions': the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000).

NHS bodies and local authorities can enter partnership arrangements made under s75 of the 2006 Act to enable at least one NHS statutory body (ICBs/NHS England or NHS trusts/foundation trusts) and LAs to collaborate across a range of the LA health-related functions and NHS health functions as prescribed within the regulations. The NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, as amended, is the relevant secondary legislation that sets out details of the permitted arrangements as follows:

- NHS bodies can carry out local authorities' health-related functions together with their NHS functions.
- Local authorities can carry out NHS functions together with their local authority health-related functions.
- NHS bodies and local authorities can establish and run a pooled fund which is made up of contributions by the partners, and out of which payments may be made towards carrying out the functions that are within the scope of the arrangement.
- Such arrangements can only be formed if it is likely to lead to an improvement in the way in which the functions are exercised.
- Any partnership arrangements entered under section 75 of the NHS Act 2006 do not affect the liability and accountability of NHS bodies or local authorities for the exercise of any of their functions (s.75(5)).

This effectively authorises NHS bodies to exercise those prescribed functions, including adult safeguarding functions. These arrangements are 'partnership arrangements' rather than 'delegations. In addition, by virtue of Regulation 4 of the 2000 Regulations, arrangements may only be entered into 'if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised'. The Local Authority would remain legally responsible for how its functions (including adult safeguarding) are carried out via partnership arrangements.' (Department of Health March 2015).

Within this policy and procedure, where there are partnership agreements under Section 75 of the NHS Act 2006, with mental health trusts, appropriately trained managers within the trust can act on behalf of the Local Authority to undertake adult safeguarding duties. Where this is done, the legal responsibility for adult safeguarding remains with the Local Authority. This is reference to who can act as a Safeguarding Adult Manager (SAM), which is a role particular to the local authority and its Section 75 partners under the above agreements and local protocols.

4.3 Cross-Authority and Inter-Authority Adult Safeguarding Enquiries

Risks may be increased by complicated cross-authority arrangements, and it may be dangerous and unproductive for organisations to delay action due to disagreements over responsibilities.

The rule for managing safeguarding adult enquiries is that the local authority for the area where the abuse occurred (host authority), has the responsibility to carry out the duties under Section 42 of the Care Act 2014, but there should be close liaison with the local authority where the person is 'ordinarily resident' (commissioning authority).

The 'commissioning authority' continues to hold responsibility for funding a placement. However, many people at risk live in residential settings outside the area of the commissioning authority.

In addition, an adult safeguarding incident might occur during a short-term health or social care stay, or on a trip, requiring police action in that area, or immediate steps to protect the person while they are in that area.

The initial lead in response to a safeguarding concern should always be taken by the local authority for the area where the incident occurred. This might include taking immediate action to ensure the safety of the person or arranging an early discussion with the police when a criminal offence is suspected.

Further action should then be taken in line with Making Safeguarding Personal toolkit on the views of the adult, and the Care and Support Statutory Guidance - GOV.UK about who is best placed to lead on an enquiry.

See: ADASS Out-of-Area Safeguarding Adults Arrangements Protocol - ADASS (October 2025).

4.4 Dispute Resolution and Escalation

Professional disagreements should be resolved at the earliest opportunity, ensuring that the safety and wellbeing of the adult at risk remains paramount. Challenges to decisions should be respectful and resolved through co-operation. Disagreements can arise in several areas and staff should always be prepared to review decisions and plans with an open mind. Assurance that the adult at risk is safe takes priority. Disagreements should be talked through and appropriate channels of communication established to avoid misinterpretation.

If operational staff are unable to resolve matters, more senior managers should be consulted.

Multi-agency network meetings should be a standard practice and a way to explore issues with a view to improving practice. In exceptional circumstances or where it is likely that partnership protocols are needed the SAB should be kept appraised of the issues and agree what type of evaluation will be undertaken.

In the case of care providers, unresolved disputes should be raised with the relevant managers leading on the concern and commissioners.

4.5 Decision Making on Closure and Feedback

At any stage of these procedures a decision could be made not to continue with them.

This can be for many reasons, but the SAM must have oversight of this decision making and the rationale for decisions should be clearly set out and recorded.

All adult safeguarding concerns referred to the local authority should be assessed to decide if the criteria for adult safeguarding are met. Keeping the person who raised the concern informed is an essential requirement under these procedures. Feedback provides assurance that action has been taken whether under adult safeguarding or not.

The following closure actions must be considered at any stage of the procedures:

1. **Outcomes are reviewed:** these have been discussed and confirmed with the adult and/or their representative.
2. **The adult and/or their representative is made aware that the Section 9 duty continues**: or they are provided with advice, information and signposting.
3. **Partner organisations and workers are made aware of this decision:** including the referrer.
4. **Learning is identified and is shared with all relevant stakeholders.**
5. **Decisions are recorded including the rationale.**

Also refer to section 4.11 after stages 2 and 3 of the procedures.

Organisations raising concerns may want to challenge or discuss closure decisions and need to be updated on what action has been taken. It is more likely that the public will continue to raise concerns, where there is an acknowledgement that their concern has reached the right agency and is being taken seriously. Feedback to the wider community needs to take account of confidentiality and requirements of data protection legislation.

Feedback to people alleged to have caused harm:
The principles of natural justice must be applied, consistently with the overriding aim of safety and the requirements of data protection legislation.

An evaluation should be carried out as to whether it is safe to share information about the complaint with the person allegedly responsible. If the adult at risk has capacity, their informed consent should be sought before sharing information with the person allegedly responsible.

However, where the sharing of information to prevent harm is necessary, lack of consent to information sharing can be overridden. It may be a necessary part of an adult safeguarding enquiry to put information to the person alleged to have caused harm, where it has not been possible to obtain consent to this. Providing information on the nature and outcomes of concerns to people alleged to have caused harm also needs to be seen in the wider context of prevention; for example, information can be used to support people to change or modify their behaviour. The person/organisation that is alleged to have caused harm should be provided with sufficient information to enable them to understand what it is that they are alleged to have done, or were at risk of doing, and to enable their view to be heard and considered.

Whilst the safety of the adult remains paramount the right of reply should be offered where it is safe to do so. Decision making should take into consideration:

- The possibility that the referral may be malicious.
- The right to challenge and natural justice.
- Whether there are underlying issues for example employment disputes.
- Family conflict.
- Relationship dynamics.
- Whether it is safe to disclose particularly where there is domestic abuse.
- Compliance with the Mental Capacity Act 2005.

Feedback should be provided in a way that will not exacerbate the situation or breach data protection legislation.

If the matter is subject to police involvement, the police should always be consulted so criminal investigations are not compromised. The Home - Local Government and Social Care Ombudsman and Welcome to the Parliamentary and Health Service Ombudsman | Parliamentary and Health Service Ombudsman (PHSO) are both useful sources to explore case examples.

The Information Commissioner's Office (ICO) provides advice on information sharing.

4.6 Target Timescales

These adult safeguarding procedures do not set out definitive timescales, as adult safeguarding responses should be led by the principles of Making Safeguarding Personal; however, target timescales are indicated below to support local decision making.

Individual local authorities or SABs may make decisions on timescales.

It is important however that timely action is taken, whilst respecting the principle that the views of the adult at risk are paramount. It is the responsibility of all agencies to proactively monitor concerns to ensure that drift does not prevent timely action and place people at further risk.

Divergence from any target timescales may be justified where:

- Adherence to the agreed timescales would jeopardise achieving the outcome that the adult at risk wants.
- It would not be in the best interests of the adult at risk.
- Significant changes in risk are identified that need to be addressed.
- Supported decision making may require an appropriate resource not immediately available.
- Persons' physical, mental and/or emotional wellbeing may be temporarily compromised.

The timescales need to reflect:

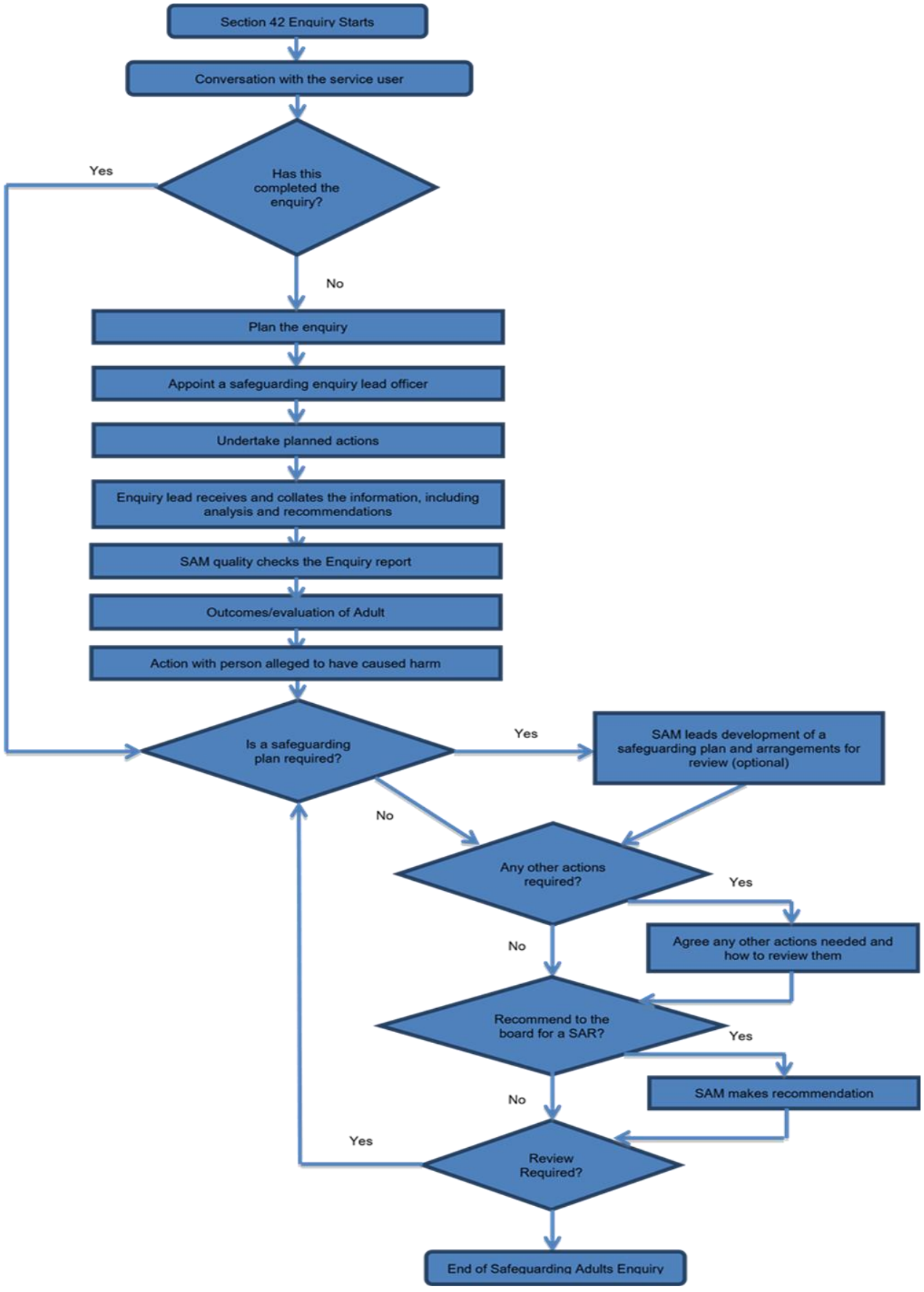
- All other investigations.
- The investigation that takes priority - this needs to be agreed on a case-by-case basis including where immediate action is needed.

4.7 The Adult Safeguarding Procedures

Stage	Description	Target Timescale
1. Concern - Pages 60-66	1. **Immediate Action:** by the person raising the concern in cases of emergency. Ensure the safety and wellbeing of the adult. 2. **Determine:** if all 3 of the s.42(1) criteria are met. Is there reasonable cause to suspect: a) The adult has needs for care and support; and b) The adult is experiencing or at risk of abuse and neglect; and c) As a result of those needs is unable to protect themselves from the abuse or neglect, or risk of it. 3. **Respond to Partner Organisations:** provide feedback (see section 4.5).	Same day
2. Enquiry - Risk Assessment pages 47-50 - Risk Management Plan pages 67-86	1. **Initial Conversation:** with the adult at risk or their representative to establish the facts and if any action is required. Ensure the safety and wellbeing of the adult. 2. **Plan the Enquiry:** assess the needs of the adult and actions to support and redress how these might be met. 3. **Complete the Enquiry:** and make decisions about further actions required. 4. **Respond to Partner Organisations:** provide feedback (see sections 4.5 and 4.11).	Same day linked to above 5 working days from above 20 working days from above 5 working days from above
3. Devising and Implementing the Safeguarding Plan - Ongoing monitoring (wherever required) is an essential part of safeguarding procedures pages 76-78	1. **Adult Safeguarding Plan:** decide how to ensure the future safety of the adult and how best to support the adult through any actions agreed. 2. **Follow up Actions:** who will be responsible for these; how these will be achieved; and by when linked to the risks. This should be agreed locally to reflect the level of risk and the individual circumstances. 3. **Respond to Partner Organisations:** provide feedback (see sections 4.5 and 4.11). 4. **Review of the Safeguarding Plan:** This is optional and should be decided locally based on the circumstances.	5 working days from enquiry report completion No more than 3 months from above Within 5 working days of conclusion To be decided locally

The procedures can be closed <u>at any</u> of the three stages if this is appropriate, but the necessary actions should be taken <u>whenever</u> they are closed or concluded: See <u>4.5 and 4.11</u>.

The Adult Safeguarding Procedures:



4.8 Stage 1 - Concern

What are care and support needs?
Statutory safeguarding concerns relate to adults with care and support needs, although an adult does not need to be already in receipt of care and support to meet the legal duty/ criteria under s.42(1) of the Care Act 2014.

Care and support needs refers to the various types of help adults need to manage their lives and to live as well as possible with any illness or disability they may have. The Care Act 2014 outlines the criteria for determining eligibility for care and support. This can be:

- An older person who is at a higher risk of some conditions that can lead to care and support needs developing.
- A person with a physical disability, a learning difficulty or a sensory impairment.
- Someone with mental health needs, including dementia or a personality disorder.
- A person with a long-term condition.
- Someone who has an addiction to a substance or alcohol to the extent that it affects their ability to manage day to day living

A concern may be raised by anyone, and can be:

- An active disclosure of abuse by the adult, where the adult tells a member of staff that they are experiencing abuse and/or neglect.
- A passive disclosure of abuse where someone has noticed signs of abuse or neglect, for example clinical staff who notice unexplained injuries.
- An allegation of abuse by a third party, for example a family/friend or neighbour who have observed abuse or neglect or have been told of it by the adult.
- A complaint or concern raised by an adult or a third party who doesn't perceive that it is abuse or neglect. Complaint officers should consider whether there are adult safeguarding matters.
- A concern raised by staff or volunteers, others using the service, a carer or a member of the public.
- An observation of the behaviour of the adult at risk.
- An observation of the behaviour of another.
- Patterns of concerns or risks that emerge through reviews, audits and complaints or regulatory inspections or monitoring visits (CQC etc.).

Good practice guidance when someone discloses abuse or neglect:

Disclosure
• Speak in a private and safe place. • Accept what the person is saying. • Don’t ‘interview’ the person; but establish the basic facts avoiding asking the same questions more than once. • Ask them what they would like to happen and what they would like you to do. • Don’t promise the person that you’ll keep what they tell you confidential; explain who you will tell and why. • Explain that you will respect their wishes where possible, but that referrals and actions can be taken without their consent. Tell them what action you will be taking. • Make a best interest decision about the risks and protection needed if the person is unable to provide informed consent. • Document rationale for sharing information.

- Explain how the adult will be involved and kept informed.
- Provide information and advice on keeping safe and the adult safeguarding procedures.

Establish

- The risks and what immediate steps to take.
- Consider the hazard within the risks and use a risk screening tool.
- Communication needs, whether an interpreter or other support is needed.
- Whether it is likely that advocacy may be required.
- Personal care and support arrangements.
- Mental capacity to make decisions about whether the adult can protect themselves and understand the adult safeguarding procedures.

Decision making - pre-referral to the local authority:

The manager/adult safeguarding lead within an organisation will usually lead on decision making. Where such support is unavailable, consultation with other more senior staff should take place. If these are unavailable, seeking the advice of the local authority should be considered.

Staff should also act without the immediate authority of a line manager:

- If discussion with the manager would involve delay in an apparently high-risk situation.
- If the person has raised concerns with their manager and they have not taken appropriate action (whistleblowing).

Decisions need to consider all the relevant information available, including, in all circumstances, the views of the adult where it is possible and safe to seek their views. If the adult does not want to pursue matters, workers should be sure that the adult is fully aware of the consequences of their decisions, that all options have been explored and that not proceeding further is consistent with legal duties.

Decision makers also need to take account of whether there is a vital or public interest to refer the concern to the local authority. Where there is:

- A significant risk of harm to the adult; or
- A significant risk of harm to other adults, children or young people; or
- A wider public interest to act because a criminal offence has occurred, and the view is that it is a safeguarding matter.

The wishes of the individual may be overridden where the sharing of information to prevent significant harm is necessary, lack of consent to information sharing can also be overridden.

This should include where the adult at risk is deceased, or the alleged perpetrator is a professional.

If people lack the capacity to provide consent, action should be taken in line with the Mental Capacity Act 2005.

Immediate Action by the Person Raising the Concern

The person who raises the concern has a responsibility to first and foremost safeguard the adult at risk:

- Make an evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
- Arrange any medical treatment. (Note that offences of a sexual nature will require expert advice from the police).
- If a crime is in progress or life is at risk, dial emergency services - 999.
- Encourage and support the adult to report the matter to the police if a crime is suspected and not an emergency.
- Take steps to preserve any physical evidence if a crime may have been committed and preserve evidence through recording.
- Ensure that other people are not in danger.
- If you are a paid employee, inform your manager. Report the matter internally through your internal agency reporting procedures (e.g. NHS colleagues may still need to report under clinical governance or Patient Safety Incident Response Framework (PSIRF), report to HR department if an employee is the source of risk).
- Record the information received, risk evaluation and all actions.

The Safeguarding Adults Manager should review action taken and:

- Clarify that the adult at risk is safe, that their views have been clearly sought and recorded, and that they are aware what action will be taken.
- Address any gaps.
- Check that their informed consent has been sought and mental capacity considered if there any doubts they can provide this.
- If a person's wishes are being overridden, check that this is appropriate, and that the adult understands why.
- Contact children's services if a child or young person is also at risk.
- If the person alleged to have caused harm is also an adult at risk, arrange appropriate care and support.
- Make sure action is taken to safeguard other people.
- Take any action in line with disciplinary procedures; including whether it is appropriate to suspend staff or move them to alternative duties.
- If your service is registered with the Care Quality Commission, and the incident constitutes a notifiable event, complete and send a notification to CQC.
- In addition, if a criminal offence has occurred or may occur, contact the Police where the crime has / may occur.
- Preserve forensic evidence and consider a referral to specialist services for example the Havens.
- Make a referral under PREVENT if appropriate.
- Consider if the case should be put forward for a SAR. Record the information received and all actions and decisions.

Concerns checklist

- Safety of adult and others made.
- Initial conversation held with the adult.
- Emergency services contacted and recorded.
- Medical treatment sought.

- Informed consent sought.
- Mental Capacity considered if there are doubts that informed consent cannot be given.
- Best Interest Decisions made and recorded.
- Vital and public interest considered and recorded.
- Police report made.
- Evidence preserved.
- Referral to special agencies e.g. Haven.
- Referral to children's services if there are children and young people safeguarding matters.
- Action taken to remove/reduce risk where possible and recorded.
- Recorded clear rationales for decision making.
- Referral to local authority included relevant information.

Referral to the local authority:
Referrers should only consider the s42(1)(a) and (b) criteria as the basis for a decision to refer an adult safeguarding concern to a local authority. See: Understanding what constitutes a safeguarding concern and how to support effective outcomes [c is for the local authority to determine].

Communicating adult safeguarding concerns:
The inability to provide the following information should not preclude a referral being made:

- Demographic and contact details for the adult at risk, the person who raised the concern and for any other relevant individual, specifically carers and relevant family members and friends, and those holding powers of attorney.
- Basic facts, focussing on whether the person has care and support needs including communication and on-going health needs.
- Factual details of what the concern is about; what, when, who, where.
- Immediate risks and action taken to address risk.
- Preferred method of communication.
- If reported as a crime - details of which police station/officer, crime reference number etc.
- Whether the adult at risk has any cognitive impairment which may impede their ability to protect themselves.
- Any information on the person alleged to have caused harm.
- Wishes and views of the adult at risk, in particular informed consent.
- Advocacy involvement (includes family/friends).
- Information from other relevant organisations for example, the Care Quality Commission.
- Any recent history (if known) about previous concerns of a similar nature or concerns raised about the same person, or someone within the same household.

Usually, partners are expected to submit concerns via electronic/ online forms and members of the public can also use online forms, in person, by telephone, email or letter. They may also be raised through specific organisation processes for example London Ambulance Notifications and police CONNECT reports.

Some concerns may not sit under adult safeguarding processes but remain concerns that may require other action. All concerns should be responded to, and SABs should be satisfied that concerns are being addressed appropriately through their oversight of adult safeguarding practice.

It is the responsibility of local authorities to determine if the adult can protect themselves, not the referrer. Referrers should share any information they may have which will help in making this distinction.

Where the adult safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it will not only be necessary to immediately consider what steps are needed to protect the adult, but also how best to report as a possible crime. Early consultation with the police is vital to and will support any criminal investigation; the SAM should ensure that this happens.

Causing others to make enquiries:
Each local authority has the lead for co-ordinating all adult safeguarding enquiries but can cause enquiries to be made by another organisation. This is not the same as requesting that another organisation takes actions as part of an enquiry being carried out by the local authority.

Each circumstance will determine the right agency. For example, a worker who has built up a relationship with the person or where someone has specific professional skills.

The local authority must agree with the organisation/worker what the enquiry should involve, this should be given in writing and should include:

- The nature, scope and purpose of the enquiry.
- How the adult's outcomes will be identified.
- Assessment of presenting risks and how harm will be minimised.
- Communication with the adult or their representative.
- Timescales.
- Responsibility for monitoring, evaluating and reviewing the actions and outcomes.
- Further guidance that may be required.
- Care and support needs.

Appropriate action must be taken in line with SAB protocol for responding to concerns about a person in a position of trust.

Statutory duty to carry out an enquiry under Section 42(1) of the Care Act:
The local authority must make or arrange an enquiry under section 42 of the Care Act. "*The Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom."*

Where the circumstances do not trigger the Section 42 adult safeguarding duty, the local authority may choose to carry out other activity e.g. Care Act assessments, to promote the adult's wellbeing and to support preventative action.

An enquiry should establish whether and what action needs to be taken to prevent or stop abuse or neglect.

Local authorities should aim to provide swift and personalised adult safeguarding responses.

The adult's views are central to any action/decision and if they require support from advocate this must be arranged. All activity must be taken in accordance with the principles of Making Safeguarding Personal.

Local authorities should record the information received, the views and wishes ascertained, the decisions taken and the reasons for them and any advice and information given. There also needs to be a focus on multi-agency communication and consideration should be given on setting up a multi-agency planning group.

Concerns related to an adult who is deceased:
There is no specific reference in the Care Act Guidance on how to respond to an adult safeguarding concern when the adult is deceased. Under the Care Act there is a continued responsibility to ensure that concerns about the risk to others or the quality of services are addressed. The overarching duty to keep others safe remains and the key objectives are to ensure that risks to others are explored and managed, duty of candour is upheld, and other appropriate investigatory processes are completed as required.

It is crucial that there is consistent and compassionate communication with representatives of the adult who has died. It is also important that there is clarity about the process (identified and agreed with the partnership involved) and potential outcomes. Where there is concern about the action/inaction of an organisation or provider this must be explored to reduce the risk of reoccurrence and harm to others.

It is the purpose of this document to seek to standardise responses across London, so consideration needs to be given to the following:

- Notify the police if:
  - The death of an adult is suspected because of abuse and/or neglect; and/or
  - There is reason to believe that a crime has been committed i.e. others may be at risk.
- Raise concern(s) to others at risk:
  - If circumstances of the death mean, there are concerns about the risks to others.
  - In this case enquiries may need to be made (reporting a concern) and actions agreed e.g. where someone dies in an organisational setting where other people receive a service.
- Refer to the SAB for a s44 SAR (see SARs):
  - If the criteria are met.
  - If it is not met, but carrying out a SAR would be beneficial.
- Inform CQC:
  - If there are concerns about how the provider has cared for the person prior to their death.
  - CQC has powers to bring criminal prosecutions against care providers for failing to provide care and treatment safely.
- Inform the appropriate local authority or ICB commissioning/contract teams in line with local processes.
- Notify the Coroner:
  - Usually done by a doctor or the police.
  - The coroner will decide whether there should be a post-mortem and whether the police should be involved.
- Notify Ofsted:
  - Do this via the Child Safeguarding Incident Notification System.

See: ChildSafeGuardingPortal (you will need a DfE sign in account to access this system.

Working Together to Safeguard Children 2023 requires that local authorities should notify Ofsted of the death of any care leaver under the age of 25, where it is aware of their care leaver status. This is regardless of the circumstances of their death.

The concern is closed, and other investigatory frameworks are followed i.e. Other investigatory frameworks include:

- Coroner's Inquests and medical examiners process[2]
- Criminal investigations.
- NHS Patient Safety Incident Response Framework (PSIRF)
- Learning Disability Mortality Reviews (LeDeR)
- Child Safeguarding Practice Reviews See: Child Safeguarding Practice Review Panel - GOV.UK
- Domestic Abuse Related Death Reviews (DARDR)
- MAPPA Serious Case Reviews
- Mental Health Homicide Reviews or NHS Independent Investigation Reports
- Maternity Review processes.
- Suicide prevention planning: PHE_LA_Guidance_25_Nov.pdf
- Homelessness Mortality Reviews.

Whatever investigatory framework is used there should be a record of the outcome of the concern on the adult's record:

- A record the exploration of risk to others (prevention of future harm) and how this is being managed.
- Confirmation that the individual concerned, and the referrer has been informed.
- The learning has been shared and embedded in within each organisation.

Dealing with repeat allegations:

All concerns should be considered on their own merit and recorded individually. An adult who makes repeated allegations that have been considered and decided to be unfounded should be treated without prejudice. Where there are patterns of similar concerns being raised by the same adult within a short time, a risk assessment and risk management plan should be developed, and a local process agreed for responding to further concerns of the same nature from the same adult. All organisations are responsible for recording and noting where there are such situations and may be asked to contribute to a multi-agency response. Information sharing to assess and analyse data is essential to ensure that adults are safeguarded, and an appropriate response is made. Staff should also be mindful of public interest issues.

In considering how to respond to repeated concerns the following factors need to be considered:

- The safety of the adult who the concern is about.
- Mental capacity and ability of the individual's support networks to raise the concern, or to increase support to meet outcomes of adult safeguarding concerns.
- Wishes of the adult at risk and impact of the concern on them.
- Impact on important relationships.
- Level of risk.
- Any issues related to care and support being provided by paid or unpaid carers.

[2] More details of the medical examiner process are also available at: NHS England » The national medical examiner system

4.9 Stage 2 - Enquiry

Role of the local authority:
The local authority should decide very early on in the process who is the best person/organisation to lead on the enquiry. The local authority retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon.

If the local authority has caused someone else to make enquiries, it is able to challenge the organisation/individual making the enquiry if it considers that the process and/or outcome is unsatisfactory. In exceptional cases, the local authority may undertake an additional enquiry, for example, if the original fails to address significant issues. The local authority therefore retains oversight and should be able to seek assurance that those enquiries 'caused to be made' are satisfactory.

The information in some referrals may be sufficiently comprehensive that immediate risks are being managed, and that the criteria are met for a section 42 enquiry. In other cases, some additional information gathering may be needed to fully establish that the three steps are met.

Decisions need to consider all relevant information through a multi-agency planning group wherever possible, including the views of the adult taking into consideration mental capacity and consent.

The degree of involvement of the local authority will vary from case-to-case, but at a minimum must involve decision making about how the enquiry will be carried out, oversight of the enquiry, decision making at the conclusion of the enquiry about what actions are required, ensuring data collection is carried out, and quality assurance of the enquiry has been undertaken.

This decision on how the enquiry is progressed is made by the manager acting in the role of the SAM at the time.

Criminal investigations:
Although the local authority has the lead role in making enquiries or requesting others to do so, where criminal activity is suspected, early involvement of the police is essential. Police investigations should be coordinated with the local authority who may support other actions but should always be police led.

Ill treatment and wilful neglect:
The police will determine whether there should be criminal investigations of people in positions of trust where there is ill treatment and wilful neglect. There are several possible offences which may apply, including the specific offences mentioned below.

- Section 44 Mental Capacity Act 2005 makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.
- Section 127 Mental Health Act 1983 creates an offence in relation to staff employed in hospitals or mental health nursing homes where there is ill-treatment or wilful neglect.
- Sections 20 to 25 of the Criminal Justice Courts Act 2015 relate to offences by care workers and care providers.

Risk assessment and management related to organisations and care providers:
Where the adult safeguarding concern raised is about a person who works with adults with care and support needs, and there may be a risk of causing harm to other adults or children, early

consideration should be given to sharing information with the employer and other partner agencies.

It is the responsibility of the person with the information to share with employers and employers to act i.e. suspend the person until an enquiry has taken place; report to regulators where people are registered professionals (Nurses, Social Workers etc.).

The local authority and/or ICS may suspend placements with the provider and or may seek a voluntary undertaking not to admit self-funders until the conclusion of the safeguarding procedures.

Conversations with the adult - including appropriate support:
In most cases, unless it is unsafe to do so, each safeguarding enquiry will start with a conversation with the adult at risk. The SAM should ensure conversations have already taken place and are sufficient. The adult and/or their representative should not have to repeat their story. In many cases staff/organisations who already know the adult well maybe best placed to lead on the enquiry. They may be a housing support worker, a GP, or other health worker such as a community nurse or a social worker. While many enquiries will require significant input from a social care practitioner, there will be aspects that should and can be undertaken by other professionals.

Points to consider:
- The pace of conversations.
- Whether the presenting issue identifies the risk to the adult's safety, or whether there are additional risks to be considered.
- Wider understanding and assessment of the adult's overall wellbeing.

The adult should be aware at the end of the conversation what action will be taken and provided with contact details for key people.

Objectives:
- Ascertain the adult's views and wishes and preferred outcomes.
- Assess the needs of the adult in terms of their protection, support and redress, and how these might be met. See s9 and s11(2)(b) Care Act 2014.
- Protect the person from the abuse and neglect, in accordance with the wishes of the adult where possible.
- Enable the adult to achieve resolution where possible.
- Wider potential risk to other adults to be considered.

See: Paragraph 14.94 Care and Support Statutory Guidance

Staff need to handle enquiries in a sensitive and skilled way to ensure minimal distress to the adult, and where information is already known, people should not have to tell their story again, although this doesn't prevent clarification being sought where necessary. There is a skill involved in eliciting information and asking the right questions, to ascertain what the concern is, how it impacts on the adult at risk, what action they would find acceptable and the level of associated risk. Whilst it is essential to put the adult at risk at ease, and to build up a rapport, the objectives of an enquiry should inform the conversations.

Desired outcomes identified by the adult:
The desired outcome(s) by the adult at risk should be clarified and confirmed at the end of the conversation(s), to:

- Ensure that the outcome(s) are achievable.
- Manage any expectations that the adult at risk may have and.
- Give focus to the enquiry.

Staff should support adults at risk to think in terms of realistic outcomes but should not restrict or unduly influence the outcome that the adult would like. Outcomes should make a difference to risk, and at the same time satisfy the persons' desire for justice and enhance their wellbeing.

For example: "I want to be safer"; "I want this to stop"; "I want to be in control"; "I want an apology"; "I want justice"; "I want the other person to change what they are doing"; "I want to change what I am doing"; "I want to live somewhere else"; "I want new friends"; "I want to know this won't happen to anyone else"; "I don't want anything to change".

The adult's views, wishes, and desired outcomes may change throughout the course of the enquiry process. There should be an on-going dialogue and conversation with the adult to ensure their views and wishes are gained as the process continues, and enquiries re-planned should the adult change their views.

Initial action and decision making under Section 42		
Action	• Establish that the adult is safe. • Establish the need for advocacy. • Establish consent and capacity to make relevant decisions by understanding the management of risk, what an adult safeguarding enquiry is, how they might protect themselves. • Is the adult aware of the safeguarding concern and do they perceive it as a concern and want action/support. • Is there suspicion that a crime may have been committed and a report to the police needed. • Ensure that the adult at risk, or their representative, has been asked what outcomes they want. • Establish whether the desired outcomes can be reasonably and safely done? • Provide feedback to the person making the referral. • Record all actions and conversations.	Enquiry lead within the local authority or another if the local authority causes others to do so (also known as delegated enquiries)
Decisions	• Who is best placed to speak with the adult at risk. • Are there any reasons to delay speaking with the adult at risk. • What the adult safeguarding enquiry might consist of. • Whether to proceed without consent. • What follow-up action may be needed. • Whether actions so far have completed the enquiry. • Is there a need for s9 Care Act assessment, s27(1) review of a care and support plan, or 27(4) Care Act reassessment of care and support needs.	Decisions made by the SAM

Talking through an enquiry may result in resolving it, if not, the duties under Section 42 continue.

If the adult has capacity and expresses a clear and informed wish not to pursue the matter further, the local authority should consider whether it is appropriate to close the enquiry. It should consider whether it still has reasonable cause to suspect that the adult is at risk and whether further enquiries are necessary before deciding whether further action should be taken.

The adult's consent is not required to take further steps, but the local authority must bear in mind the importance of respecting the adult's own views.

This decision must be made by the SAM (including SAMs working under a s75 agreement) by checking with the adult and consulting with relevant partners and advocate.

Planning an enquiry under section 42 duties:
All enquiries need to be planned and co-ordinated and key people identified. No agency should undertake an enquiry prior to a planning discussion, unless it is necessary for the protection of the adult at risk or others.

In order to develop an Enquiry Plan the Enquiry Officer should be clear about the nature and details about the concern including details about the event(s) which caused a concern about a risk of abuse or neglect; what led to the event(s); what information is already available and what other information is required, including who will be seeking this information.

Dependent upon the complexity of an enquiry the SAM may wish to convene a multi-agency enquiry planning group.

Enquiries are proportionate to the situation. The circumstances of each individual case determine the scope and who leads it. Enquiries should be outcome focussed and best suit the circumstances to achieve the outcomes for the adult.

Section 6 and 7 of the Care Act 2014 sets out the statutory duty of co-operation. In most cases, there will be an expectation that enquiry will be made as requested. The statutory duty does not apply if co-operation would be incompatible with its own duties or would have an adverse effect on its own functions.

Local authorities and their relevant partners must respond to requests to cooperate under their public law duties to act reasonably.

If an organisation declines to undertake an enquiry or if the enquiry is not done, local escalation procedures should be followed. The key consideration of the safety and wellbeing of the adult must not be compromised during any discussions or escalation, and it is important to emphasise that the duty to cooperate is mutual.

Planning an enquiry needs to include steps to minimise confirmation bias and promote concerned curiosity. This might include:

- Stating clearly what the concern is. This should be more that a statement of a category of abuse or neglect. It can be useful to try to address the questions of who, what, where and when about the events that gave cause for concern about a risk of abuse or neglect.
- Consider what different reasons, or hypotheses, that may have led to these events that you might want to consider in this enquiry. A useful rule of thumb is to consider at least three hypotheses. For each hypothesis, consider what information you might need to know if that hypothesis were true. It can be helpful to consider what information would help you rule that hypothesis out.

- Consider what information you already have, what gaps there are between what you need and what you already have and decide on who needs to do what to fill those gaps.
- Consider whether the adult at risk can represent themselves in the enquiry or if they need someone to support and represent them, who will do this?
- Determining what outcomes, the adult at risk wants. Consider the adult's own strengths and support networks.

Communication and actions:
It will be helpful to agree the best way to keep the adult and relevant parties informed. Where an enquiry is complex and more than one person or organisation is involved, a planning meeting should be set up. Action, however, should not be 'on hold' until a meeting can be convened.

Good practice guide: Involving adults in safeguarding meetings
Effective involvement of adults and/or their representatives in adult safeguarding meetings requires professionals to be creative and to think in a person-centred way. • How should the adult be involved. • Where is the best place to hold the meeting. • How long should the meeting last. • Timing of the meeting. • Agenda. • Preparation with the adult. • Who should chair. • Agreement by all parties to equality.

Information sharing should be timely, co-operation between organisations to achieve outcomes essential and action co-ordinated keeping the safety of the adult as paramount. Information sharing should comply with all legislative requirements.

Where one agency is unable to progress matters further, for example a criminal investigation may be completed but not necessarily achieve desired outcomes (e.g. criminal conviction), the Local authority in consultation with the adult and others decide if and what further action is needed.

Support networks:
The strengths of the adult at risk should always be considered. Mapping out with the adult and identifying their strengths and that of their personal network may reduce risks sufficiently so that people feel safe without the need to take matters further.
Enquiries can range from non-complex single agency interventions to multi-agency complex enquiries. The key questions in choosing the right type of enquiry, is dependent on:

- What is the proportionate response to the concern?
- What outcome does the adult want?
- How can enquiries be assessed as successful in achieving outcomes?
- What prevention measures need to be in place?
- How can risk be reduced?

Identifying the primary source of risk may assist in deciding what the most appropriate and proportionate response to the individual enquiry might be. There are no hard and fast rules and

judgement will need to be made about what type of enquiry and actions are right for each situation.

Linking different types of enquiries or investigations and managing competing priorities:
There are several different types of enquiries. It is important to ensure that where there is more than one enquiry that information is dovetailed to avoid delays, interviewing staff more than once, making people repeat their story.

Other processes, including police investigations, can continue alongside the safeguarding adult's enquiry. Where there are HR processes to consider, it is important to ensure an open and transparent approach with staff, and that they are provided with the appropriate support, including trade union representation. The remit and authority of organisations need to be clear when considering how different types of investigations might support Section 42 enquiries.

Enquiry reports:
Once all actions have been completed a report should be written, using information from others about the enquiry, by the Enquiry Officer overseen by the SAM. In some more complex enquiries, there may be several actions taken by other staff that support the enquiry. Where there are contributions from other agencies/staff, these should be sent to the Enquiry Officer within agreed formats and timeframes, so that there is one comprehensive report that includes all sources of information.

Reports need to be factual, accurate and include professional judgement. Reports should be drafted and discussed with the adult with care and support needs or their representatives. Reports need to address general and specific personalised issues. They should cover:

- Views of the adult with care and support needs.
- Evidence of abuse or neglect – what were the underlying factors for undertaking a Section 42 enquiry.
- Whether outcomes were achieved.
- Whether any further action is required and if so by whom.
- Who supported the adult and if this is an on-going requirement.

In some enquiries, there will be an investigation for example, a disciplinary investigation, which may form part of the Enquiry Report. In drawing up the report, the risk assessment should be reviewed, and any adult safeguarding plan adjusted accordingly.

Monitoring actions - recommendations, including actions and responsibilities for individual organisations and workers should be included.

Standards and analysis:
The report should be tested to ensure that it meets the standards above, and analysed to assess whether there are gaps, contradictions and that information has been triangulated, i.e. is the report evidence based, and is there sufficient corroboration to draw conclusions.

The report and recommendations of the enquiry should be discussed with the adult at risk and or their advocate, who may have a view about whether it has been completed to a satisfactory standard.

Overall, the local authority should decide if the enquiry is completed to a satisfactory standard. In reaching this decision, the local authority may wish to consult partner organisations involved in the enquiry. If another organisation has led on the enquiry, the local authority may decide that

a further enquiry should be undertaken. The exception to this is where there is a criminal investigation, and, in this case, the local authority should consider if any other enquiry is needed that will not compromise action taken by the police.

Deciding on the findings of an enquiry:
All enquiries should aim to determine the effectiveness of interventions. Decisions should be made whether:

- The adult has needs for care and support.
- They were experiencing or at risk of abuse or neglect.
- They were unable to protect themselves.
- Further action should be taken to protect the adult from abuse or neglect.

These decisions are made by the SAM in consultation with the adult and other parties involved in the enquiry.

Views of the adult at risk or their representative:
It is important to understand how actions have impacted on the adult at risk and whether their desired outcome(s) were met.

1. Were the desired outcomes met? (In exploring this, there is a need to clarify whether they were):
   a. Fully met.
   b. Partially met.
   c. Not met.
2. Do they feel safer?
   a. Yes.
   b. Partially - in some areas but not others.
   c. No.

Outcome for the person(s) alleged to have caused harm:
To ensure the safety and wellbeing of other people, it may be necessary to act against the person/organisation alleged to have caused harm. Where this may involve a prosecution, the police and the Crown Prosecution Service will take the lead, sharing information within the statutory guidance.

The police may also consider action under the Common Law Police Disclosure (CLPD). The CLPD addresses risk of harm regardless of the employer or regulatory body and there are no lists of specific occupations. The CLPD focusses on:

- Disclosure where there is a public protection risk.
- Disclosures are subject to thresholds of ‘pressing social need’.
- The ‘pressing social need’ threshold for making a disclosure under common law powers is the same as that required for the disclosure of non-conviction information by the Disclosure and Barring Service under Part V of the Police Act 1997 (as amended).

If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service - GOV.UK (DBS).

The legal duty to refer to the DBS also applies where a person leaves their role before a disciplinary hearing has taken place following a safeguarding incident and the employer/volunteer organisation feels they would or might have dismissed the person based on the information they hold.

Where it is considered that a referral should be made to the DBS careful consideration should be given to the type of information needed. This is particularly pertinent for people in a position of trust. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council the Nursing and Midwifery Council and the Health & Care Professions Council. The legal duty to refer to the Disclosure and Barring Service may apply regardless of a referral to other bodies.

Even if the safeguarding concerns arising from a person in a position of trust have been satisfactorily resolved in an individual case, where there is an ongoing risk of that person in a position of trust causing harm to adults at risk or children consideration should be given to:

- Sharing information with the employer and other partner agencies.
- The local authority and/or ICS issuing an improvement notice under their contract with the provider requiring the concerns to be resolved and risks to be managed.
- Increasing the number of visits by quality control officers.
- The local authority and/or ICS suspending placements with the provider and seeking a voluntary undertaking not to admit self-funders until the concerns are resolved and risks managed.
- Care providers will be expected to work together with the local authority, ICS and other partner organisations to resolve concerns, manage risks and to make any necessary improvements.

Support for the person who was the source of the risk:
Where the person is also an adult who has care and support needs, organisations should consider what support, and actions may help them not to abuse others. For example, enquiries may indicate that abuse was caused because the adult's needs were not met and therefore a review of their needs should be made.

Where the person alleged to have caused harm is a carer, consideration should be given to whether they are themselves in need of care and support. In some circumstances the person may be able to access an IMCA.

Checks might be made whether staff were provided with the right training, supervision and support. Whilst this does not condone deliberate intentions of abuse, prevention strategies to reduce the risk of it occurring again to the adult or other people should be considered.

People who are known perpetrators of domestic abuse may benefit from the Domestic Violence/Abuse Prevention Programmes. Perpetrator Programme | DV-ACT Programmes
When considering action for people who abuse, prevention and action to safeguard adults should work in tandem.

Recovery, resilience and redress:
Paragraph 14.94 of the Care Act Guidance sets out the objectives of an enquiry into abuse or neglect and including ascertaining the adult's views and wishes...support and redress and how they might be met... adult to achieve resolution and recovery'.

Adults who have experienced abuse and neglect may need support to build up their resilience to move on from the incident. This support should enable people to use their own strengths and abilities to overcome what has happened, learn from the experience and develop an awareness that may prevent a reoccurrence. As a minimum it should enable people to recognise the signs and risks of abuse and neglect and know how to contact support if required.

Resilience is supported by recovery actions, which includes adults identifying actions that they would like to see to prevent the same situation arising. The process of resilience is evidenced by:

- The ability to make realistic plans and being capable of taking the steps necessary to follow through with them.
- A positive perception of the situation and confidence in the adult at risks own strengths and abilities.
- Increasing their communication and problem-solving skills.

Resilience processes that either promote wellbeing or protect against risk factors, benefits individuals and increases their capacity for recovery. This can be done through individual coping strategies assisted by:

- Strong personal networks and communities.
- Social policies that make resilience more likely to occur.
- Handovers/referrals to other services for example care management, or psychological services to assist building up resilience.
- Restorative practice.

If no further safeguarding action is required and there are alternative ways of supporting adults where they may be needed, then the adult safeguarding procedures can be closed.

Actions and decisions under Section 42 Enquiries		
Actions	• Plan the enquiry. • Identify the enquiry lead Identify links to other procedures in progress. • Identify actions that need to be taken at this stage to reduce the risk of abuse of neglect to the adult with care and support needs. • Undertake agreed actions to reduce the risk to the person with care and support needs. • Agree how communication to the adult with care and support needs or their representative; other organisations/workers. • Agree outcomes for person(s) alleged to have caused harm. • Make referrals as agreed in relation to the person alleged to have caused harm. • Make referrals in relation to the adult evaluation by the adult/advocate. • Explore recovery and resilience.	Adult with care and support need or their representative
Questions	• What type of enquiry is appropriate and proportionate. • Who should lead and who should contribute. • Does the report meet required standards.	SAM in consultation with the adult and others

	• Whether to close the enquiry down or take forward for review. • What are the actions for the adult. • What are the actions for the person alleged to have caused harm.	

4.10 Stage 3 - Devising and Implementing the Safeguarding Plan

On completion of an adult safeguarding enquiry, s42(2) Care Act 2014 requires the local authority to decide whether any actions should be taken and, if so, what they are, and who should take those actions. These actions form the basis of the Safeguarding Plan.

An adult Safeguarding Plan is not a care and support plan, and it will focus on care provision only in relation to the aspects that safeguard against abuse or neglect, or which offer a therapeutic or recovery-based resolution. In many cases the provision of care and support may be important in addressing the risk of abuse or neglect, but where this is the intention, the adult Safeguarding Plan must be specific as to how this intervention will achieve this outcome.

The Safeguarding Plan should set out:

- Steps to be taken to assure the future safety of the adult at risk.
- The provision of any support, treatment or therapy, including on-going advocacy.
- Any modifications needed in the way services are provided (e.g. same gender care or placement; appointment of an OPG deputy).
- How best to support the adult through any action they may want to take to seek justice or redress.
- What will be done to meet needs of the adult for protection, support and redress, in line with their wishes is any on-going risk management strategy appropriate?
- What will be done to protect them from the abuse and neglect, in accordance with their wishes.
- What follow-up action should be taken regarding the person or organisation responsible for the abuse or neglect.
- What will be done to enable the adult to achieve resolution and recovery.

The plan should outline the roles and responsibilities of all individuals and agencies involved and should identify the lead professional who will monitor and review the plan, and when this will happen. Plans should be person-centred, and outcome focused.

Safeguarding Plans should be made with the full participation of the adult and/or their representative.

In some circumstances it may be appropriate for Safeguarding Plans to be monitored through ongoing processes for one or more organisations. These will usually be “business as usual” processes for one or more of the organisations involved, such as ongoing care management, or provision of health or social care services, or support from a voluntary sector service.

Some actions might be for the adult and their family, friends or other support network to take forward. i.e. health or social care provisions; support from the voluntary sector; what the adult needs, their family, friends or support network will do.

See: Care Act Guidance Paragraph 14.94

Review of the enquiry (optional as necessary):
The identified SAM should monitor the plan on an on-going basis, within agreed timescales. The purpose of the review is to:

- Evaluate the effectiveness of the adult safeguarding plan.
- Evaluate whether the plan is meeting/achieving outcomes.
- Evaluate risk.

Reviews of adult Safeguarding Plans, and decisions about plans should be communicated and agreed with the adult at risk. Following the review process, it may be determined that:

- The plan is no longer required; or
- The plan needs to continue.

Any changes or revisions to the plan should be made, new review timescales set (if needed) and agreement reached regarding the lead professional who will continue monitoring and reviewing; or, it may also be agreed, if needed, to instigate a new adult safeguarding Section 42 Enquiry.

4.11 Closure Summary Record

At the end of an enquiry the SAM is responsible for ensuring that a clear summary of all actions taken and any ongoing risk management plan. The following should be recorded:

- All the views of the adult or their representative about the adult safeguarding work needs to be noted. This should include any agreements/disagreements about decisions. Whether their desired outcomes have been achieved and if not/why not.
- Any further referrals for assessment and support and who to.
- Any advice and information provided.
- All organisations involved in the enquiry to be updated and informed.
- Feedback has been provided to the referrer.
- Any action(s) taken with the person alleged to have caused harm.
- Any action(s) taken to support other people.
- Referral to children and young people made (if necessary).
- Whether to refer to a SAB for consideration for a s44 Care Act Safeguarding Adults Review
- Any lessons to be learnt.
- Agreement on how matters will be followed up with the adult if there are further concerns.
- Recording key data in an anonymised way that can be used to inform practice, provide aggregated outcomes information for Safeguarding Adults Boards and enable the statutory Safeguarding Adults Collection (SAC) NHSE Digital return to be completed.
- There may be circumstances when the enquiry has closed but ongoing monitoring is required to manage risks and/or establish if the agreed actions are appropriate. In these circumstances, in addition to the actions outlined in the closure summary report outlined above consideration should be given to referring to a multi-agency panel to share the management of people at high risk of abuse.
- Professional/concerned curiosity should be maintained throughout.
- Agreement on the monitoring arrangements and by whom should be agreed and recorded in the closure summary record).
- It is good practice where a care management assessment or review, Care Programme Approach (CPA), health review, placement review or any other pre-booked review is due to take place following the safeguarding enquiry, for a standard check to be made that there has been no reoccurrence of adult safeguarding concerns.

End of the adult safeguarding work:
There may be some situations where the risks cannot be reduced or mitigated adequately, and ongoing support or case management is required. Multi-agency high risk panels may assist workers to escalate risks, share information, hold risk collectively and explore creative solutions for particularly complex situations. In these circumstances whilst a specific enquiry may be completed, ongoing monitoring and review may be required.

Processes that continue after the safeguarding adult procedures close or are concluded:
The adult safeguarding procedure may be closed but other processes may continue, for example, a disciplinary or professional body investigation.

Where there are outstanding criminal investigations and pending court actions, the adult safeguarding process can also be closed providing that the adult is safeguarded.

These processes may take some time, and consideration should be given to:

- The impact of these on the adult, the risk management plan.
- How this will be monitored and by who? (This should include changes to care plans which may have changed as a direct result of safeguarding recommendations
- How often.
- How will concerns be escalated.
- This should all be recorded in the adult safeguarding enquiry report.

Part Five Appendices

5.1 Appendix 1: Organisational Abuse Including Provider Support Procedures

1. Introduction

This section focuses on working with organisations to achieve high quality and safety, and positive practice. The focus of this section is where adult safeguarding concerns relate to patterns of abuse or neglect in the care and support delivered by an organisation or service, as opposed to single adult safeguarding concerns that are addressed under a section 42 enquiry.

The focus of this section is to promote safe and supportive cultures through the application of the six principles of safeguarding, open and honest dialogue, and defining roles, responsibilities and accountability.

2. Who Does this Apply To?

This section applies to organisations within a borough, including all care and support provision, whether directly commissioned or not by a local authority or Integrated Care Board, NHS Trust or NHS England, and irrespective of whether the organisation is regulated by CQC. It also applies to local authorities and NHS Trusts as providers.

A provider is any care or health provider who delivers care and support. care. This includes but is not exclusive to the following:

- Domiciliary care/homecare, residential care homes, nursing homes, supported living.
- NHS commissioned provision and private hospitals.
- Day care/opportunities providers.
- Voluntary and community organisations.
- Adult education organisations.
- Faith organisations.
- Voluntary and community organisations.
- Local authorities.

3. Working in Partnership

Frontline staff; commissioners; all organisations that provide care and support; regulators; the public, community, voluntary and faith organisations; and providers should build and maintain relationships to work together to improve the quality of care and support delivered. They should work in partnership to assist with the early identification of quality issues and/or failing standards of care and support that might lead to wider concerns and the need for safeguarding interventions, including where there may be organisational abuse. This includes partnerships across Integrated Care System, London and nationally.

There should be arrangements in place to offer support and guidance to commissioned and non-commissioned providers in each borough in relation to safeguarding policies and procedures. Provider forums/groups led by commissioners in borough and across the Integrated Care System, or specific agencies who advocate on behalf of and support providers, are a useful means of regular communication and support for providers.

Local authorities should have policies, procedures and pathways in place outlining how to report an adult safeguarding concern and a quality in care concern. They should also have information about their local organisational abuse and the provider support procedures/processes available to enable organisations and providers to understand this and their roles and responsibilities.

4. Information Sharing Related to Quality in Care and Adult Safeguarding Concerns

Transparency and information sharing about quality in care concerns, safeguarding adult concerns and promoting the exchange of information between frontline workers; commissioners; all organisations that provide care and support; regulators; the public; community, voluntary and faith organisations; and providers is an important way to:

- Enable a preventative approach.
- Ensure a focus on high standards of care and support.
- Assess risk; and
- Ensure a timely, proportionate and coordinated response if concerns occur.

Formal mechanisms for sharing information between agencies are recommended. The culture of an organisation can impact on its transparency related to quality in care concerns and adult safeguarding concerns being reported, and culture, religion and beliefs must be considered in this context.

If information is shared that indicates a crime has been committed, this information must be reported to the police.

Most local authorities have established and lead on formal information sharing meetings, and this is recommended. The purpose of these “quality and safeguarding meetings” or “multi-agency joint intelligence groups” are to:

- Share soft and hard intelligence to avoid silo working and key information not being shared across the across the local system.
- Reduce the need for safeguarding interventions under the provider of concerns procedure (see section below), through early intervention and support.
- Enhance the standards of care and support by sharing early warning signs with providers and agreeing an improvement plan.
- Agree the necessary actions to be taken by all agencies involved when quality and /or safeguarding concerns are identified.
- Provide a governance and joint accountability role in decision making regarding whether to place or remove a provider from provider concerns processes.

Support a culture of openness, transparency, trust, continuous improvement and partnership work.

Where an organisation or provider is providing NHS funded care the response should be in conjunction with place, system, regional and national quality governance arrangements – including the relevant system quality group.

5. Organisational Abuse

The Care Act Guidance section 14.7 states the following related to organisational abuse:
“Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice because of the structure, policies, processes and practices within an organisation.”

6. Identifying Organisational Abuse

Assessment, information-sharing and professional judgement is required to determine whether poor practice has become organisational abuse. Several individual safeguarding enquiries at the same place/within the same organisation may indicate wider organisational concerns about

poor quality care or indicate the need for further review. Examples of causes for concern and further investigation:

- A series of medication errors.
- An increase in the number of falls, minor injuries or pressure ulcers.
- An increase in calls to London Ambulance Service.
- An increase in the number of visits to the Emergency Department especially if the same injuries occur more than once.
- Changes in the behaviour and demeanour of people drawing on care and support.
- Signs of neglect such as dirty clothes or nutritionally poor food.
- Repeated missed visits by a homecare worker.
- An increase in the number of complaints.
- An increase in the number of agency staff or high turnover of permanent staff.
- A pattern of missed dental, GP or other medical appointments.
- An unusually high or unusually low number of safeguarding concerns or enquiries.

See: Notifications - Care Quality Commission

7. Organisational Incidents, level of Risk, Impact and Potential Action Table

Incidents	Level	Impact of Risk on People Using the Service	Potential Action
There should be a careful analysis of what constitutes intentional and unintentional harm, although where there is unintentional harm e.g. due to poorly trained staff may also constitute organisational abuse. - A death where abuse or neglect may have been the cause. - Concern related to serious abuse or neglect. - CQC enforcements related to quality of care. - Criminal proceedings relating to poor care.	**Major**	- People who use the service are not protected from unsafe or inappropriate care. - The provision of care does not meet quality & safety standards.	Immediate suspension of new placements. Initiate Provider Support Procedure - follow steps and agree action plan. Contact all residents to ascertain their views and review their care and support to ensure their safety. Formal meeting with provider following police advice.
- Information linking quality and/or safety concerns to the manager or person responsible for the service. - High use of agency staff, high turnover, poor induction and training.	**Moderate**	- People who use the service are generally safe, but there is a risk to their health and wellbeing. - Provision of care is inconsistent and may not always meet quality & safety standards.	- Suspension or 'place with caution'. - Consultation with the Police. Increased monitoring activity by commissioners/Quality Assurance leads. Formal meeting with the provider/organisation to agree an improvement plan.
A disproportionate number of low-level concerns identified, from contract monitoring/Quality Assurance or concerns raised by other agencies.	**Minor**	People who use the service are safe, but care provision may not always meet safety and quality standards.	Enhanced monitoring visits, spot checks. Formal meeting with the organisation/provider.

8. Responsibility of Organisations and Providers

Organisations and providers are responsible for delivering safe, quality services that reduce the need for safeguarding interventions. They should underpin their own policies and procedures with the six adult safeguarding principles and empower adults to fully participate in how care and support is delivered, maintaining a respectful, open and trusting culture where people's views are listened and responded to.

Organisations and providers are accountable to adults drawing on their services and to commissioners for meeting the expected standard of care agreed in individual care plans and contracts. They are expected to have a robust quality assurance framework in place that gives evidence of the commitment to prevention and early intervention. Such commitments are about recognising potential abuse and learning from past situations to inform better practice.

Undertaking regular staff training, supervision and appraisals, self-audits and making changes as a result, reduces the risk of matters escalating to safeguarding concerns.

Organisations and providers should publish an open and transparent complaints and whistleblowing procedure with the assurance of no retribution to individuals; and offer ways of gaining feedback from people who draw on care and support, cares and others, that supports empowerment and quality assurance. Independent advocacy and regular adult/carer/patient led meetings are also important to ensuring that care and support is influenced and improved by people who draw on them.

It is important that organisations and providers understand:
- The difference between an adult safeguarding concern and a quality in care concerns and how to report both.
- What organisational abuse and the provider of concern/provider support process is.

9. Responsibility of Commissioners
Commissioners should set out clear expectations to organisations and providers about their safeguarding duties within contracts and ensure that safeguarding principles and standards are embedded in all documents such as service specifications, invitations to tender and contracts.

Commissioners should monitor compliance with these standards through a quality assurance framework. Commissioners need to assess the effectiveness of the policies, procedures and standards to deliver high quality and safe care and support.

Commissioners should work in partnership with other agencies, organisations, providers and operational colleagues to determine the level of risk and address issues proactively. For example, there may be a local decision to carry out a spot check site visit of a provider, file audits or a period of enhanced monitoring with a provider.

10. Host Commissioner – Learning Disability and Autism:
In January 2021 NHS England January 2021 launched the Learning disability and autism – host commissioner guidance to support oversight by enabling host commissioner arrangements to be put into place. This involved any mental health inpatient unit which provides care commissioned by Integrated Care Boards to people with a Learning Disability, or Autistic people, to have an identified host Integrated Care Board. This includes units which provide assessment and treatment, long-term rehabilitation, and other specialist inpatient care. This includes both NHS and independent sector provision.

The host commissioner is a point of contact for placing commissioners and for the CQC, Ofsted, and the Regulator of Social Housing etc for issues relating to quality and safety, in respect of commissioner oversight. The CQC has the oversight for units where mental health care is delivered to people living with a learning disability and Autistic people, including acute mental health settings. They should have mechanisms in place to share intelligence and be an interface with the relevant local authority adult social care safeguarding service, and with the local Safeguarding Adults Board so that any safeguarding concerns are raised with the host local authority and dealt with by the local authority as the lead agency for adult safeguarding, as directed under Section 42 of the Care Act 2014.

11. Roles and Responsibilities in the Provider Support Procedure
Host authority - the local authority in the area where the organisational abuse has occurred. The host authority is responsible for the following:

- Liaising with CQC or Ofsted if the concerns raised relate to a regulated provider.
- Determining whether other authorities are making placements/using the service, alerting them and liaising with them about the concerns.
- Ensuring there is an appropriate chair for meetings, the administration of meetings and responsible leads for actions with agreed timescales.
- Coordinating the agreed action plans and monitoring that the agreed actions are completed.
- Ensuring advocacy arrangements are in place where needed.
- Commissioning Authority – the local authority and/or Integrated Care Board that has commissioned the service for an individual where there is a provider concern. The placing authority is responsible for the following:
  - The care management responsibilities for individuals.
  - Contributing to safeguarding activities as requested by the host authority and maintaining overall responsibility for the individuals they have placed.
  - Ensure the placement continues to be safe and meet needs, and take any necessary steps if risks are identified Informing the host authority of any changes in an individual's circumstances and/or service provision that has a bearing on the provider concerns procedure.

12. Provider Support Procedure/Processes

It is recommended that local authorities develop a Provider Support Procedure/Processes (PSP) (or equivalent) which addresses at an organisational scale issue arising from quality monitoring, adult safeguarding work and other sources. The procedure can help the local authority meet is duty under s5 Care Act 2014 to promote an efficient and effective market of high-quality services for meeting care and support need. The PSP addresses organisational concerns and is relevant for all adults at risk regardless of how their care is funded. The PSP does not replace or lead on individual safeguarding enquiries, Patient Safety Incident Responses in the NHS or Care Quality Commission regulatory action and should not replace individual adult safeguarding enquiries being undertaken under Section 42 of the Care Act 2014.

A PSP should only be initiated where there are repeated patterns, or significant one-off risks, related to adult abuse or neglect, or serious quality issues resulting in risks to adults who use services to meet their care and support needs. Patterns or concerns leading to a PSP may be identified through different mechanisms such as contract monitoring and quality assurance, complaints; an allegation from a whistleblower, for example, about the management of a service; or following an adult safeguarding enquiry; an NHS Patient Safety Incident Response Framework (PSIRF); a Safeguarding Adults Review; or a Coroner's Inquest.

Abuse, neglect and poor practice may take the form of isolated incidents of unsatisfactory care at one end of the spectrum through to pervasive ill treatment and gross misconduct at the other end. Incidents between individual people or individual members of staff may occur without any failings on the part of the organisation (see table above).

Assessment, information sharing and professional judgement is required to determine whether poor practice has become an issue leading to organisational abuse. It is helpful to have a group/information sharing panel as a forum to determine such matters (see section above).
It is important to answer the following questions to determine the decision to initiate the PSP.

- Does the type/nature of incident indicate organisational abuse?
- Is the incident/s of a degree/scale to indicate organisational abuse?
- Is there a pattern and prevalence of concerns about the service/organisation which indicates organisational abuse?

Please see the table above – this provides some guidance about possible thresholds for different levels of concern. It is recommended that there are local discussions to agree actions that will be taken to address the different levels of risk. See: Newham-provider-quality-handbook

13. Six Steps of a Provider Support Procedure

This joint health and adult social care procedure is a distinct process but may run concurrently with a Section 42 enquiry or Patient Safety Incident Response Framework (PSIRF) and may also run concurrently with a Safeguarding Adults Review or CQC regulatory action.

Where health agencies are funding or providing support to the organisation i.e. district nursing support, health will need to be involved in the process.

In all instances, consideration must be given to reducing duplication. If it is suspected that a crime may have been committed, or if a criminal investigation is ongoing, the Police must be consulted to ensure initiating a PSP will not compromise any criminal investigation.

Where individual section 42 enquiries or other investigations have commenced or are completed prior to a PSP being initiated, the completed findings reports should be fed into the PSP as evidence considering the risks of sharing sensitive personal or commercially sensitive information.

The local authority where the organisation sits should lead on the PSP. Where the organisation has multiple sites of concern, across multiples boroughs, an agreement is required on which local authority should lead. This may be the local authority where the organisations HQ is, or where the largest number of people are supported.

13.1 Step 1 - Initiation

Local processes should set out who and how a decision to initiate a PSP is made. Concerns on a scale potentially requiring a PSP should be discussed at Director level in the local authority in partnership with their equivalent post in the Integrated Care Board.

Patterns or concerns leading to PSP may be identified through several different mechanisms, such as:

- Contract monitoring and quality assurance processes by the local authority or the ICB.
- Complaints to the local authority, the ICB or partner agencies.
- Monitoring of performance data by an individual agency or by the Safeguarding Adults Board,
- An allegation from a whistleblower.
- Through regular formal information sharing meetings/panel, between the local authority, the ICB and CQC.
- During/ following a section 42 safeguarding enquiry or the NHS Patient Safety Incident Response Framework (PSIRF).
- During/ following a Safeguarding Adults Review.
- During/ following a Coroner's Inquest.

Immediate actions:
The Director of Adult Social Services (DASS) or their nominated lead taking the decision should arrange for the following decisions/actions to be taken promptly:

- Appointment of a lead organisation for the PSP and a suitable PSP chair along with any directions for membership and the objectives of the PSP panel.
- Any further immediate actions required to safeguard adults or others.

- A referral to the police if required, and discussion on how to conduct the PCP in a way that will not jeopardise any criminal investigation.
- Whether to suspend use of the organisations or provider's services, and all necessary steps taken to implement this decision.
- Consideration of the interface with any statutory duties around market oversight and business failure.
- Consideration of whether to contact placing authorities and/or health commissioners, considering the statutory duty to responsibly safeguard adults balanced with the legal requirement not to negatively impacts the organisations or provider's ability to trade.
- Arrangements for a risk assessment and management plan to be drawn up, along with any relevant improvement plans/enhanced monitoring arrangements with the provider.
- The securing of records, including asking any other relevant agencies to do so.
- The DASS (or through delegation to the PSP chair) to notify in writing the Chief Executive officer (or equivalent) of the organisation or provider that a PSP has been initiated outlining the rationale and providing a copy of the PSP.
- The organisation or provider should also be given the opportunity of meeting with relevant staff prior to the initial PSP panel meeting to further understand the concerns and make any initial response to the evidence presented.
- Notification to the organisation or provider and an initial PSP meeting will be implemented as soon as it is safe to do so. If there is a criminal investigation, the provider will be informed in accordance with police advice.

It is recommended that following the decision to initiate the PSP, actions should be completed within 5 working days.

13.2 Step 2 - Initial Provider Support Meeting
The PSP chair should convene a PSP meeting of appropriate membership and representation, including whether the provider should be included in this initial meeting.

The chair will ensure an agenda and supporting papers for the PSP panel outcomes meeting are sent in advance and plan for appropriate attendance.

The PSP chair should ensure there is appropriate administrative support for the PSP meeting (e.g. minute taking) and should ensure records are agreed as accurate and stored in accordance with GDPR and the Data Protection Act 2018.

The purpose of the initial PSP panel meeting is to:
- Clarify roles and responsibilities – including confidentiality and information sharing arrangements.
- Declaration of any conflicts of interest.
- Consider the known views of the organisation or provider.
- Agree how to involve the organisation or provider.
- Agree how to involve the residents drawing on care and support, their carers and relevant others.
- Ensure access to appropriate advocacy and support for residents drawing on care and support.
- Identify and consider the requirements of any adults who are subject to a Lasting Power of Attorney or Deputyship.

- Agree the communication strategy (both internal and external communications including senior management, the organisation or provider, frontline staff, press, elected members and other placing authorities where relevant.
- Agree the risk assessment, management plan and relevant improvement plans with enhanced monitoring arrangements.
- Agree the Quality Improvement Plan - This is a service-level quality improvement plan to address the concerns and risks identified through the PSP, written in partnership with the commissioners/contract managers within the local authority or ICS and the provider organisation. Its purpose is to support providers to make and sustain improvements to the services they are providing and to ensure the safety and wellbeing of adults with care and support needs is maintained. The plan must clearly set out the issues, actions to be taken (risk assessed for priority), action owners, timescales and expected outcomes/ measures of success. Overall ownership of the plan lies with the organisation or provider but must be agreed and monitored by the PCP panel. The quality improvement plan will be the agreed reference point for assessing and monitoring progress, including quality assurance activities, the timescales for which must be agreed with the organisation or provider.

Set a date of the PSP panel review and outcomes meetings – taking account of Police advice if there is an on-going criminal investigation.

13.3 Step 3 - Involving the Organisation or Provider

Organisation or provider involvement is essential to the PSP. It enables steps to be taken for the immediate protection of people, for the development and implementation of protection plans for individuals and overall improvement plans for the service.

However, it may be necessary to hold an initial PSP meeting without the organisation or provider present, for example if:

- There is possible complicity by the staff and managers in the issues under investigation.
- There is a possibility that the organisation or provider may tamper with or destroy evidence to protect themselves against allegations made.
- Specific advice from the Police or CQC relating to the exercise of their statutory powers.
- Depending on the size of the organisation or provider, the nature of the allegations and the circumstances in relation to the investigation/s to be carried out, consideration should be given to involve the following:
  - The Manager of the Service (the Registered Manager and Nominated Individual if the service is subject to CQC Registration).
  - The Area or Regional Manager, particularly if concerns relate to the conduct of the Service Manager.
  - The Owner, Company Director or Accountable Officer (the ‘Responsible Person’ as registered by CQC may be the most appropriate person).

The organisation or provider should:

- Ensure provision of information regarding names of those who draw on care, the authority funding their placement, if they are self-funding, their representative and/or their next of kin.
- Support/assist in the investigation of any individual safeguarding concerns and actions taken or to be taken as a result, noting that any adult safeguarding Section 42 enquiries or other investigations sit outside of the PCP itself. Clear instructions must be given to the organisation or provider regarding timescales of the investigation and realistic outcomes, including their responsibilities in the investigation.
- Assist in the investigation of allegations where appropriate in relation to organisational abuse.

- Provide written reports of any findings and recommended/ actions.
- Provide a detailed action/improvement plan, including milestones and review dates, setting out how all risks will be mitigated. A single improvement plan should be used where possible to include the commitments of each organisation involved - the local authority, the Integrated Care Board and the CQC.
- Provide appropriate representation at PSP meetings.
- Ensure adherence to any agreement made during the PSP including those relating to suspensions and responsibilities for ensuring that people drawing on care and support, and other stakeholders, are kept informed of any organisational safeguarding proceedings taking place.
- Evidence a business continuity plan to assist them in working through any period of investigation. Where there are concerns of market failure, this should include details of the support that the organisation or provider is delivering.
- While appropriate and co-operative behaviour by the organisation or provider is expected, it may not be appropriate to delegate aspects of the PSP to them. This will be discussed at the PSP strategy meeting. However, due regard will be given to the organisation or provider's own mechanisms and how any intention to deploy these related to the PSP and the improvement plan.

13.4 Step 4 - Involving Adults Supported by the Organisation or Provider

The experiences of people drawing on care and support from the organisation or provider, and their carers/ relevant others and advocates, should be central to the PSP. Their views should form critical evidence for decision-making within the PSP, and the desired outcomes they identify should shape the PSP enquiries plan and quality improvement plan.

The recommendation is that PSP meetings are not attended by adults, carers or relevant others as they are intended as meetings to focus on progressing and overseeing the PSP process. Instead, the initial PSP meeting should agree, and set out in the PSP plan a communications strategy, how to make adults, carers or relevant others aware of the concerns and how their views and experiences will be obtained to ensure they are safe. Their views should also form evidence for the PSP. This could be done, for example, by individual meetings, homes visits, existing group meetings, surveys and/or a dedicated telephone line for raising concerns.

Speaking out may not be easy for people who draw on care and support services, and therefore encouragement and support should be provided to enable people to raise complaints, concerns and queries. Where individuals may have substantial difficulty in participating and giving their views, the PSP chair should ensure that appropriate advocacy is arranged for them in line with statutory duties set out in the Care Act 2014 and Mental Capacity Act 2005.

13.5 Step 5 - PSP Enquiries and Review Meetings

The PSP enquiries should be undertaken by named leads and according to the timescale set out by the initial PSP strategy meeting. The data and information gathered through the enquiries should be reported back to the PSP meeting, including any findings reports (without person identifiable information) from individual section 42 enquiries, and/ or Patient Safety Incident Response Framework (PSIRF), and any other investigations taking place.

Review meetings should be scheduled as required.

The purpose of a PSP Review meeting is to:

- Receive updates, review progress and agree any other actions.
- Establish if there are trends, patterns or evidence that indicates the concerns are valid.

- Review the probability, level and impact of risk to the safety of people who draw on care and support and ensure there is an appropriate risk management plan in place. Agree and review actions that could be taken to safeguard people, including making recommendations to suspend placements, relocation of residents, decommissioning of the service, the risks associated with those actions, and informing other local authorities.
- Monitor at appropriate time intervals until all actions are completed and the PSP panel is assured that: -
  - There are no further concerns.
  - The organisation or provider has implemented a sustainable change.
  - Improvements are embedded in practice.
  - Ongoing risk has been satisfactorily managed.

Where there are individual Section 42 Care Act 2014 enquiries, the responsibility for monitoring each Safeguarding Plan will lie with the SAM for each enquiry and not the PSP panel.

The PSP chair may arrange further PSP review meetings to update stakeholders when necessary. If there are serious delays by the provider to implement the quality improvement plan, a further meeting should be held to consider the level of risk and appropriate actions required.

If the organisation or provider advises of possible service failure or interruptions, and/ or there is high risk and likely need to source alternative provision, consideration will need to be given to local policies in relation to provider failure and service interruption to manage this, working in partnership with the PSP.

The scheduling of further PSP review meetings will depend on the organisation or provider's progress with the quality improvement plan and the level of risk.

13.6 Step 6 - De-Escalation and Conclusion

Following evidence-based improvement, identified through the quality improvement process, the PSP panel will formally conclude. The chair will arrange for a final PSP meeting to:

- Confirm that the quality improvement plan has either been completed with sustainable change or is making satisfactory progress, and that ongoing monitoring arrangements agreed for any outstanding actions do not require PSP panel oversight.
- Review and update the risk assessment and management plan, to show that the probability, level and impact of risk to the safety of people who receive care and support from the organisation or provider has been sustainably reduced.
- Reach consensus that the PSP has achieved its stated aims/ outcomes.
- Ensure clarity across all partners on the circumstances and conditions that would trigger a PSP being re-commenced, and gaining assurance that people know how to raise any further concerns.
- Lift any suspensions on new placements and packages of care being commissioned and communicating this with other placing authorities.
- Agree any further action required to manage risks and/or sustain improvements
- Confirm if any escalation to the Safeguarding Adult Board is required.
- Complete an after-action review and report to share any learning.

The PSP Chair will formally notify in writing all relevant parties of the conclusion of the PSP, including the DASS, the organisation or provider, and the CQC where appropriate. The PSP chair will also notify any other placing authorities of the conclusion of the PSP. The PSP chair

will update the London Association of Directors of Adult Social Services if information about the PSP commencing was shared.

14. Information Sharing and Record Keeping

All aspects of the PSP will comply with UK GDPR guidance and resources | ICO and the Data Protection Act 2018. All information should be shared in accordance with the adult safeguarding principles. It is the responsibility of the local authority to retain safe storage of information relating to the PSP. This should enable the local authority and Integrated Care Board to maintain a record of all PSP investigations for future profiling, background information and monitoring.

The documentation will be treated as confidential and shared only with permission from the chair. The outcome of the PSP must also be recorded on any open safeguarding referral connected with the PSP. See:

- Making Safeguarding Personal: what might 'good' look like for health and social care commissioners and providers? | Local Government Association
- Strengthening the role of advocacy in making safeguarding personal co-produced with NDTi on behalf of PCH/CHIP highlights the significant contribution of commissioners of advocacy.
- Practical examples of Making Safeguarding Personal from commissioners and providers of health and social care | Local Government Association
- Making Safeguarding Personal for commissioners and providers of health and social care
- Our work on closed cultures - Care Quality Commission
- Our updated human rights approach - Care Quality Commission
- Equally outstanding: Equality and human rights - good practice resource Care Quality Commission
- CQC Emerging Concerns Protocol
- For providers: Safeguarding - Care Quality Commission
- For local authorities: Assessment Framework - Care Quality Commission
- Creating a positive safeguarding culture - SCIE
- Overview | Safeguarding adults in care homes | Guidance | NICE
- CELDA Project Thematic Analysis Findings and Releases Risk Matrix Summary | UEA Health & Social Care Partners
- Montgomery, L. and Cooper, A. “Adult safeguarding within institutional settings: a narrative overview of the literature focused on the care of people with mental ill-health and learning disability " The Journal of Adult Protection Vol. 26 No. 2, pp. 59-71 (2024) Safeguarding adults within institutional settings: a narrative overview of the literature focused on the care of people with mental ill-health and learning difficulties | Emerald Insight

5.2 Appendix 2: Adult Safeguarding Structures, Roles and Functions, and Organisations

1. Structures

Safeguarding Adults Boards (SAB):
All local authorities must establish a SAB as set out in the Care Act. The Act (Schedule 2) gives the local SAB three specific duties it must:

1. Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan, it must consult the Local Healthwatch organisation and involve the community.
2. Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any SARs including any ongoing reviews.
3. Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings.

SCIE have produced a checklist and resources provides a comprehensive narrative and account of the roles and responsibilities of the SAB: Role and duties of Safeguarding Adults Boards - SCIE

The national network for SAB Chairs nationalnetwork.org.uk includes a range of helpful information for SAB chairs and board managers.

Community Safety Partnerships:
Community safety partnerships (CSPs) are made up of representatives from the 'responsible authorities', which are the:

- Police.
- Local Authorities.
- Fire and Rescue Authorities.
- Probation Service.
- Health.

The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

Local Safeguarding Children Partnership (LSCP):
These are arrangements made by the local authorities, police and health to work with relevant agencies to safeguard and protect children within their areas. The multi-agency response to children and families who need help - GOV.UK

Health and Wellbeing Boards:
The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. They are an important feature of the NHS reforms and are key to promoting greater integration of health and local government services. Boards strike a balance between status as a council committee and role as a partnership body.

NHS England:
NHS England and the Department of Health and Social Care functions are in the process of merging with the overall aim of being fully integrated into the Department of Health and Social Care during 2027, following the necessary legislative change.

The general function of NHS England is to promote a comprehensive health service to improve the health outcomes for people in England. NHS England regional teams have a statutory requirement to oversee assurance of ICBs in their commissioning role and from April 2026 take a lead on overall provider trust performance

Panels:
Across the local authority SAB area, various panels exist to ensure that individuals at risk receive the most appropriate support and intervention. Each panel has a distinct role, yet they are interconnected, working collaboratively to safeguard and promote the welfare of adults at risk.

See: Lambeth Complex Case Pathway Framework Self Neglect & Hoarding - Greenwich SAB

Understanding these panels and how they interrelate is essential for making appropriate referrals, ensuring timely interventions, and escalating concerns when necessary.

Panels do not operate in isolation; they often interrelate when individuals have complex, overlapping risks. To navigate these panels effectively, staff should be aware of referral pathways and escalation protocols. If a referral is deemed more suitable for another panel, panel coordinators should communicate and coordinate to ensure the case is directed appropriately. Clear documentation and a multi-agency approach are key to ensuring individuals receive the right level of intervention at the right time.

2. Roles and Functions

See: Adult safeguarding: roles and responsibilities in health and care services | Local Government Association

Senior strategic roles:
The Care Act 2014 prescribes that each SAB should include the Local Authority, the Integrated Care Board and the Police. The Chief Officers[3] must sign off their organisation's contributions to the Strategic Plan and Annual Reports. Chief Officers should receive regular briefings of case law from the Court of Protection and the High Courts.

Briefings produced by Skills for Care provide further detail on the role of the three statutory members of the SAB. In relation to senior strategic roles in health and ICBs – these are set out as recommended by the following:

- NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework
- Accountability and Assurance
- Framework: Safeguarding children, young people and adults at risk in the NHS
- Adult safeguarding assurance information resource for directors of adult social services | Local Government Association

[3] Borough led for the MPS

Strategic leadership and practice leadership:
Each SAB member agency should appoint a senior manager to take the lead strategic and inter-agency role in safeguarding arrangements, including the SAB.

Within each partner agency, clearly understood roles should be created for practice leadership in safeguarding.
Principal Social Workers are well placed to provide professional leadership, act as Safeguarding Adult Managers or Leads (SAMs) and to provide additional advice and guidance to social workers in complex and contentious cases.

Healthcare providers should have in place named professionals to provide additional advice and support in complex and contentious cases within their organisations.

There should be a designated professional lead within the ICB, to act as the lead in the management of complex cases and to provide advice and support to the governing body. Arrangements should be made to enable officers investigating safeguarding concerns to access advice from specially trained investigators and/or units within the police. See:
- Principal social workers in adult services: roles and responsibilities - GOV.UK
- Adult Social Care Services | RCOT

Police:
Although the police are a mandatory member of the SAB by virtue of s43 of the Care Act, they are not an agency responsible for the provision of care. The police role in adult safeguarding is related to their policing function. The core duties of the police are to:
- Prevent and detect crime.
- Keep the peace.
- Protect life and property.

The Police are now represented on every local SAB and contact details for the individuals concerned will be available to the board and all board members. Each SAB is supported by a senior officer, Superintendent or Detective Chief Inspector. Each Community Safety Unit is headed up by a Detective Inspector.

If you are unsure which police force area you need to contact, then contact the force area where the incident or concern is/was located. This is the way primacy for investigation is determined within the police.

Local authorities:
Local authorities have the lead responsibility in managing safeguarding concerns and determining safeguarding duties and S42 enquiries. This takes in the responsibility to ensure a partnership approach. They must ensure:
- Any safeguarding adult concern is acted upon and is consistent with these multi agency procedures.
- Actions are co-ordinated and relevant agencies/organisations, including the LA are taken in accordance with their own duties and responsibilities.
- Focus on the adult with due consideration to other adults or children.
- Key decisions are made reflecting the principle of ‘no delay’.
- An interim and final safeguarding plan is put in place with adequate arrangements for review and monitoring.

- Actions leading from enquiries are proportionate and should enable the adult to remain in control unless there are clear recorded reasons why this should not be the case.

Elected members of Local Councils:
Elected Members have the following responsibilities in relation to adult safeguarding:
- They understand their own organisational responsibilities for safeguarding persons at risk.
- The corporate strategy identifies the council's role in safeguarding persons at risk and what priority this is given
- The council formally considers the annual report of the Safeguarding Adults Board, and the issues this identifies for the local Council area.

3. Organisations

Care Quality Commission (CQC):
Safeguarding is a key priority for CQC and people who use services are at the heart of their policy.

Their work to help safeguard children and adults reflects both their focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services.

Health and adult social care regulated services all have a key role in safeguarding vulnerable children and adults at risk. The CQC will monitor how these roles are fulfilled through its regulatory processes by assessing the quality and safety of care provided based on the things that matter to people. It does this by using five key lines of enquiry to ensure that health and social care services provide people with safe, effective, caring, responsive and well led services.

CQC will share with local partners, where they are not already aware, the safeguarding information that it receives so that they can take the appropriate action to protect the individual. Safeguarding information is also used within its intelligent monitoring systems to assess its impact upon the service and the associated level of risk. This information is then used to inform CQC inspection process.

Although there are differences in the statutory basis and policy context between safeguarding children and adult safeguarding, the CQC have the same approach with an overarching objective of enabling people to live a life free from abuse.

The CQC also has a role in health and safety in collaboration with the Health and Safety Executive.

Commissioners:
Commissioners from the ICBs, NHST, Local Authority, and NHS England are all vital to promoting adult safeguarding. Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they procure and ensure that contracts have explicit clauses that holds providers to account for preventing and dealing promptly and appropriately with any concerns of abuse and neglect. Commissioners have a shared and common vision to prevent, reduce and delay the need for care and support. For safeguarding this means, ensuring that people have easy access to information and advice, and early intervention services. Increasingly there is joint commissioning to meet the growing needs within a financial climate of austerity, with greater emphasis on prevention and early intervention. This is in line with the safeguarding principles.

Coroner:
Coroners are independent judicial officer holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody or otherwise in state detention, which must be reported to them. The coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisation.
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
- Where a death has occurred and there are concerns for others in the same household or setting (such as a care home) or
- Deaths that fall outside the requirement to hold an inquest but follow-up.
- Enquiries / actions are identified by the coroner or his or her officers.

The National Safeguarding Adults Board Chairs Network has agreed the National SAB Guidance on the Interface between SARs and Coronial Processes

Crown Prosecution Service (CPS):
The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

Court of Protection:
The Court of Protection deals with decisions and orders affecting people who lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- Decide whether a person has capacity to make a particular decision for themselves.
- Make declarations, decisions or orders on financial and welfare matters affecting individuals who lack capacity to make such decisions:
  - Appoint deputies to make decisions for persons lacking capacity to make those decisions.
  - Decide whether a lasting power of attorney or an enduring power of attorney is valid.
  - Remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare will be able to be made legally without making an application to the court, if the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005 and the Best Interests Checklist and any disagreements can be resolved informally. However, it may be necessary and desirable to make an application to the Court in a safeguarding situation where there are:

- Particularly difficult decisions to be made.
- Disagreements that cannot be resolved by any other means.
- Ongoing decisions needed about the personal welfare of a person who lacks capacity to make such decisions for themselves.
- Matters relating to property and/or financial issues to be resolved.
- Serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration.
- Concerns that a person should be moved from a place where they are believed to be at risk.

- Concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed adult safeguarding actions may amount to a deprivation of liberty outside of a care home or hospital.

Environmental Health Services:
Responsible for health and safety enforcement in businesses, investigating food poisoning outbreaks, pest control, noise pollution and issues related to health and safety. Local authorities are responsible for the enforcement of health and safety legislation in shops, offices, and other parts of the service sector.

Environmental Health Services and specifically, their Private Sector Housing Team can have an effective role in safeguarding adults at risk and children in their homes.

Officers from Private Sector Housing are field workers and as such are often the first people to engage with clients in their home and to make safeguarding referrals where someone is having trouble.

Environmental Health Services frequently contribute to multi-agency working and will respond to referrals from other partner agencies where a safeguarding investigation has been raised.

It is important to note that Environmental Health Services are primarily an enforcement team and that they will be engaged when all other efforts to mediate have been tried or if there is an immediate Public Health Risk which requires urgent action.

Common legislation used where there are safeguarding concerns include links to The Public Health Act 1936 - In particular: Sections 83 and 84 Cleansing of Filthy or Verminous Premises:

- Where a local authority, upon consideration of a report from any of their officers, or other information in their possession, are satisfied that any premises—
  (a)are in such a filthy or unwholesome condition as to be prejudicial to health, or
  (b)are verminous,
- If the property is deemed filthy and verminous, the officer may then serve a notice requiring cleansing or treatment for vermin and under s84 of the act they may require removal of filthy or verminous articles that are incapable of being cleaned.
- Service of notice will be on Owner or Occupier of the property that is deemed filthy or verminous.
- The notice contains a period within which the works are to be completed. This will typically be 28 days to provide an acceptable period for an appeal but may be shorter if necessary.
- These powers do not rely on a presumption that the individual affected by such intervention lacks mental capacity, however, in practice, Magistrates Courts are scrupulous that all attempts to engage and represent a vulnerable client have been made and documented by all partner agencies.
- Under section 287 of The Public Health Act 1936 an officer may apply through the Magistrates Court for a warrant to gain access to assess the condition of a property or to carry out works in default of a notice requiring cleaning or treatment for vermin. It is important to note that the Magistrates Court will scrutinise any application for warrant closely to ensure that the recipient has been made aware of the warrant application and their right for legal representation in accordance with The Human Rights Act. Failure to do this may result in the warrant being refused.
- It is Ultra Vires (Outside the scope of the legislation) to use a Public Health Act Warrant to gain access to a property for any purpose other than to affect a deep clean or treatment for vermin: The warrant may not be used to gain access for repairs or to remove excessively

hoarded items that contribute to an excessive fire load. The powers therefore are limited to the removal of Public Health Risk.
- When enforcing the notice, where there is vulnerability, good multi-agency planning may be required to carry out works in default of the notice and this may require close work with Housing Officers, Police, Fire Services, Mental Health nurses. This also ensures correct provision for aftercare is made.
- As the Public Health Act 1936 notice may be served on an owner or occupier.
- Special consideration may be needed for properties that are infested with bedbugs as this often requires complex preparation for treatment which a client may not be able to manage without considerable assistance; for instance, clearing a property or heat-treating infested clothing or bedding. An Environmental Health Officer would also be able to advise on best practices to avoid cross contamination and how to coordinate a block treatment programme.
- Environmental Health practitioners are mindful that reasonable adjustments are made to communications or that advocacy or support is given to a recipient of the notice or warrant of entry where needed.

The Prevention of Damage by Pests Act 1949 – s4 and s6:
- On officer may serve notice where there is a significant rodent infestation and works may include removal of items likely to harbour or encourage rodent infestation.
- Works may also be specified to rodent proof a dwelling as well as bait and in practice, this notice may be served concurrently with a Public Health Act Notice.

Other Public Health Act Provisions:
- As part of a safeguarding investigation, an Environmental Health Officer may encounter a situation where an amenity such as a WC, bath or shower is blocked, inoperable or otherwise insanitary. An officer may then consider service of other Public Health Act provisions to restore that amenity: For example, a notice under s45 of the Public Health Act may be used to restore a defective WC capable of repair.

Building Act 1984, s59:
- Vulnerable tenants often experience major problems with drainage or other amenity if self-neglect and isolation has been severe.
- This may extend to serious drainage defects and blockages in privately rented property and may be used to safeguard other residents affected by loss of sanitation or major water leaks.

The Environmental Protection Act 1990 – s80 and Statutory Nuisance:
- A statutory nuisance is an activity that unreasonably interferes with a person's use of their property or is a threat to public health. It is a criminal offence.

What is considered a statutory nuisance?
- Smoke: Smoke, fumes, or gases from premises, vehicles, machinery, or equipment.
- Dust, steam, or smell: From premises, vehicles, machinery, or equipment.
- Noise: Noise from premises, vehicles, machinery, or equipment.
- Animals: Animals kept in a way that is prejudicial to health or a nuisance.

Who can act?
- Local authorities can act under the Environmental Protection Act 1990.
- Individuals can act under the Environmental Protection Act 1990.
- A "statutory nuisance" refers to an activity that significantly impacts someone's use and enjoyment of their property, often related to noise, smell, or clutter, and can be legally

actionable under the Environmental Protection Act 1990; while "hoarding" describes the excessive accumulation of items in a living space, which can be considered a statutory nuisance if it reaches a level that negatively affects the health and safety of others or the surrounding environment, often due to fire hazards, pest infestations, or obstruction of access to the property.

- Impact on others:
- For hoarding to be considered a statutory nuisance, the clutter must significantly affect the quality of life of others, such as neighbours, by creating health risks, obstructing access, or causing pest infestations. In effect, to be prejudicial to health or a nuisance.

Housing Act 2004 and HHSRS:

- In assessing Safeguarding, An Environmental Health Officer may also assess a private dwelling under the provisions of The Housing act 2004, specifically for hazards under The Housing Health and Safety Rating System (HHSRS).
- There are 29 hazards that may be assessed within the HHSRS framework.
- Where a Category one hazard has been identified in a private dwelling, the local authority has a legal duty to act.
- Typically, the most common hazards encountered as part of a safeguarding investigation would frequently include:
  - Excess Cold,
  - Dampness
  - Fall Hazards and
  - the most vulnerable occupier would typically be older people.
- If the property is private rented, repairs would be affected by notice on the property owner, licensee or manager.

Hospital Discharge and Grants Service or equivalent:

- Safeguarding is often triggered when a person has been admitted to hospital and a property may be a severe state of disrepair or an occupier, owner or tenant has become physically or mentally incapacitated.
- The Environmental Health Team may take Emergency Remedial Action or facilitate Emergency repair grants to make a property suitable for hospital discharge or to create an environment sustainable for a longer-term care package.
- The Environmental Health Team when carrying out an active Safeguarding would also advise on situation where a tenancy or owner occupation are unsustainable without major action, and this can involve coordination of Emergency Temporary Accommodation with partner agencies. See:
  - Self-neglect - NHS Safeguarding
  - Self-neglect at a glance - SCIE
  - https://safeguarding-guide.nhs.uk/types-of-abuse-exploitation-and-neglect/s3-15/working_with_people_who_self-neglect_pt_web.pdf
  - Local multi agency self-neglect policies should be followed, e.g: Waltham Forest: Self-Neglect Multi-Agency Guidance
  - Working with people who self-neglect: Practice Tool (2020) | Research in Practice
  - Self-neglect - NHS Safeguarding
  - Hoarding disorder - NHS;
  - Advice for carers and support workers- Hoarders and fire safety | London Fire Brigade
  - Regulatory standards for landlords - GOV.UK

Health:
The NHS is a complex system, which can sometimes make it difficult to understand – especially working out who is responsible for what. It is made up of a wide range of different organisations with different roles, responsibilities and specialities. These organisations provide a variety of services and support to patients and carers.

Health is devolved across the four nations of the United Kingdom. The NHS in England is overseen by NHS England, across 7 regions, of which London is one.

Responsibility for local commissioning arrangements and partnerships sits with Integrated Care Boards. There are currently 5 across London with a planned merger of some ICBs in 2026.

Each ICB covers several local authority areas and will have several NHS Provider Trusts (acute hospitals, community healthcare services, mental health services and Primary Care Networks) within its footprint.

The NHS (ICBs and providers) work together with local authorities and voluntary sector as part of an integrated system to meet the health and care needs of local populations.

Public Health is overseen by The Office for Health Improvements and Disparities (OHID), which is part of The Department of Health and Social Care. Local authorities have important functions in commissioning local public health services: Office for Health Improvement and Disparities - GOV.UK

Safeguarding is firmly embedded within the core duties and statutory responsibilities of all organisations across the NHS and health system. However, there is a distinction between providers' responsibilities to provide safe and high-quality care, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.

NHS England
The chief nursing officer (CNO) for NHS England has executive lead and accountability to ensure the effective discharge of NHS England statutory responsibilities. The CNO is the lead board executive director for safeguarding and has several forums through which assurance and oversight is sought. The system-wide National Safeguarding Steering Group (NSSG) co-ordinates these forums and gains assurance on behalf of the CNO.

It is important to be aware that NHS England will undergo significant reform and change throughout 2026-2027. This could include some changes relating to how its functions are exercised.
NHS England ensures that the health commissioning system is working effectively to safeguard and promote the welfare of children, young people and adults. NHS England is the policy lead for NHS Safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Its key duties are to:

- Provide leadership support to safeguarding children, children in care and adult professionals, including education and training of both the general and the specialist workforce.
- Ensure the implementation of effective safeguarding assurance arrangements and peer review processes across the health system, from which assurance is provided to the board via the NSSG.
- Provide specialist safeguarding advice to the NHS.
- Encourage a culture that supports staff in raising concerns regarding safeguarding issues.

- Ensure that robust processes are in place to learn lessons from cases where someone has died or are seriously harmed, and
- Abuse or neglect is suspected.
- Ensure that NHS England teams are appropriately engaged in the local place based multi-agency safeguarding partnerships.
- SABs, community safety partnerships and HWBs to raise concerns about the engagement and leadership of the local NHS.

NHS England is devolving as many of its direct commissioning responsibilities as possible to ICBs to allow them to plan services from end to end, enabling a shift from tertiary towards preventative services

NHS England support for safeguarding professionals NHS England has also established safeguarding peer groups and forums, with access to an online community of practice to support system leaders to:

- Underpin system accountability through peer review-based assurance and other sources of intelligence, to identify local safeguarding improvements for children, children in care and adults
- Support development of safeguarding arrangements, practice and values in ICBs
- Identifying and share good practice initiatives across the local health system
- Analysing the health implications of, and learning from, local incidents including practice reviews and individual management reviews and developing local action plans as appropriate.
- Maintaining an up-to-date risk register and an appropriate escalation mechanism.

The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by CCGs and the direct commissioning functions of NHS England. It is important to be aware that ICB's are likely to undergo significant reform and change throughout 2026-2027. This could include some legislative changes relating to existing statutory functions. It is possible that delivery of these may change in the future.

The ICB is currently the statutory health partner for local Safeguarding Adults Boards and Safeguarding Children's Partnerships. They are a key stakeholder in local multi-agency safeguarding arrangements.

The Integrated Care Board is currently required to have an executive lead that is accountable for the statutory commissioning assurance functions of NHS Safeguarding across the ICB.

ICBs are required to fulfil their statutory duties and responsibilities to safeguarding children, adults at risk and looked after children. The responsibilities for safeguarding forms part of the statutory functions for each organisation and its executive board must therefore ensure the effective discharge of their duties within agreed baseline funding. The NHS England Safeguarding Accountability and Assurance Framework set outs the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. The framework aims to provide guidance and minimum standards but should not be seen as constraining the development of effective local safeguarding practice and arrangements, in line with the underlying legal duties.

Therefore, designates roles are strongly recommended in line with Safeguarding Accountability and Assurance Framework, but not mandated. ICB executive accountability for safeguarding

cannot be delegated and they are likely to oversee place-based partnership structures of clinical leads to collaborate with local safeguarding partnerships and SABs.

Safeguarding named professionals in providers do not usually work in commissioning however they may provide safeguarding expertise for subcontracted services within their provider organisation.

This is not specifically referenced within the Safeguarding Accountability and Assurance Framework, however, is in line with it: "*All health providers, including provider collaboratives, are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver".* NHS England Safeguarding Accountability and Assurance Framework (SAAF) set outs the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations: NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework

All health providers, including provider collaboratives, are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of adults at risk of harm and abuse in every service that they deliver.

Providers must demonstrate that safeguarding is embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. These arrangements include:

- The contractual requirements as laid out in Schedule 32 of the NHS Standard Contract.
- Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult safeguarding allegations against staff this could be a named professional from any relevant professional background.
- Safe recruitment practices and arrangements for dealing with allegations against staff.
- Provision of an executive lead for safeguarding children, adults at risk and PREVENT.
- An annual report for safeguarding children, adults and children in care to be submitted to the trust board.
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate safeguarding competencies.
- Safeguarding must be included in induction programmes for all staff and volunteers.
- Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals).
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.
- Developing and promoting a learning culture to ensure continuous improvement.
- Policies, arrangements and records, to ensure consent to care and treatment is obtained in line with legislation and guidance.

Named professionals (health providers) have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the SAB.

Safeguarding adult leads support and advise commissioners on adult safeguarding within contracts and commissioned services. They also have responsibility to improve systems and embed referral routes for adults at risk across the health system. They provide a health advisory role to the SAB, supporting the ICB SAB member.

Community nurses largely provide treatment in individual's own homes which includes care homes. A high proportion of people they visit are adults at risk of abuse or neglect by the fact that they have care and support needs, and many cannot protect themselves. Community nurses are trained to recognise the signs of abuse and neglect, and to raise their concerns through their line manager, or directly with Local Authorities. The most common concerns raised relate to neglect.

Through holistic assessments, nursing staff may identity that the person is not getting their health or social care needs met. This could be because of gaps in what is provided by the statutory agencies, or because of decisions made on their behalf by family or friends. Nurses are in a good position to identify possible abuse or neglect particularly financial abuse or domestic abuse, including where this could be a response to the pressures of caring.

Pressure ulcer management and quality of care in care settings, are further areas that nursing staff can use their clinical judgements about whether abuse and neglect has or is likely to arise. Because community nurses make repeated visits to their patients, they are also in a good position to review risks and the effectiveness of safeguarding plans in response to concerns.

Medical Examiners following regulations laid in Parliament in April 2024, Death Certification Reforms came into force in September 2024. From this date, all deaths in England and Wales must be independently reviewed. All deaths in any health setting (e.g.: hospital, hospice, care home, home or community setting) that are not investigated by a coroner will be reviewed by NHS medical examiners.

Medical examiners are senior medical doctors who are contracted to provide independent scrutiny of the causes of deaths not investigated by coroners, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. They have statutory responsibilities which are set out in regulations. Medical Examiners:

- Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths.
- Ensure the appropriate direction of deaths to the coroner.
- Provide bereaved people with an opportunity to ask questions and raise any concerns to someone not involved in the care of the deceased.
- Improve the quality of death certification.
- Improve the quality of mortality data.

For more information re Medical Examiners can be found NHS England » Medical examiners

Primary Care:
General Practice and other primary care services such as Dental Practices are regulated by the CQC. Primary Care Providers should adhere to the following fundamental standards in relation to safeguarding: Regulation 13: Safeguarding service users from abuse and improper treatment - Care Quality Commission

Often the Practice Manager may take on the function of organisational safeguarding lead. ICB's may also have a specific Named GP for adult safeguarding – this is however not a statutory role as is for Safeguarding Children.

The Royal College of General Practitioners published new Safeguarding Standards for General Practice in October 2024. The aim of the RCGP safeguarding standards is to set professional safeguarding standards for GPs and all staff in general practice. These outline the expected all-age safeguarding knowledge, capabilities and competencies for GPs and some other general practice employees. RCGP safeguarding standards for general practice

Dental Teams, Pharmacists and Optometrists have a statutory duty of care to all patients which includes ensuring that safeguarding arrangements are in place. See:
- Safeguarding in general dental practice - GOV.UK
- Safeguarding | RPS
- Protect and safeguard patients, colleagues and others from harm

The London Ambulance Service (LAS) has several ways in which staff may receive information or make observations which suggest that an adult at risk has been abused, neglected or is at risk of abuse and neglect. At a strategic level LAS have embedded the six safeguarding principles into its business plans and aims to translate them into practice by using them to shape strategic and operational safeguarding arrangements:
- Use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur.
- Work to support SABs by providing policy updates, and its annual report to support, patients and community partners to create safeguards.
- Provide leadership for safeguard adults policies.
- Ensure accountability and use learning within the service and the partnership to bring about improvement

Health and Safety Executive (HSE):
Adult Safeguarding in Social Care – HSE Role includes reportable incidents to patients and service users that may in some circumstances fall within the definition of abuse and may be a safeguarding issue, for example:
- If a nursing home fails to ensure the safety of a resident during hoisting.
- If a care provider failed to implement adequate controls, identified through assessment, which contributed to severe scalding during bathing.
- If a care provider failed to assess an individual's care needs and this contributed to harm.

Healthwatch:
Healthwatch England is the national consumer champion in health and care and must be consulted on the SAB's strategic plan. It has significant statutory powers to ensure the voice of the consumer is strengthened. It challenges and holds to account commissioners, the regulator and providers of health and social care services.

Healthwatch:
- Identifies common problems with health and social care based on people's experiences.
- Recommends changes to health and social care services that they know will benefit people.
- Hold those services and decision makers to account and demands action.

As a statutory watchdog, their role is to ensure that health and social care services, and the government, put people at the heart of their care.

Housing providers:
The Care Act states that a local authority must consider cooperating with social housing providers to exercise its care and support duties. An authority must do this when protecting adults at risk of harm and neglect and when identifying and sharing lessons to be learned from cases of serious abuse or neglect.

Social housing providers are registered with, and regulated, by the Homes & Communities Agency. They are also known as Registered Providers of Social Housing (RPs) or Registered Social Landlords (RSLs). They include local authority landlords, arm's-length management organisations (ALMOs) that manage council housing stock, private for-profit or not-for-profit housing providers, and Voluntary Sector Providers such as alms houses. Most not-for-profit RPs are also known as Housing Associations.

RPs provide a wide range of housing and housing-related services. They provide much of the supported accommodation in England, such as sheltered housing, care homes, supported living scheme housing, extra care schemes, hostels, foyers for young people, domestic abuse refuges, etc.

Local authorities must consider that the suitability of accommodation is a core component of wellbeing and good housing provision can variously promote that wellbeing. This includes minimising the circumstances, such as isolation, which can make some adults more vulnerable to abuse or neglect in the first place. The nature and diversity of RPs' work, therefore, can mean that their staff are often well placed to:

- Have a good knowledge of the individual and the communities with whom they work.
- Be working with persons who are unable to protect themselves from abuse or neglect due to their care and support needs, but who are not already known to Adult Social Care Services.
- Identify individuals experiencing or at risk of abuse or neglect and raise concerns.
- Be the first professionals to whom individuals might first disclose abuse or neglect concerns.
- Be the only professionals working with the adult at risk.
- Provide essential information and advice regarding the adult at risk.
- Contribute actively to person-led safeguarding risk assessments and arrangements to support and protect an individual, where appropriate.
- Carry out a safeguarding enquiry, or elements of one.
- Work with agencies to support someone who is hoarding.
- Work together with agencies to resolve issues with someone who refuses support or self-neglects, or when someone may not be eligible for a safeguarding service or social care support.
- Work with local authorities to promote safeguarding awareness, information and prevention campaigns.
- Be instrumental in helping a local authority to successfully exercise its safeguarding and wellbeing duties.

Housing Providers should ensure that they develop a safeguarding culture through:

- Board and Leadership commitment & ownership of safeguarding responsibilities.
- Policies or guidance that promote the 6 principles of adult safeguarding.
- Policies that reflect the adult safeguarding framework set out by a SAB.
- Staff being vigilant about adult safeguarding concerns.
- Learning and development for staff on adult safeguarding and the Mental Capacity Act 2005. enabling them to fulfil their roles and responsibilities.

- Sharing information appropriately to safeguard adults at risk and engaging with Information Sharing Agreements where required.
- Developing inter-housing networks as well as multi-agency mechanisms.

London Fire Brigade (LFB):
LFB staff become aware of safeguarding concerns in several ways, not only when responding to emergency calls, but during community safety preventative work such as home fire safety visits.

LFB staff receive safeguarding training so that they are able to identify whether an adult has been or is at risk of being abused and/or neglected and are aware of how to report concerns following the procedures for recording, managing and referring concerns to local authorities set out in our safeguarding policies.

The Head of Community Safety is the appointed Lead Officer for safeguarding within LFB and is supported by members of the LFB Central Community Safety team and local borough commanders in discharging this function.
Borough commanders represent LFB locally at SAB as non-statutory members. Each LFB borough commander reports any adult safeguarding concerns through their SAB and engages in multi-agency partnerships and information sharing as appropriate.

Prison Governors and HM Prison and London Probation Service:
They have respective responsibility for people in prison and those in approved premises. Senior representatives of these services may sit on the SAB and play an important role in the strategic development of adult safeguarding. They may also ask for advice from the local authority when faced with a safeguarding issue that they are finding particularly challenging.

Local authorities do have a duty under the Care Act 2014 to undertake needs assessments for adults who are in prison or who live in approved premises. The SAB can also act as a forum for members to exchange advice and expertise to assist prison and probation staff in ensuring that all people in custodial settings are safeguarded.

London Probation Service supervises individuals on licence and those subject to community and suspended sentence orders including those under Multi-Agency Public Protection Arrangements (MAPPA. Other key responsibilities include preparing reports for the criminal courts and for the Parole Board, delivering offending behaviour programmes, supporting and providing information to victims of serious violent and sexual offences eligible for the victim contact or victim notification scheme. A key focus is on continuous assessment and risk management to protect adults at risk, children, young people, and victims of crime. This involves routine checks with appropriate agencies to inform risk assessments and management of risk.

There is an emphasis on partnership working across London at a strategic and local level including through MAPPA. The MAPPA framework aims to reduce the risks posed by sexual and violent people in prison and on probation, thereby protecting the public.

The responsible authorities in MAPPA are the Police and HM Prison and Probation Service. They have a duty to ensure that local MAPPA meetings are established, and the risk assessment and management of all identified MAPPA nominals are effectively addressed through multi-agency collaboration.

Care and health providers:
All commissioned service provider organisations should produce their own guidelines that are consistent with the multi-agency adult safeguarding policy and procedures. These should set out the responsibilities of staff, clear internal reporting procedures and clear procedures for reporting to the local adult safeguarding process. In addition, provider organisations' internal guidelines should cover:

- A 'whistleblowing' policy which sets out assurances and protection for staff to raise concerns.
- How to work within best practice as specified in contracts.
- How to meet the standards in the Health and Social Care Act 2008 (regulated activities) and the Care Quality Commission (Registration) Regulations The Care Quality Commission (Registration) Regulations 2009
- How to fulfil their legal obligations under statutory processes.
- Robust recruitment arrangements.
- Training and supervision for staff.

Public Health:
The Health & Social Care Act 2012 set out the legislative framework for the changes to the health and care system that led to the creation of Public Health England and the transfer of responsibility for most public health duties at a local level to local government. Public Health England (PHE) was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service, for the first-time combining health protection and health improvement in one organisation.

Trading Standards:
Trading Standards provide advice for businesses and is responsible for enforcing laws covering the safety, descriptions and pricing of products and services. Trading Standards Officers have skills in dealing with fraud, tricks and scams.

The Voluntary Sector or **Community Sector:**
The non-profit sector or 'not-for-profit' sector is the duty of social activity undertaken by non-statutory organisations. The sector should include adult safeguarding within their induction programmes.

Safeguarding should be integral to policies and procedures and policies, for example:

- Staff and volunteers are aware of what abuse is and how to spot it.
- Having a clear system of reporting concerns as soon as abuse is identified or suspected.
- Respond to abuse appropriately respecting confidentially.
- Prevent harm and abuse through rigorous recruitment and interview process.

The Voluntary and Community organisations can promote safeguarding and support statutory organisations through consultations on policy and developments, work on prevention strategies and promoting wider public awareness. The SAB has the discretion to invite membership to Voluntary and Community Sector and other regulatory bodies i.e. Ofsted. See: Involving volunteers, safeguarding and inclusion | London City Hall

5.3 Appendix 3: Adult Safeguarding and Homelessness (Reviewed by Gill Taylor 2025)

Introduction:
The purpose of this appendix to the London procedures is to provide an overview of current evidence and good practice in relation to people experiencing homelessness, as well as information about discrete law, policy and resources for workers.

The content of this appendix is drawn from a range of sources, including two Local Government Association/Association of Directors of Adults Social Services briefings[4] and the second national analysis of Safeguarding Adults Reviews[5]. Importantly, learning and resources from the Covid-19 pandemic are now included as are insights from the London Participation Network a group of people with lived experience of homelessness and social exclusion who work with Groundswell[6], to influence positive change in services and systems.

This appendix ends with two checklists that may be helpful for workers and decision-makers to understand opportunities to strengthen safeguarding policy and practice in your borough.

Definitions:
There are varied and sometimes conflicting definitions of homelessness in law and practice, with some experiences of homelessness highly visible, such as rough sleeping, whilst others remain hidden, such as sofa-surfing and living in cars.

In adult safeguarding, 'multiple exclusion homelessness' is a commonly used phrase that describes the interplay between homelessness experiences and other needs, risks and vulnerabilities. Multiple exclusion homelessness (referred to in the homelessness sector as multiple disadvantage[7]) comprises extreme marginalisation arising from interconnected experiences of childhood trauma, physical and mental ill-health, substance misuse and/or experiences of institutional care.[8] People who experience multiple exclusion homelessness often have care and support needs and are made especially vulnerable to all forms of abuse and neglect (including self-neglect) because of their circumstances.

Multiple exclusion homelessness is itself a safeguarding concern because it exposes adults at risk to heightened risks and discrete experiences of harm.

It is good practice to remain open to working with different definitions and understandings of homelessness and housing insecurity. The London Participation Network highlighted how negative social attitudes, and stigma can result in people downplaying their experience of homelessness to avoid shame, not realising they are homeless because 'hidden homelessness' is not well understood or, using words to describe where they live which may be unknown to you[9]. As a practitioner, it is good practice ask questions about where people are living, if they feel safe and secure where they sleep at night and what words they would like to use to describe their housing status.

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[4] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. London: LGA and ADASS, and Preston-Shoot, M. (2021) Adult Safeguarding and Homelessness: Experience Informed Practice. London: LGA and ADASS
[5] Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023 | Local Government Association
[6] Get involved with the London Participation Network | Groundswell
[7] Making Every Adult Matter (n.d.) About Multiple Disadvantage: About Multiple Disadvantage - MEAM
[8] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' Research, Policy and Planning, 33 (1), 3-14.
[9] For example, 'a bash' is a makeshift sleeping structure erected on the streets, usually from found objects and cardboard.

Tackling Stigma:
Stigma arises from socially generated biases about individuals or groups. People who experience homelessness have been characterised as untrustworthy, anti-social and unclean in law, policy and the mainstream media since at least the 17th century. Not only are these stereotypes of homelessness dehumanising, but they are also simply incorrect. Research shows that people who experience homelessness are significantly more likely to be the victims of crime than the housed population[10] and that experiences of victimisation are amongst the main causes of homelessness[11].

Research and lived experience testimony highlights the impact of stigma in professional responses to rough sleeping, mental health and addiction[12]. Importantly, stigma or anticipated stigma is understood to prevent people from reporting violent victimisation, hate crime and all types of abuse, due to fears of not being believed, no action being taken or even of being criminalised themselves. Stigma and prejudice towards homelessness is compounded for people who experience other forms of marginalisation and exclusion, such as racism, ableism and misogyny.

Importantly, when professionals frame abusive relationships, self-neglect or recurrent health crises using phrases such as 'lifestyle choice', the risks become normalised and decision-making becomes cynical, dehumanised and lacks creativity. The reasons someone might find it difficult to leave an abusive relationship, to accept an offer of accommodation or to engage with professional help are complex and individual, and using professional curiosity to understand more about the person's choices, fears and previous experiences will enable more generous and personalised decision-making.

Workers and system leaders must remain alert to practices and policy choices that give unconscious preference to individuals most likely to be viewed as safe, good and/or deserving of care and protection. It can be difficult to detect when words, actions or decisions are reinforcing stigmatising attitudes, so remaining open to feedback from colleagues and service users is good practice. It is especially crucial that procedures that give power to workers to exclude people, whether these are about personal characteristics, unacceptable behaviour or eligibility criteria, are developed and reviewed with an anti-oppressive lens[13].

Reflecting on the language you use to describe people is crucial to tackling individual bias and stigma. Team meetings, supervision and reflective practice are good places to reflect collectively and individually on the power and meaning behind commonly used phrases that describe experiences such as rough sleeping, drug/alcohol dependency, sex work and mental distress. Checking in with individuals about how they would like to be referred to, challenging the pre-judgements of colleagues and working with lived experience forums when developing policy and practice guidance, are small acts towards tackling stigma in safeguarding practice.

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[10] Newburn, T., & Rock, P. (2006). Urban Homelessness, Crime and Victimization in England, *International Review of Victimology,* 13(2), pp 121-156. Available at: Urban Homelessness, Crime and Victimisation in England - Tim Newburn, Paul Rock, 2006, Scurfield, J., Rees, P. & Norman, P. (2009) Criminal victimization of the homeless: an investigation of Big Issue vendors in Leeds, *Radical Statistics Group*. 99: Criminal victimisation of the homeless: an investigation of Big Issue vendors in Leeds

[11] MHCLG (2024) Statutory homelessness in England: April to June 2024: Statutory homelessness in England: April to June 2024 - GOV.UK

[12] Taylor, G., Clint, G., and Price, C. (2022) 'Seen but not heard: why challenging your assumptions about homelessness is a matter of life and death' in Preston-Shoot, M. and Cooper, A. (eds), in *Adult Safeguarding and Homelessness: Understanding Good Practice,* pp. 40-58. London; Jessica Kingsley Publishing; The Kings Fund and University of York (2019) Health and Care Services for People Sleeping Rough: Health And Care Services For People Sleeping Rough | The King's Fund

[13] SCIE: Anti-Oppressive Practice

Legal Literacy:
There are various legal powers and duties across the health, housing and social care sectors that are likely to be relevant when supporting adults experiencing multiple exclusion homelessness. Typically, legal duties are the foundation of decision-making around access to housing and social care. There is a somewhat complex interplay between the Care Act (2014) and Housing Act (1996) which is important to understand, to ensure that people experiencing homelessness can access housing, care and support that meets their needs without falling through the gaps.

Legal literacy[14] is a crucial element in making defensible statutory decisions and to ensuring the best use of discretionary powers and formal guidance when making decisions about individuals who do not fit neatly into legal definitions and criterion.

When safeguarding people experiencing multiple exclusion homelessness legal *powers* just alongside *duties*, enable creativity and person-centred decision-making around the provision of support and accommodation. This is especially useful when supporting an adult at risk is unclear or complicated regarding entitlement/eligibility for support. This is particularly relevant when looking to prevent the escalation of risk or need whilst assessments are being carried out, and when supporting someone who is rough sleeping with no recourse to public funds (NRPF) or other immigration-related restrictions.

The effective practice standard for multi-agency practice is evidencing the consideration of all legal options, including human rights responsibilities, powers and duties with respect to meeting care and support needs, mental capacity and referral to the High Court's inherent jurisdiction. Here, particularly, it may be helpful to draw on specialist legal advice, case law and on learning from Safeguarding Adult Reviews.

Learning from Covid-19 – Health:
Responses to homelessness at the height of the Covid-19 pandemic generated significant learning about effective safeguarding practice for people who experience multiple exclusion homelessness. Several research projects and reports have summarised this learning, including a recent policy paper series[15].

Learning from the pandemic reinforced the crucial role of inclusion health services in safeguarding homeless adults at risk. Timely access to well-informed primary care, mental health and substance use services saves lives and prevents future harm. Therefore, safeguarding concerns raised about people experiencing homelessness should always consider the individuals access to, and relationships with, relevant health services.

This is important because research had already shown that at least one third of deaths affecting people who rough sleep is from treatable conditions[16], with serious problems in accessing local GP registration, cancer screening and access to treatment for a range of conditions, leading to poor health outcomes. Another recent study highlighted that people experiencing multiple

[14] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. London: LGA and ADASS: Adult safeguarding and homelessness: a briefing on positive practice | Local Government Association
[15] Papers are written by various contributors, and cover the following topics – safeguarding, primary care, mental health, housing and data: Pathway Policy Papers for Inclusion Health – Pathway
[16] Aldridge R.W., Menezes D., Lewer D et al. (2019) Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England, Wellcome Open Research, 4:49: Caused of Death Amongst Homeless - wellcomeopenresearch

exclusion homelessness in their 40's are living with frailty that is equivalent to people in the mainstream population who are in their 80's[17].

In October 2023 NHS England published a national framework[18] to respond to the health inequalities faced by people experiencing homelessness and other marginalised populations, including sex workers, those leaving prison and Gypsy, Roma and Traveller communities. The framework emphasises the importance of an awareness of safeguarding in the provision of health services and recommends that every Safeguarding Adults Board has a named Inclusion Health lead.

Importantly for London, safeguarding and care planning activity for people experiencing homelessness is likely to require the involvement of multiple statutory agencies working across different boroughs and Integrated Care Systems. Hospital discharge planning, temporary accommodation arrangements and s117 aftercare support for people leaving mental health inpatient settings should prioritise proactive information sharing and multi-agency professionals' meetings, to ensure robust handovers and clarity about individual and agency responsibilities. Importantly, queries about someone's local connection or ordinary residence should not slow down collaborative action to respond to need or prevent harm.

Integrated Care Systems looking to understand and enhance their safeguarding practice for inclusion health populations should complete the OHID Inclusion Health Self-Assessment Tool, which can be found on NHS Futures. As well as the over-arching self-assessment, there is a linked self-assessment for safeguarding policy and practice which includes examples of good practice as well as pointing to areas where practice improvement is needed.

Taking a Whole Systems Approach:
Adult safeguarding is one element of a complex system of legal duties and powers, public and voluntary organisations, local and national services and frontline and strategic responsibilities around adult homelessness.

When working with individuals, this often means there are multiple organisations supporting a person and a range of needs and issues beyond those directly concerned with safeguarding duties and interventions. When considering strategy and governance, this often means that homelessness is a feature in the priorities of multiple SAB partners, and each will have a contribution to make to shape shared priorities around homelessness related system improvements.

Best practice indicates taking a whole systems approach, where informed local strategy and governance enables proactive multi-agency practice which, in turn, supports workers to work flexibly and creatively with individuals. The diagram below visualises the different layers of the system around an individual in need of support.

[17] Rogen-Watson, R & Shulman, C. & Lewer, D. & Armstrong, M. & Hudson, B. (2020) Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel, *Housing, Care and Support,* 23:3, pp. 77-91, Emerald Publishing Limited: Premature frailty, geriatric conditions and multimorbidity among people experiencing homelessness: a cross-sectional observational study in a London hostel | Emerald Insight

[18] NHS England » A national framework for NHS – action on inclusion health

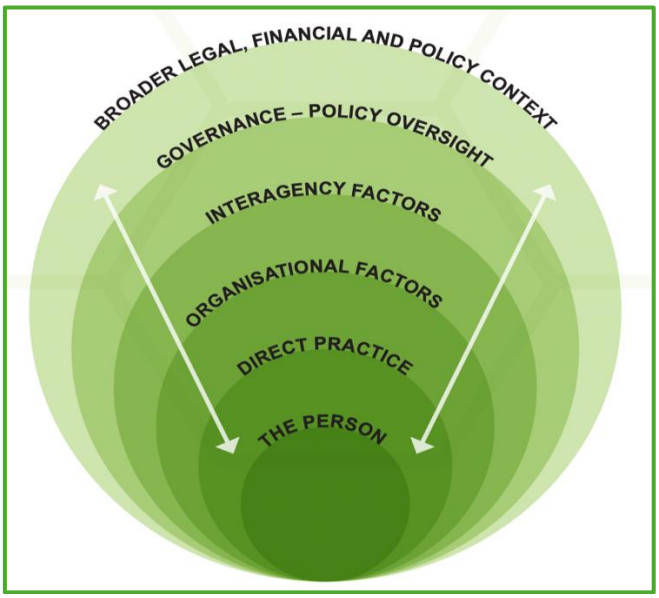

Figure 1: 'Whole System Understanding'

Although influencing the broader national legal and policy context are important elements of strategic leadership, taking a whole systems approach to safeguarding and homelessness focuses on four primary domains of operational and strategic practice within the direct scope of local systems: direct practice, organisational support, multi-agency factors and governance.

Direct Practice:
Safeguarding work with people experiencing homelessness is, in many ways, no different from working with any other adult with care and support needs who is at risk of abuse or neglect (including self-neglect). Person-centred practice, professional curiosity and anti-oppressive practice are key elements of effective direct work with all individuals, and there are a wide range of resources (some included at the end of this appendix) that can assist workers looking to expand their knowledge and skills supporting individuals.

Pace and Persistence:
Person-centred practice is key to working with people experiencing homelessness, core components of which are: being human, compassionately persistent, open and transparent, respectful use of language, listening and giving time and commitment. Effective practice involves hearing the voice of people with lived experience, identifying what is important to the individual, sharing reflections about possibilities and demonstrating professional curiosity about their history, about both the 'there and then' and the 'here and now' of their human story.

Importantly, working with people with complex histories of trauma and professional failure requires going at the pace of the person – it is their journey, in their time. Working toward change, which involves them fully, proceeds from this foundation and likely will take longer than with those adults who are less likely to start from a position of mistrust or caution. It may also require more persistence and tenacity to build trust and rapport; missed appointments of difficulties getting hold of someone on the phone should be considered important reasons to persist in trying to reach someone and not reasons to give up.

Flexibility:
Professional curiosity is especially important when there are episodes of non-engagement. Is the person unwilling and/or unable to engage?[19] Has sufficient account been taken of the impact of stigma and shame, or of how services are organised? Not everyone can manage office-based appointments at set times. Outreach may be more effective. Are services being sufficiently creative and flexible, making reasonable adjustments in line with the Equality Act 2010? Are the right questions being asked? It is too easy to close cases without stepping back to ask if everything has been done to stay alongside the person.

Advocacy:
Involvement of family and friends might assist with understanding and resolving issues of engagement although many people who experience homelessness have unusual family relationships which workers should remain open to. Are there circles of support to tap into? Where family and/or friends are not available, the principle of empowerment should lead to consideration of advocacy to enable people to participate in assessments and planning.

Informal advocacy is offered by many organisations working with people who experience homelessness in recognition that traditional and formal advocacy is often unprepared to support people whose needs extend beyond the traditional remit of adult social care. It is good practice to invite workers from grassroots community organisations, peer support services and charities to accompany people experiencing homelessness to meetings and appointments, and with the permission of the individual, to seek their observations, knowledge and insights into the persons health, care and support needs. See:

- Strengthening the role of advocacy in making safeguarding personal
- Reviewing advocacy for people with a learning disability and autistic people in mental health settings, which highlights key issues: A review of advocacy - NDTi

Recognising Trauma, Brain Injury and Fluctuating Capacity:
People who experience multiple exclusion homelessness are disproportionately affected by the cognitive and behavioural impacts of trauma, brain injury, drug and alcohol dependency. These impacts can be hidden and are easily misunderstood within stigmatising ideas of 'non engagement', 'lifestyle choice' and anti-social behaviour and aggression.

Research encourages workers to apply an understanding of executive capacity and how adverse childhood experiences, trauma, brain injury, substance misuse, coercion and 'enmeshed' situations can affect cognition and decision-making.[20]

Mental capacity assessments should explore, rather than simply accept, notions of lifestyle choice. Repeating patterns of behaviour, failure to follow through on expressed intentions and extreme reactions to seemingly mundane situations can be important indicators of these issues and require risk and capacity assessments to be conducted over time rather than in one-off meetings. Securing a clinical diagnosis of brain injury, post-traumatic stress disorder and neurodivergence can be challenging for people living with co-morbid substance misuse or mental health needs but can be crucial to understanding vulnerability to abuse and neglect.

[19] Braye, S., Orr, D. and Preston-Shoot, M. (2014) Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care. London: SCIE.
[20] NICE (2018) Decision Making and Mental Capacity. London: National Institute for Health and Clinical Excellence.

Organisational Factors - Supporting the Workforce:
For multi-agency support to be effective, organisations need to ensure that management support and organisational cultures enable confident and creative frontline practice.

Support and Supervision:
Effective and reflective supervision and line management are essential to enable staff to manage the demands of working with people who experience multiple exclusion homelessness. It is important that supervision recognises and responds to the distress and stress that can arise from supporting people living with complex risks, which should consider the evidence about vicarious trauma, moral injury and burn out[21]. Separating discussions about actions/outcomes from those about emotional impacts is good practice here.

Responsiveness to escalation of concerns is also an essential element of operational and strategic management. This may indicate that management intervention is required to enable action that falls outside the delegated authority of individual workers or to raise concerns about silo working at the appropriate level within the system. Strategic managers may want to consider repeated issues raised by staff when advocating for change in policy or procedure.

One feature of effective staff support is access to legal, safeguarding, mental capacity, mental health and housing specialists who can provide robust advice, challenge and guidance. One area where such access will be especially important is how organisations should support those with no recourse to public funds where options for reducing risk may not be straightforward. Such access promotes confidence and competence and enables operational staff to navigate complexity.

Permission and Flexibility:
People experiencing homelessness will not necessarily (be able to) respond to office or clinic-based services, may not be able to attend appointments at set times or may require support for longer periods than others. Organisations may need to consider how they are enabling frontline staff to build confidence in working flexibly and creatively, for example by encouraging home visits, street outreach or co-location with other teams.

Working flexibly requires confidence between workers and their organisations, particularly in instances where decisions made in good faith don't have the intended outcomes. Organisations should encourage positive risk-taking and should have clear mechanisms in place for staff to record their decisions, reflect on their outcomes and learn from things that did not go to plan without the fear of undue reprisal.

Workforce Development:
Effective workforce development in this area will invest in building the experience and skills of workers with the aim of enhancing their expertise around commonly occurring needs and issues, such as drug and alcohol dependency, fluctuating capacity and trauma. It also enhances staff wellbeing, enables workforce retention and enhances career development opportunities.

Training in legal literacy, trauma-informed care, mental capacity assessments, adult safeguarding and multiple exclusion homelessness are potential areas for knowledge and skill enhancement. Learning and development opportunities may be informal, such as shadowing

[21] Waegemakers Schiff, J., & Lane, A. M. (2019). PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector. *Community mental health journal*, *55*(3), 454–462: PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector | Community Mental Health Journal

other workers, and should prioritise learning from lived experience as well as from professional evidence and best practice. Workforce development will prove less effective if the workplaces that staff return to after training do not enable them to implement their learning, knowledge and skills.[22]

Safeguarding Adults Reviews (SARs) can be a useful source of learning[23] about gaps and opportunities in local service provision or challenges with service delivery. Learning can prompt system change by enabling multi-agency reflection and encouraging a local culture of continuous improvement.

Workforce development should also challenge stigma and work to undo siloed working between local authority departments and between agencies. It should also challenge commonly held but inaccurate beliefs about what constitutes care and support needs[24] and how adult safeguarding responsibilities should be engaged[25]. This is likely to mean a focus on the impact of chronic drug and alcohol dependency, dual diagnosis and self-neglect.

Team Cultures:
A key question for leadership to answer relates to what type of culture will characterise the organisation and its work with people experiencing multiple exclusion homelessness. Principles defined by 'Making Every Contact Count'[26] and 'Making Every Adult Matter'[27] approaches are strong examples of such cultures. Building supportive and collaborative cultures within and between teams may require policy and procedure development, for example around information-sharing, flexible eligibility criterion and how to understand overlapping needs holistically. Trauma-informed practice indicates the importance of humanising the organisation, its expectations of staff and the support available for those in frontline roles. It recognises the value of giving autonomy, permission and space to staff to devote time to build relationships, to understand a person's background and needs, and to respond in a personalised rather than process-driven manner.

Reflective practice can be effective in building strong team cultures and in responding to vicarious trauma. This can be externally facilitated by a specialist organisation or practitioner, or simply by someone independent from the team. It can be offered for teams working for the same organisation or for multi-agency teams working with a particular group of people. It is good practice for managers not to attend these sessions, unless invited by the team.

Interagency Factors - Team around the Person:
Safeguarding people experiencing multiple exclusion homelessness will usually involve multiple organisations, services and workers from diverse disciplines. Safeguarding practice should build on the expertise of all agencies involved, recognising that people experiencing homelessness are often most connected to third sector organisations and may also be supported by peer support workers and other informal advocates.

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[22] Braye, S., Orr, D. and Preston-Shoot, M. (2013) A Scoping Study of Workforce Development for Self-Neglect Work. Leeds: Skills for Care.
[23] Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews. London: Kings College London.
[24] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. London: LGA and ADASS: Adult safeguarding and homelessness: a briefing on positive practice | Local Government Association
[25] Hodson, B. and Lawson, J. (2019) Making Decisions on the Duty to Carry Out Adult Safeguarding Enquiries. London: LGA and ADASS: Making decisions on the duty to carry out Safeguarding Adults enquiries
[26] Public Health England (2016) Making Every Contact Count (MECC): Consensus Statement.
[27] The MEAM Approach (2019) Making Every Adult Matter. London: Homeless Link and Mind.

Lead Professional Arrangements:
Practice needs to be co-ordinated, and this can become more difficult when multiple agencies are involved. Working together requires those involved to understand each other's roles and responsibilities, and the knowledge and skills they can bring to meeting someone's unique set of needs. Whether or not co-located, the aim is to create a partnership, a multi-agency team around the person, to agree a clear purpose and to achieve a creative and flexible response.

One way of achieving this is by identifying a lead professional, who will be responsible for sharing information with the rest of the 'team around the person' and for acting as the main point of contact for the person. The lead professional does not need to be the most senior, or from a statutory agency, but should be selected based on their relationship with and knowledge of the individual and supported by the rest of 'the team' to take the lead role. Where possible, people should be encouraged to identify who they would want to be the lead professional in their care, and their consent sought for information to be shared with them. A robust outline of the role and function of the lead professional can be found in guidance related to children's safeguarding[28], and individual boroughs and partnerships may wish to develop their own specific to adults experiencing multiple exclusion homelessness in their area.

Lead professional arrangements should be documented in case records, and safeguarding concerns and enquiries should be shared with them, to enable effective information sharing and appropriate consideration in meetings and discussions with the wider team.

Information Sharing:
Effective information-sharing is built on the recognition that the law allows information to be requested and shared, proportionately, when necessary to safeguard the wellbeing of an adult at risk (Data Protection Act 2018). The Pan-London agreement (to be reviewed) on information-sharing sets this out in more detail and information sharing agreements between local agencies should be referred to where they are in place. It is good practice to establish multi-agency information sharing agreements that describe how people experiencing multiple exclusion homelessness can expect that information will be shared about them, in what circumstances and how they will be informed when this happens or asked for their consent. This is especially helpful to build trust and rapport between people and the agencies supporting them.

Effective information sharing when making referrals between agencies is crucial. Referrers should be careful to differentiate between fact and opinion, should draw on historical experiences sensitively and appropriately and should ensure that acronyms, diagnoses and sector-specific words are explained. For example, the word "vulnerability" used in a housing context has a different meaning to the social care context. The multi-agency team around the person is reaching for a common, shared language for understanding the person and their needs.

Information sharing is especially important when there are multiple agencies working with someone, especially where the risk of abuse and neglect may not be the same in all settings and situations. Feedback about the outcome of safeguarding enquiries (whether formal or informal) ensures that those raising concerns understand any action taken and can apply relevant information and learning to their work with the individual. This can be particularly

[28] Director General Education and Justice (2022) Getting it right for every child (GIRFEC) Practice Guidance 3 – The role of the lead professional: Getting it right for every child (GIRFEC) Practice Guidance 3 – The role of the lead professional

important for people who come into regular contact with police, who may not be aware that someone is vulnerable or in need of an appropriate adult.
Another aspect that has been shown to improve effective information-sharing is enabling shared access to relevant IT systems or shared case management approaches that enable professionals from across services to see and contribute to care planning and risk assessment and to build a shared understanding of the persons needs and wishes without them needing to repeat their story to multiple professionals.

Responding to Risk:
People living with multiple risk factors and as yet unknown or unmet needs may experience complex and ongoing risks and vulnerabilities. Avoiding the normalisation of, or desensitisation to, risk is important and requires agencies working with an individual to continuously reappraise risk and to avoid downplaying risks that occur repeatedly or arise due to the individuals perceived 'choices', such as rough sleeping, the use of drugs or alcohol or continuing relationships with abusive individuals.

One component of working effectively together is use of multi-agency meetings, whether framed as high-risk panels, complex case panels, harm reduction forums or multi-agency risk management meetings. These can assist with the often-reported difficulty of getting the right people around the table to understand risk and engage in shared problem solving. The focus of these spaces should be on sharing responsibility, working flexibly across boundaries and criterion, and offering creative ideas and solutions that may not be available to individual workers or teams. Respectful of each other's expertise, no handoffs are allowed. Plans should be agreed, with clear lines of responsibility, contingency planning and mechanisms for reviewing outcomes and should avoid.

For decision-making to be defensible, decisions and the reasons for them should be recorded alongside information about the factors considered and the actions to be taken by whom. When plans are agreed, it should be clear what aims are being sought and how the unfolding situation will be reviewed. It is good practice to talk to people about how they would like to be supported around risk and to explain what support is available. People should know what action to expect from agencies, especially if this may happen without their consent.

Transitions:
Learning from SARs indicates that transitions, including hospital and prison discharge, leaving care settings or when moving into an independent tenancy for example, can be positive opportunities that enable people to move forward in their lives. However, transitions can become 'cliff edges' when multi-agency arrangements fail, and people are left without proper support in place to manage the change[29].

Effective transitions rely on consistent communication between professionals and a shared commitment to centre the feelings and wishes of the person when conducting risk assessments and making plans to move people between the care and support of different agencies. Enabling short periods of overlapping support between agencies can be crucial here, especially when someone is moving between services or settings where the level of support is available is significantly changing.

[29] SARs identify transitions as critical points. See Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews. London: Kings College London. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' Journal of Adult Protection, 21 (4), 219-234.

Reviews[30] and national guidance[31] recommends that NHS Trusts review their discharge policies and procedures and work closely with housing and social care services to prevent discharge from hospital to no fixed abode and to ensure safeguarding and other risks are properly understood as part of the discharge planning process. Evidence from analysing 'out of hospital care' models indicates that integrated multi-agency support to enable safe discharge can reduce emergency readmissions by 25% and A&E visits by 56%[32].

People leaving prison are at significantly increased risk of exploitation and abuse from others, accidental overdose and of acute mental distress if they do not have safe accommodation identified upon release. Those identified at risk of homelessness should be supported by a multi-agency plan that proactively addresses care and support needs, safeguarding risks, housing needs and other support issues upon release. Discharge planning guidance[33] is clear that this should start *before release* to enable a smooth transition and that accommodation, health care and re-establishing family and other support networks should be prioritised.

Governance and Strategic Leadership:
The Safeguarding Adults Board (SAB) holds the statutory mandate for governance of adult safeguarding. However, there is no one model or location for the systems governance of homelessness and the following forums will all have a role to play:

- SAB and Children's Safeguarding Partnership.
- Health and Wellbeing Board.
- Homelessness Reduction Board.
- Integrated Care Partnership and Board.
- Community Safety Partnership.
- Combatting Drugs Partnership.
- VAWG Board.

What works may vary on individual borough and sub-regional structures. What's important is that strategic leadership and governance around homelessness is visible, values-driven and robustly evidence-led. Getting governance right will minimise silo working between departments and agencies, by providing strategic and holistic overview and direction. It should be straightforward to evidence collaboration between statutory and voluntary agencies in respect of how homelessness overlaps with health and social care responsibilities and activities, as well as how learning has informed improvement.
Establishing homelessness as a priority as part of SAB annual strategic planning can offer a mechanism through which to seek assurance from SAB partners and relevant boards and forums. Whatever governance arrangements are agreed locally, they need to be able to hold relevant organisations and system leaders to account for shared priorities, which will likely include regular reporting on safeguarding activity, improvement activity and relevant policy and strategy changes.

[30] See, for example, Taylor, G and Bateman, F. (2024) SAR 'Caleb', Redbridge Adult safeguarding Board: RSAB SAR Caleb Overview Report May 2024
[31] Department for Health and Social Care (2024) Discharging people at risk of or experiencing homelessness: Discharging people at risk of or experiencing homelessness - GOV.UK
and NICE (2022) Integrated health and social care for people experiencing homelessness: Recommendations | Integrated health and social care for people experiencing homelessness | Guidance | NICE
[32] Tinelli, M and Zhang, K (2023) Out-of-Hospital Care Models (OOHCMs) Programme for People Experiencing Homelessness, London School of Economics and Political Science Dashboard Oxford October 2023:
[33] Ministry of Justice (2022) HMPPS Pre-Release and Resettlement Policy Framework: HMPPS Pre-Release and Resettlement Policy Framework - GOV.UK

One responsibility of effective governance will be to ensure that lessons are learned from serious incidents and deaths and to seek assurance that recommendations arising from reviews are implemented robustly. Safeguarding Adult Reviews, whether mandatory or discretionary as per Care Act (2014) Section 44, are useful in identifying critical practice and system improvements. In addition, boroughs are increasingly adopting discrete Homelessness Fatality Review processes, which achieve best practice when conducted under Care Act powers in Section 44(4). Learning from such reviews indicates their value, not only in identifying learning and improvement opportunities, but also as a supportive mechanism for workers to explore and understand feelings of grief, guilt or frustration.[34] Importantly, reviews can identify national law and policy issues that SAB Chairs and other strategic leaders may wish to escalate with London and national policy makers.

Best practice in safeguarding and homelessness governance recommends the development of discrete briefing notes, policy and procedure guidance and workforce development opportunities that cement the importance of integration and collaboration between key partners. These may be particularly useful to set out expectations and responsibilities around complex issues such as self-neglect and mental capacity, but may also be employed to enhance legal literacy, respond to professional differences and to embed learning from SARs and Fatality Reviews.

Working Across Authorities or Boroughs:
Policy development and audit will need to focus on relationships and protocols, not just within a SAB's area but across local authority areas. This is particularly relevant for people experiencing multiple exclusion homelessness, who may frequently move between borough boundaries and where it may be deemed appropriate for housing to be in one place and for care, support and health services to remain in another. Protocols should be established at a senior level that provide clear guidance for agencies and their staff on the law relating to issues such as ordinary residence and transient people who present within a local authority's boundaries and local practice within and between agencies and boroughs about how to avoid 'hand-offs' and 'cliff edges' when supporting homeless adults with care and support needs.

It may be the appropriate for Safeguarding Adult Reviews and other learning and review activity to be commissioned by more than one borough. Such reviews might consider issues individual to boroughs and shared between them, with a focus on the gaps and opportunities around joint commissioning arrangements and other cross-borough initiatives that reduce barriers and increase choice and control for individuals.

Conclusion:
Effective safeguarding for people experiencing multiple exclusion homelessness relies on strong multi-agency collaboration that enables confident and proactive decision-making to reduce risk that centres the provision of person-centred and trauma informed support.

Although boroughs and SABs will want to develop local policies and procedures that reflect the population of people experiencing homelessness in their area, system and organisational cultures should prioritise embedding learning from SARs in the removal of barriers to accessing appropriate housing, health and social care and in enabling the frontline workforce to act creatively and flexibly.

[34] Preston-Shoot, M., and Taylor, G. (2022) 'Learning from Safeguarding Adult Reviews and Fatality Review' in Preston-Shoot, M. and Cooper, A. (eds), *Adult Safeguarding and Homelessness: Understanding Good Practice,* pp. 174-194. London; Jessica Kingsley Publishing

Importantly, effective safeguarding for adults experiencing multiple exclusion homelessness requires visible and values-driven leadership at the most senior level, as well as effective governance that builds a robust picture of need and experience to enable system improvements, integrated commissioning and effective multi-agency support for individuals. See:

- Safeguarding Multiple Exclusion Homelessness Toolkit 2023
- Mental Health Service Interventions for People Sleeping Rough – Pathway
- Safeguarding Adults at Risk | Homeless Link
- Understanding the Mental Capacity Act | Homeless Link
- Adult safeguarding and homelessness: a briefing on positive practice
- Making Safeguarding Personal | Local Government Association

Practice Checklist - Adult safeguarding Experiencing Homelessness:
This checklist will be useful for social workers, frontline workers and their managers.

It does not include everything you may need to do or consider but offers a framework to think about the knowledge, skills and ways of working workers need to support people experiencing homelessness.

Area	Checklist Item	Yes/No	If no, what action is required?
Awareness	Do you understand the different forms and causes of homelessness?		
Awareness	Do you know about the accommodation and support services available to people experiencing homelessness and rough sleeping in your area?		
Awareness	Do you understand how stigma affects people experiencing homelessness? Could you identify stigmatising language and behaviour in yourself and others?		
Awareness	Do you understand how self-neglect is expressed by younger adults, especially those who experience addiction and social isolation?		
Legal Literacy	Are you familiar with the legal duties to prevent and relieve homelessness under the Homelessness Reduction Act 2017?		
Legal Literacy	Do you understand the role of the Mental Capacity Act 2005 in relation to safeguarding decisions?		
Legal Literacy	Do you understand the Care Act 2014 intentionally low thresholds for assessment and safeguarding?		
Practice	Are you conducting thorough risk assessments that consider the health and wellbeing effects of homelessness alongside abuse and neglect, including self-neglect?		
Practice	Do you have clear procedures for escalating concerns about someone if risk management measures are not working?		
Practice	Does your role allow you apply a trauma-informed approach to working with people?		
Practice	Are you ensuring that individuals feel safe, heard, and respected in interactions?		
Person-centred practice	Do you ensure that people experiencing homelessness can make choices around the format, time, date and place they interact with you?		
Multi-Agency Working	Do you hold professionals' meetings about people experiencing homelessness, to learn		

Area	Checklist Item	Yes/No	If no, what action is required?
	who is in the 'team' and ensure relevant information is shared effectively?		
Multi-Agency Working	Do you have Lead Professional arrangements in place to enable better coordination between agencies?		
Multi-Agency Working	Do you have a multi-agency risk panel in your borough, where workers can go to seek help when supporting someone at risk?		
Multi-Agency Working	Do you know what to do if you and another professional disagree about a formal decision, such as mental capacity? Is there a policy or procedure about this?		
Multi-Agency Working	Do you work closely with others when someone experiencing homelessness is being discharged from hospital or prison to prevent discharge to the streets? Is there a hospital and/or Prison Discharge Protocol?		
Safeguarding Referrals	Do you understand your responsibilities around raising or responding to formal safeguarding concerns about people experiencing homelessness?		
Safeguarding Referrals	Do you communicate with other professionals when making or responding to a safeguarding concern?		
Safeguarding Referrals	Do you know what to do and who to speak to if you don't agree with a decision or action taken about a safeguarding concern?		
Support	Does supervision and 1:1 support from managers prioritise vicarious trauma and other emotional impacts of working with people living complex and risky lives?		
Support	Is reflective practice or another form of peer support in place, for workers to share their experiences and learning about working with people experiencing homelessness?		
Professional Development	Do you have access to training on the following subjects, that explicitly covers homelessness? - Self-neglect - Mental Capacity - Making Safeguarding Personal - Assessing needs - Trauma-informed care		

5.4 Appendix 4: Cultural Competency, Cultural Humility, and Cultural Safety (Written by Sola Afuape 2025)

1. Introduction

London is a diverse region with individuals from a wide range of cultural, ethnic, and socio-economic backgrounds. These are important considerations when responding to an individual's safeguarding needs given that cultural factors may influence the person's understanding of and approach to safeguarding and willingness to engage with services. To ensure effective and equitable safeguarding, it is critical that multi-agency professionals involved in abuse and neglect related assessments and interventions develop and use the necessary skills in Cultural Competency, Cultural Humility, and Cultural Safety.

This section provides guidance for workers to enhance their understanding and approach to working with individuals from all backgrounds.

2. Cultural Competency in Adult safeguarding

Cultural competency refers to the ability to understand, communicate, and interact effectively with people across cultures. It involves developing an awareness of cultural differences and integrating this understanding into safeguarding practice. Cultural competency helps professionals understand how cultural, ethnic, and religious factors may influence an individual's behaviour, decision-making, and interactions with services as well as the wider community dynamics that may influence safeguarding efforts.

3. Key Elements of Cultural Competency

- Understanding Cultural Differences: Workers must be aware of how culture influences behaviour, values, beliefs, and expectations. Cultural competence involves understanding the norms, practices, and values of different cultural groups and how they may affect an individual's experience of abuse or neglect.
- Effective Communication: Workers must develop skills in communicating across cultural boundaries, including language barriers, different communication styles, and the use of interpreters or culturally relevant resources.
- Recognising Cultural Biases: Safeguarding professionals must reflect on their own cultural biases and how these might impact their assessment of risk or their engagement with individuals from different cultural backgrounds. It is important to challenge stereotypes and ensure that decisions are based on individual needs rather than assumptions or cultural misunderstandings.
- Adapting Safeguarding Practices: Cultural competency requires flexibility in applying safeguarding policies and procedures, ensuring that they are sensitive to the cultural context of the individuals involved. This may include adapting interview techniques, risk assessment processes, or the types of support provided.
- Training and Education: Professionals should receive ongoing training to develop and maintain their cultural competency. This includes learning about the cultural backgrounds of the communities they work with and understanding the impact of cultural factors on safeguarding.

Practitioner's actions:

- Build one's knowledge base about the cultural backgrounds of the individuals they serve
- Share this knowledge with other workers and model best practice within multi-agency settings.
- Adapt care plans to reflect cultural preferences, including for example family dynamics, gender roles, and spirituality.

- Ensure that interventions are respectful and do not unintentionally marginalise or invalidate cultural practices.

4. Cultural Humility in Adult safeguarding
Cultural humility builds on cultural competency by emphasising an attitude of openness, self-reflection, and lifelong learning in working with individuals from diverse cultural backgrounds. Rather than assuming expertise in another culture, workers practicing cultural humility approach each case with a sense of humility, respect, and an understanding that there is always more to learn about an individual's lived experience.

Key principles of cultural humility:
- Self-Reflection: Workers must engage in ongoing self-reflection to identify their own biases, stereotypes, and assumptions. This reflection ensures that decisions are not influenced by unconscious prejudice, and that interactions with individuals are based on respect and empathy.
- Recognising Power Imbalances: In safeguarding cases, there may be a power imbalance between the professional and the individual at risk. Cultural humility acknowledges these power dynamics and actively seeks to involve the individual in decision-making, empowering them to express their needs and preferences.
- Openness to Learning: Cultural humility involves acknowledging that individuals are the experts on their own cultures. Workers should be open to learning from the people they are supporting, asking questions, and understanding the reasons behind certain behaviours or choices.
- Respectful Collaboration: Professionals should seek to further their understanding and practice through collaborating with individuals, families, communities, and cultural leaders when appropriate.

Practitioner's actions
- Engage in regular self-reflection to recognise, address personal biases and incorporate into supervision.
- Be open to learning from the individual’s own understanding of their cultural identity.
- Create a space where the individual feels empowered to make decisions that reflect their cultural values.

5. Cultural Safety in Adult safeguarding
Cultural safety focuses on creating an environment in which individuals feel safe to express their cultural identity without fear of discrimination or disrespect. This requires workers to have undertaken work to develop cultural competency and cultural humility. In safeguarding practice, cultural safety ensures that interventions are delivered in a way that recognises and affirms cultural differences, and that individuals are not marginalised or culturally harmed by the services offered.

Key aspects of cultural safety:
- Creating Safe Spaces: Workers must foster environments where individuals feel comfortable discussing their cultural identity and concerns. This includes being mindful of language barriers, religious practices, and culturally specific health beliefs. There may be tensions between an individual’s cultural beliefs and expectation and the practitioner’s or service provider’s need to effectively safeguard; safe spaces create opportunities for these to be carefully negotiated through respectful informed discussion.
- Ensuring Non-Discriminatory Practices: Cultural safety involves challenging discriminatory practices and ensuring that individuals from minoritised or marginalised groups are treated

with respect. Safeguarding workers must guard against imposing their cultural norms on the individual.
- Acknowledging Historical and Structural Inequalities: Some individuals from minority and minoritised groups may have experienced historical or systemic discrimination, which could impact their trust in formal services. Cultural safety includes understanding these dynamics and taking steps to rebuild trust with those who may feel marginalised or unsafe in institutional settings.
- Holistic and Person-Centred Approach: Cultural safety means considering the individual's entire cultural context—family structure, community ties, and traditions—when designing interventions. It also means listening to and validating the individual's lived experience, even if it differs from the professional's understanding.

Practitioner's actions:
- Engage with the individual in a way that respects their right to cultural expression, ensuring they are not made to feel unsafe or marginalised.
- Be sensitive to cultural trauma and past experiences that might influence the individual's relationship with services.
- Involve advocates who understand and can advise on key elements of cultural context, when needed, to ensure the individual's needs are being fully understood and respected.

6. Multi-Agency Approach to Cultural Competency, Humility, and Safety within Adult Safeguarding Practice

The integration of cultural competency, humility, and safety into adult safeguarding practice requires a multi-agency commitment to equity, diversity and inclusivity. This includes:
- Policies and Procedures: Safeguarding policies and procedures should explicitly reference cultural competence, humility, and safety. This ensures that professionals are aware of the cultural dimensions of their practice and are equipped to respond effectively to diverse communities.
- Multi-Agency Collaboration: Agencies involved in adult safeguarding must work together to share knowledge, resources, and expertise on cultural diversity. Collaborative working across organisations ensures a comprehensive response that is culturally informed.
- Community Engagement: Engaging with local communities and their leaders can help safeguarding professionals understand the specific needs and concerns of different cultural groups. Involving individuals from diverse backgrounds in the design and evaluation of safeguarding services ensures that the services provided are responsive and culturally safe.
- Evaluation and Feedback: Ongoing evaluation and feedback from service users and communities are vital for ensuring that safeguarding services are culturally competent, humble, and safe. This process allows workers to identify areas for improvement and adapt their practices accordingly.

Practical application at a local level requires that all workers involved in safeguarding assessments and interventions understand the importance of these principles. The following approaches should be incorporated into practice:

a. Comprehensive cultural assessment:

Each assessment should include a cultural component that considers how cultural factors may be influencing the individual's behaviour, care choices, and response to services. This includes:
- Identifying any relevant cultural, religious, or ethnic factors.
- Understanding the role of family, community, or religious groups in the individual's care and wellbeing.
- Considering any language barriers or communication challenges that might hinder the individual's engagement with services.

b. Building trust and engagement:
Establishing trust is essential when working with individuals. Workers should:

- Show respect for the individual's cultural values and demonstrate genuine interest in understanding their background and needs.
- Use culturally appropriate communication methods, such as engaging recognised advocates, support from community leaders or interpreters where appropriate and when necessary.
- Take time to build rapport with individuals, showing that their cultural identity is not only acknowledged but celebrated.

c. Collaborative approach:
Engage with the individual's family, regarded advocates, or other representatives with the relevant expertise to ensure that interventions are culturally sensitive and acceptable to the person at risk. This collaborative approach helps build trust and ensures that safeguarding measures are not imposed in a way that alienates the individual from the support they need.

d. Training and supervision:
Ongoing cultural competency, and safety training should be provided to all workers involved in adult safeguarding. This will ensure that they are equipped to:

- Recognise and address any cultural issues that may arise.
- Reflect on their own biases and assumptions through regular supervision and professional development opportunities.
- Implement culturally appropriate interventions while respecting the dignity and autonomy of the individual.

Inclusive practices to adult safeguarding:
Under the Equality Act 2010, there are nine protected characteristics that must be considered in safeguarding practice to ensure services and support are fair, inclusive, and non-discriminatory.

These characteristics are critical considerations when assessing risks and designing interventions that respect the individual's identity and lived experience. The Public Sector Equality Duty (PSED), as set out in the Equality Act 2010, further strengthens this approach by requiring public bodies to actively eliminate discrimination, advance equality of opportunity, and foster good relations between people with different characteristics.

By embedding the PSED into safeguarding practice, professionals can ensure that safeguarding interventions:

- Eliminate discrimination: Workers must be vigilant in identifying and addressing any form of discrimination that may arise based on an individual's protected characteristics, such as age, gender, race, or disability.
- Advance equality of opportunity: Safeguarding interventions should not be one-size-fits-all. Workers must ensure that care and support plans are tailored to the individual's needs, recognizing that different cultural, religious, social backgrounds and protected characteristics may require distinct approaches.
- Foster good relations: Safeguarding professionals should create an environment that respects and values diverse identities, promoting inclusion, mutual respect, and understanding, which helps break down barriers to engaging with safeguarding services.

Incorporating the nine protected characteristics into safeguarding practice is essential to fulfilling the Public Sector Equality Duty, ensuring that individuals at risk of abuse and neglect receive services that are responsive to their cultural, social, and personal needs, and that their rights and dignity are respected throughout the safeguarding process.

The 9 Protected Characteristics:

1. Age: Safeguarding practice must ensure that age-related factors, such as the needs of older adults or young adults, are considered when addressing abuse.
2. Disability: People with physical or mental disabilities may experience abuse and neglect in different ways, and they may require additional support or reasonable adjustments. Workers must ensure that care plans address their specific needs and guard against discriminate based on the nature of their disability.
3. Gender Reassignment: Transgender and non-binary individuals may face vulnerabilities, including social isolation or discrimination, which can exacerbate abuse. Safeguarding professionals should ensure their practices are inclusive and respectful of all gender identities.
4. Marriage and Civil Partnership: Family dynamics, including marital or civil partnership status, can influence abuse and neglect. In some cases, an individual's partner or spouse may be the source of neglect or may prevent the person from seeking help. Practitioners must consider how marital, or partnership status impacts the individual's wellbeing.
5. Pregnancy and Maternity: Biologically based as women who are pregnant or recently having given birth may face physical or mental health challenges that put them at risk of abuse or neglect. Safeguarding professionals should ensure they have the necessary information to ensure that there is access to the appropriate support, including health care services and practical assistance.
6. Race: Individuals from racialised communities experience of poor outcomes and access to support may impact their willingness to engage with services. Understanding racial dynamics and how racism can affect an individual is essential in understanding how it may lead to abuse and requires providing culturally competent safeguarding support.
7. Religion or Belief: Religious practices can play a crucial role in self-care and decision-making. Safeguarding professionals must respect religious observances and incorporate them into care plans, especially when these practices influence nutrition, hygiene, or care preferences.
8. Sex: Gender-related issues, such as gender-based violence or stigma, can affect women, men, and non-binary individuals differently when they are at risk of abuse and neglect. Safeguarding practice must ensure that all genders are treated equitably and receive support based on their unique needs.
9. Sexual Orientation: LGBTQ+ individuals may experience abuse due to discrimination or stigma. Workers must ensure that support is given is appropriate, respectful, and confidential, and that cultural safety is maintained throughout their engagement with safeguarding services.

7. Conclusion

Cultural competency, humility, and safety are essential principles in adult safeguarding. By integrating these concepts into practice and considering the protected characteristics outlined in the Equality Act 2010, there can be better understanding of the complex needs of individuals from diverse and cultural backgrounds, offering support that is respectful, inclusive, and tailored to the person's unique circumstances to ensure the best possible care. This approach also strengthens trust and collaboration between individuals and workers and services providers and supports compliance with the Equality Act 2010.

5.5 Appendix 5: Joint Protocol Between the MPS and ASC for Responding to an Adult Safeguarding Concern

Protective marking (including exemption)	Official Sensitive
Suitable for Publication Scheme Y/N	N
Purpose	Joint protocol between the MPS and ASC for responding to an adult safeguarding concern
Date	August 2024
Review date	August 2025

The Metropolitan Police Service (MPS) and Adult Social Care (ASC) joint response protocol for responding to a suspected wellbeing or safeguarding concern:
Purpose

The purpose of this document is to outline clear and well-defined protocols for how the MPS and ASC, across London, respond to suspected safeguarding concerns, including the roles and responsibilities of each organisation, and the timeframes for response. This will ensure cohesive and effective collaboration and serve as a structured framework for responding to safeguarding concerns promptly and comprehensively, enabling accountability and ownership.
This document is to be read in conjunction with London Multi-Agency Adult Safeguarding Policy & Procedures, ADASS 2019, or whichever document replaces it, and in no way replaces the guidance contained within.

Principles
The MPS and ASC response to a suspected safeguarding concern will be guided by the following principles:

- For any decision-making to be effective it must be legally literate. Decisions must conform to legislation that supports and protects the rights and safety of citizens. Legal obligations are non-negotiable in making these decisions.

- Decisions should be based on a shared understanding and application of fundamental principles that are at the heart of the Care Act (2014) and the associated Statutory Guidance. This introduces a duty to promote wellbeing and to adopt a flexible approach, focusing on what matters most to the individual.

- The six statutory adult safeguarding principles[35] (in the context of the Human Rights Act, 1998) underpin all aspects of adult safeguarding work. These should be clearly and openly addressed from the outset and placed at the heart of decision-making and action. Application of the six statutory safeguarding principles supports practice capable of achieving a wide range of

[35] Paragraph 14.13, Care and Support Statutory Guidance, DHSC, 2018 – Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability

responses tailored to meet the needs of the individual. Alongside this there must be transparency in applying the five principles of the Mental Capacity Act (2005).

- There must be a strong focus on the person concerned, the outcomes they want to achieve and how that may be accomplished (whether an enquiry is carried out under the s42 (2) duty or not). This is at the heart of Making Safeguarding Personal. Adults must be involved in decision-making and where the adult has a 'substantial difficulty' in being involved the support of a suitable person or advocate must be offered. However, if a person declines safeguarding support and/or a s42 enquiry that is not the end of the matter. Consideration should be given to ways in which the risk to the adult could be managed or mitigated.

- Make safeguarding personal - adult safeguarding is person-led, outcome-focused, engages the person and enhances involvement, choice and control, improves quality of life, wellbeing and safety.

- People are treated according to their needs and wishes. Respect for the rights and dignity of adults. Treating them with compassion and empathy.

- Taking a proactive approach to opposing discrimination, appropriately supporting victims, encourage reporting and prevention of future incidents.

- Transparency and information-sharing within the boundaries of legal and ethical considerations.

- Timely and appropriate responses to safeguarding concerns and enquiries.

- Regular monitoring, evaluation, and continuous improvement of our collaboration.

- A commitment to improving partnership working and fostering a culture of co-operation.

Joint response to a suspected safeguarding concern

Identification & recording:

- The MPS will identify and refer any adults who may require safeguarding or be classed as an 'adult at risk of abuse & neglect' as per the s.42 Care Act 2014 definition, to ASC. This will be done through a CONNECT 'Vulnerable Person to Notice' Investigation report. They will conduct a THRIVE+ risk assessment.

- This also encompasses 'wellbeing concerns' (MPS Green BRAG gradings) which fall outside of the s42 Care Act definition but under S1 & 2 Care Act (duty to promote wellbeing and Prevention of care and support needs). These will include adults where there are concerns about their wellbeing which affects their ability to manage day-to-day living. A CONNECT 'Vulnerable Person to Notice' Investigation will be created for these adults and referred by MASH to ASC.

MPS responsibilities:

- Where criminal offences have been identified the MPS will lead on the investigation, they will ensure adherence with the Home Office Crime Recording Standards. Where there is a safeguarding concern, the officer in the case (OIC) will keep ASC updated regularly with the progress of the investigation and plans where possible, this will include risk assessments and risk mitigation measures enacted. ASC staff will also be involved where needed to help

safeguard and mitigate risk of abuse/neglect/harm to the adult where this is relevant, this could include an application to the Court of Protection.

Local processes to be established to ensure suitable lines of communication by BCU Adult Safeguarding Leads and suitable representatives from ASC.

Standards of Connect VPTNs:

- The CONNECT 'Vulnerable Person to Notice' Investigation will contain sufficient detail to identify the adult, suitable methods of contact, as well as obtaining their views, where possible, and their views on their information/details being sent onto other agencies, or not where this is appropriate. It will outline what the safeguarding concern is, what the officer/staff member have done to keep the person safe and what area of concern are they wishing to highlight to the Local Authority.

  This will ensure that the report is of appropriate quality to enable an assessment as to whether a Safeguarding Enquiry or other input from ASC should occur to safeguard or meet any care and support needs the individual may have.

- Whilst it is expected that a CONNECT 'Vulnerable Person to Notice' Investigation is created at the point where any safeguarding concern is identified, there may be instances where this needs to be delayed. This might be required to gather further intelligence or personal details in relation to the subject, or to ensure any active operations/policing enquiries are not compromised. Any decision to delay the creation of a Connect report should be discussed, by the MPS officer/staff member dealing, with a line manager, and a risk assessment undertaken with any decision-making rationale documented locally. The report should then be created at the earliest opportunity.

Mental Capacity Act:

The principles of the Mental Capacity Act 2005 (MCA) should be always adhered to by MPS and Local Authorities. The MCA covers those who are aged 16 and over. Regarding police usage of the MCA, it is most likely to be necessary in emergency situations when officers are faced with someone lacking mental capacity, whose life may be at risk or who may suffer harm if action is not taken. In non-emergency situations (such as a pre-planned mental health assessment) other powers and tactical approaches may be more appropriate. If there is a chance that the subject may regain capacity to make a particular decision, and the matter is not urgent, then the decision should be delayed until later. Local authorities have additional powers and duties in respect of people who lack the mental capacity to make decisions on a matter. Such powers include taking proactive steps to ensure that an appropriate person is authorised to manage the adult's property and finances to prevent financial abuse.

- A person is considered to lack capacity in relation to a matter if at the material time, they are unable to decide because of an impairment of or disturbance in the functioning of their mind or brain. Since a lack of capacity cannot be established merely by reference to the person's age, appearance, condition or aspect of his behaviour, MPS officers are not required to carry out an MCA mental capacity assessment prior to a referral to the relevant MASH or ASC. Their observations should, however, be flagged in the referral.

- The following principles apply for the purposes of the MCA:
  (1) A person must be assumed to have capacity unless it is established that he lacks capacity.
  (2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
(4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

MASH processes:

- Once the MASH has received the report, they will review it and conduct intelligence checks, for appropriate reports, to establish what else the police know about that individual to inform subsequent decision making. A MASH supervisor is then responsible for risk assessing the report and assigning a grading (BRAG) along with accompanying rationale. They will then decide whether the report is shared with ASC, via locally agreed methods. A rationale for sharing, or not sharing, the report will be placed on the Connect report.

- Where the adult does not consent to their details be shared with other agencies. The MASH teams will utilise the following principles – where there is a risk to the person or others, a public interest consideration, or based on professional judgement or where there appears to be a non-negotiable statutory duty on the local authority to take action, then a referral will be made to ASC. The rationale for this will be recorded.

Support for victims:

- The MPS will be responsible for providing support to vulnerable adults who have been victims of crime, including those subjected to abuse or neglect. This support could include the utilisation of and referral onto other agencies or organisations, as well as bespoke assistance through the criminal justice system through the application of special measures under the Youth Justice and Criminal Evidence Act 1999 provision.

Working in partnership:

- The MPS will collaborate with other agencies to safeguard adults at risk of abuse or neglect. This includes coordination with ASC staff to attend s42 planning meetings/Safeguarding Enquiries to share information, assist with actions where they fall into the police's core responsibilities to ensure that adults at risk are effectively safeguarded, and their needs are understood. This also includes attendance and active participation in SABs and SARs. Each BCU will have a named senior officer, or officers, for this purpose.

SAR criteria

- MASH staff, when reviewing VPTNs, will consider whether they meet the Safeguarding Adult Review referral criteria under Section 44 of the Care Act 2014:

There is concern that partner agencies could have worked together more effectively to protect an adult with care and support needs if they:

- *die as a result of abuse or neglect, whether known or suspected; or*
- *where the adult would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life, as a result of abuse or neglect.*

The purpose of a SAR is to promote agencies' learning and improve practice, with the intention of reducing the risk of reoccurrence of the safeguarding incident.

Where MASH staff think these criteria may be met, they will inform their relevant BCU Adult Safeguarding Lead who will consider a referral into the SAB, following local processes.

Triage and review by ASC:

- Once the MASH has referred the safeguarding concern into ASC, this will be triaged and reviewed by ASC in a timely manner, taking account of any risk to that individual.

- ASC will involve the MPS in responding to safeguarding concerns – whether further information is required to assist with fact finding or MPS attendance is required at a s42 planning meetings /Safeguarding Enquiries to ensure that actions are set and co-ordinated across all relevant agencies. Where there is a crime report then the officer in the case (OIC) will be the main point of contact. In non-crime scenarios where police attendance/involvement is required, such as 'cuckooing', the person with relevant knowledge of the adult should attend. This will be decided at a local level based on who is most appropriate to attend given the circumstances. If escalation is required, then ASC supervisors should contact their designated BCU Adult Safeguarding lead. MASH staff will not attend s42 planning meetings/safeguarding enquiry meetings.

- ASC are the lead agency for Adult Safeguarding – if they decide that a s42 planning meetings /Safeguarding Enquiry is required then the MPS must attend unless there are exceptional circumstances.

See: What constitutes a safeguarding concern and how to carry out an enquiry | Local Government Association on challenges presented by the North East and East of England regions about safeguarding concerns across health and social care, including about organisational abuse and how this should be responded to and reported. Includes: What constitutes a safeguarding concern and carrying out safeguarding enquiries FAQs | Local Government Association.

Section 42 planning meetings/ Safeguarding Enquiry:

- The MPS role at a s42 planning meetings/Safeguarding Enquiry is to share relevant information that may assist with the safeguarding of that individual and agree actions to keep the person safe. This may include MPS officers/staff leading on actions where they fall into the police remit.

- If an MPS officer feels that a safeguarding meeting is required to assist them dealing with an issue relating to the wellbeing of an adult with care and support needs (whether they are classed as an adult with care and support needs or not) then they also have an obligation to raise this with Adult Social Care. This is best done through the BCU MASH supervisor who can obtain a point of contact within ASC for this to be discussed, and a course of action decided upon.

Feedback and learning:

- ASC will ensure that prompt feedback regarding the suitability, relevance or risk grading of the CONNECT 'Vulnerable Person to Notice' Investigation is fed-back into their police MASH supervisor, who can then raise themes and performance issues with the BCU Adult Safeguarding lead or relevant BCU supervisors.

ASC responsibilities:

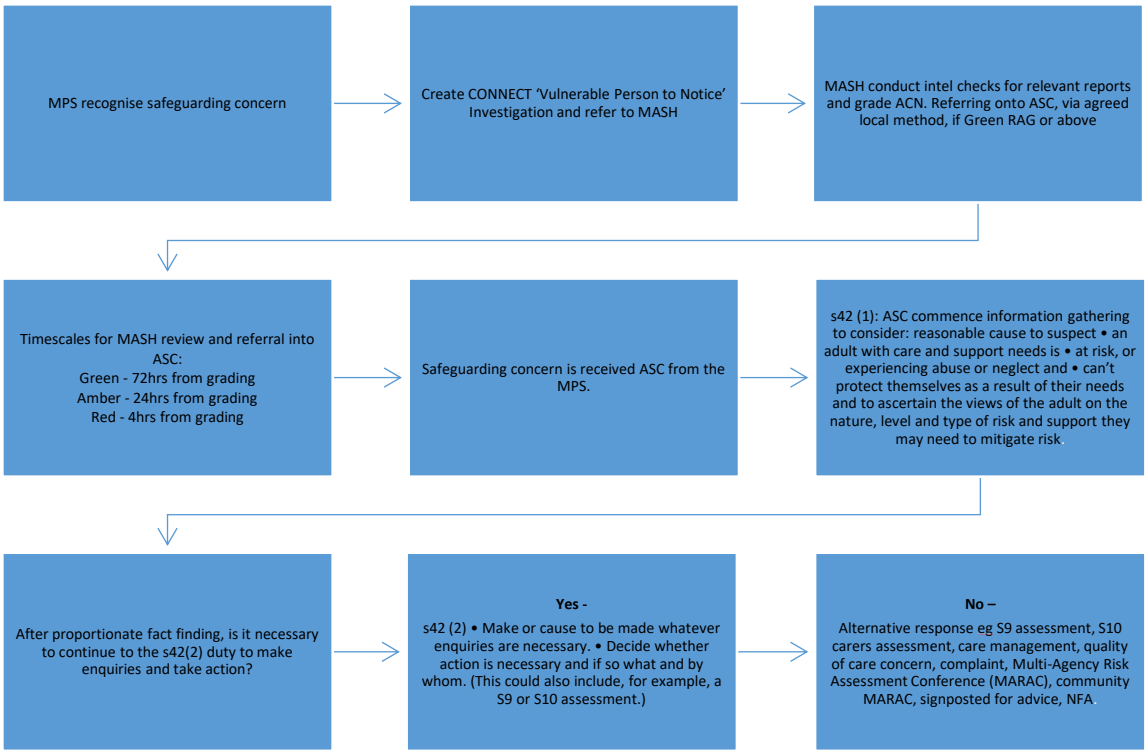
- ASC will lead on information gathering (under s42 (1) Care Act 2014) to consider if there is a reasonable cause to suspect an adult with care and support needs is at risk or experiencing

abuse or neglect and cannot protect themselves because of their needs. To ascertain the views of the adult on the nature, level, and type of risk and the support they need to mitigate that risk.

After proportionate fact-finding ASC should decide whether it is necessary to continue to the s42 (2) duty to make enquiries and act to safeguard, protect and mitigate harm to that individual. The s42 duty on the local authority exists from the point at which a concern is received. This does not mean that all activity from that point will be reported under the duty to make enquiries (s42(2) of the Care Act). It may turn out that the s42(2) duty is not triggered because the concern does not meet the s42(1) criteria.

- ASC will co-ordinate and provide appropriate support to adults at risk of abuse or neglect. They will develop individualised care plans that address the identified needs of adults aiming to support them and prevent future risk of abuse and neglect, involving social workers, police, healthcare providers, and support staff as needed.
- ASC will highlight any organisational learning relevant to the MPS in a timely manner to their BCU Adult Safeguarding Lead to ensure it can be acted upon where relevant.
- The Local Authority also has a duty under s2 Care Act 2014 to preventing needs for care and support - this states that the Local Authority must contribute towards preventing or delaying the development by adults in its area of needs for care and support. It must also have regard to the importance of identifying services, facilities and resources available to perform this duty.
- s9 Care Act refers to the Local Authority duty to assess care and support needs, unless the adult refuses that assessment. s11(2) places restrictions on who can refuse an assessment, and an adult at risk of abuse or neglect cannot refuse a s9 Care Act assessment. s27 Care Act then refers to a duty to review care and support plans and, where circumstances have changed in a way that affects a care and support plan, to carry out a reassessment of the person’s care and support needs.

Flow chart to show the process for the MPS and ASC working together to respond to a safeguarding concern[36]



Criminal offences –

Wherever practicable, the consent of the adult affected should be sought before reporting a suspected crime to the police. However, if an adult does not give consent but discloses a suspected crime to their professional, it is the professional's responsibility to consider reporting this to the police.

There may of course be circumstances where consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to contact the police. Whether or not the adult has the capacity to give consent, the police will need to be informed if other people are already or would be at risk. The police should also be informed where it is in the public interest due to the seriousness of the alleged criminal offence.

In certain circumstances an adult's right to confidentiality is overruled. Information about a suspected crime should be shared with the police in the following circumstances:

- If others are, or may be, at risk of abuse or neglect.
- Where there are legal or professional responsibilities of staff who have become aware of the concern, for example, if this relates to a breach of regulation, professional code of conduct, or an offence appears to have been committed.
- Where the adult to whom the concern relates lacks capacity and, in this situation, the Mental Capacity Act should be followed.

[36] Taken and adapted from *Making decisions on the duty to carry out Adult safeguarding enquiries, ADASS, 2019*

If the adult is believed to be subject to undue influence such that they are unable to exercise free will, for example Modern Slavery, controlling and coercive behaviour or domestic violence and abuse.

Where the safeguarding concern is referred into ASC from another agency, if there are criminal offence concerns this is to be reported either online, through 101 (non-urgent) or 999 (urgent). This will enable the matter to be investigated and officers to be dispatched to report the crime/safeguard the individual where necessary. MASH staff can give advice or clarify whether incidents are crimes. If a crime is evident in a safeguarding report that has not been recorded, then it is MASH staff's responsibility to ensure that the crime is recorded.

Where there are no criminal offence concerns, but police input is required from a research/intelligence point of view, then the police MASH supervisor is to be consulted to ensure intelligence checks on police indices are conducted and fed back to ASC.
Where there are no criminal offence concerns, but police input is required from safeguarding point of view, then the police MASH team, is to be spoken to ensure an appropriate point of contact is found to liaise with ASC from the adult's local Safer Neighbourhood Team.

Where 3rd party referrals have been received by ASC concerning adults where it appears a crime has been committed, these must be reported to police either online, through 101 (non-urgent) or 999 (urgent) even if consent of the adult has not been provided. The fact that consent has not been provided and provenance of where the information came from should be conveyed to the police. This will enable a crime to be recorded where needed and an assessment to take place about whether action is required to safeguard that individual/disrupt an offender as well as record relevant intelligence.

Request from ASC for information about an adult
ASC will inform the MASH through either the relevant locally agreed form or email. The MASH will complete a VPTN about the circumstances and intelligence will be conducted where relevant. This will be then sent back to ASC via the relevant mailbox and the requester of the information will be emailed so that they are aware that their request has been completed.
Timescales for MASH review and referral into ASC:

- Green - 72hrs from receipt
- Amber - 24hrs from receipt
- Red - 4hrs from receipt

Part Six Glossary, Acronyms and Further Information

Phrases, wording or acronyms have been used throughout this document. The following section provides more information and, where necessary, a definition:

6.1 Letters A-C

Abuse and neglect refer to the types and categories of abuse and neglect that can take many forms. Agencies and organisations should not be constrained in their view of what constitutes abuse or neglect and should always consider the circumstances of the individual case. Abuse includes physical abuse, domestic violence or abuse, sexual abuse, psychological or emotional abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational or institutional abuse, neglect or acts of omission and self-neglect.

Adults at risk is a person aged 18 or over who has care and support needs (whether or not those needs are already being met by the local authority), who is experiencing or at risk of abuse or neglect, and because of those needs is unable to protect themselves against the abuse or neglect, or the risk of it.

Adults safeguarding means protecting a person's right to live in safety, free from abuse and neglect.

Adults safeguarding lead is the title given to the member of staff in an organisation who is given the lead for adult safeguarding.

Advocacy is supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need. See:
- Providing independent advocacy under the Care Act: self-study pack for independent advocates
- Recommendations | Advocacy services for adults with health and social care needs | Guidance | NICE

Appropriate Adults is a specific role prescribed under the Police & Criminal Evidence Act 1984. The role of an appropriate adult is confined to instances where a police officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as a vulnerable adult and supported by an 'Appropriate Adult'. See:
- Appropriate Adult provision | London City Hall
- Appropriate Adults UK

Appropriate individual within this document an 'appropriate individual' is a person who supports an adult at risk typically but not exclusively in an advocacy role and is separate to an Appropriate Adult as described above.

Basic Command Unit (BCU) the regional units of the Metropolitan Police based on the 32 London Boroughs.

Best Interests - section 4 of the Mental Capacity Act 2005 (MCA) – see below states that if a person lacks mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf must do so in the person's best interest.

Best Interests decisions must take account of:

- Whether the person concerned is likely to regain capacity in relation to the decision in question.
- The participation of the person in the decision as far as this is practicable.
- In cases of life-sustaining treatment the decision must not be motivated by a desire to bring about the person's death.
- The past and present wishes, feelings, values and beliefs of the person (and any relevant written statement made by them when the person had capacity).

The views of people engaged in caring for the person or in his or her welfare or any person holding an Enduring or Lasting Power of Attorney or a court appointed deputy. If this has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

Caldicott Guardian UK Caldicott Guardian Council - GOV.UK **–** this is a senior person working in NHS and local authorities who is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

Caldicott Principles The Caldicott Principles - GOV.UK **–** there are 8 Caldicott Principles including: Justify the purpose(s) for confidential information; use confidential information only when necessary; use the minimum necessary confidential information; access to confidential information should be on a need-to-know basis; everyone with access to confidential information should be aware of their responsibilities; comply with the law; the duty to share information for individual care is as important as the duty to protect patient confidentiality; inform patients and service users about how their confidential information is used.

Care Act 2014 Care Act 2014 and Care and support statutory guidance - GOV.UK combined various existing pieces of legislation which previously shaped how social care was arranged in Britain. The intention was to make it easier for people to access care and how the public to understand why things happen in a particular way. Crucially it sets out key principles for adult safeguarding including that: local authorities must lead a multi-agency local adults safeguarding system; principles emphasising the involvement of people in assessing their safeguarding needs; an adult at risk is someone over 18 with care and support needs who is experiencing or at risk of abuse or neglect.

Care and support needs is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. For example, an older person, someone with a physical disability, a learning difficulty or a sensory impairment, with mental health needs, including dementia or a personality disorder, a long-term health condition or someone who misuses substances or alcohol.

Care setting or services is where a person receives care and support from health and social care organisations. This includes hospitals, hospices, respite care units, nursing homes, residential care homes, day opportunities/arrangements, befriending or advice services, housing support, and services provided in someone's own home by an organisation or paid employee via a personal budget.

Care at Home the Safe Care at Home Review was jointly led by the Home Office and Department of Health and Social Care (DHSC). This review makes the case that a stronger response is needed to protect and support people with care and support needs who are at risk of, or experiencing, abuse in their own homes by people providing their care. In care

relationships, deciding what is deliberate abuse, neglect or inadvertent harm may not be clear-cut. This makes it even more challenging to detect, report and investigate. This may be the case not just for professionals but also for the people experiencing the harm, who may not recognise themselves as victims. This could be due to several factors, such as the victims' dependence on their carer; the trust they place in their carer, the manipulation they experience; and the gradual and systematic grooming strategies which some perpetrators employ. In many cases, victims may feel unable to report the abuse as the abuser may be their only way of communicating with the community. They may feel dependent on the perpetrator for care and support and feel uncertain as to how they would be supported and cared for without the perpetrator.

Characteristics or conditions such as age, mental illness, disability, dementia or fluctuating mental capacity may also exacerbate barriers to reporting harm and abuse. See: Safe care at home review - GOV.UK

Carer is someone who spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. Throughout this document carers are referred to as a Family/Friend Carer as distinct from a paid carer, who is referred to throughout as Support Worker.

Channel Panel is a safeguarding programme aimed at supporting individuals identified as vulnerable from being drawn into violent extremism or terrorist related activity. Channel is reliant on a multi-agency response and multi-disciplinary work to minimise and manage the risk to an individual. Channel is voluntary so the individual must give consent. This draws on existing collaboration between local authorities, the police, statutory partners and the local community.

Closed cultures have been identified as a major risk to the wellbeing and human rights of people with care and support needs, who are unable to protect themselves from abuse or neglect, due to their care and support needs: See:

- Closed cultures in social care: Guidance and questions to ask | Local Government Association
- Closed cultures in social care: Guidance and questions to ask | Local Government Association

Commissioning is the cyclical activity, to assess the needs of local populations for care and support services, determining what element of this, needs to be arranged by the respective organisations, then designing, delivering, monitoring and evaluating those services.

Community Safety Units (CSUs) operate in every area in London with dedicated staff who receive special training in community relations, including local cultural issues. The CSUs will investigate the following incidents: domestic abuse, homophobia, transphobia and racism, criminal offences where a person has been targeted because of their perceived 'race', faith, sexual orientation or disability.

Community Safety Partnerships is a strategic forum bringing agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, Police, police authorities, local authorities, Fire and Rescue, Integrated Care Boards and the Probation Service**.**

Concern is the term used to describe when there is or might be an incident of abuse or neglect and it replaced the previously used term of 'alert'. (pre–Care Act 2014).

Contracting is how a process is made legally binding. Contract management is the process that then ensures that services continue to be delivered to the agreed quality standards.

Consent is the voluntary and continuing permission of the person to an intervention. It is based on adequate knowledge, likely effects and risks of the intervention, including the likelihood of any success and the alternatives.

Contemporaneous notes are notes taken at the time of a meeting, both in person and on-line, phone call, visits during an investigation.

CONNECT are reports completed by operational police officers and sent to local authorities where they have concerns about people who may be adults at risk, whether they are a victim, witness, suspect or member of the public. The police will decide about whether to refer to the local authority, using their operational toolkit.

Co-production: Working together as equals
The Care Act Guidance says local authorities should, where possible, actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and the community.

Co-production means people working together as equals to make decisions and design or deliver services that work for everyone. This might include those such as:
- People who use services.
- Others with lived experience.
- Unpaid carers.
- Professionals (like support workers, social workers, and healthcare staff).

Why is co-production important? Co-production is important because people who use services know their needs best. When they are involved in designing and delivering services, the results are better for everyone. Co-production leads to:
- More effective and relevant services.
- Empowered individuals and communities.
- Stronger relationships between people who use services and professionals.

How does co-production work?
- Equal Partners: Everyone involved in co-production has an equal voice.
- Early Involvement: People with lived experience must be included from the very beginning from planning and design to delivery and evaluation.
- Mutual Respect: All contributions are valuable. Everyone works together, listens to each other, and shares responsibility.
- Meaningful Participation: Everyone should be supported to participate in a way that works for them. See:
- Think Local Act Personal (TLAP) Home - TLAP This website has lots of information about co-production, including examples and practical tips. Including Top 10 Tips and the co-production hub. See:
- Co-production: what it is and how to do it - SCIE
- Making Safeguarding Personal: supporting increased involvement of services users
- Ladder of co-production - TLAP

The following guide was developed by Healthwatch Croydon and Healthwatch England, and whilst focused on Healthwatch, the process and steps provide a useful framework: How to coproduce with seldom heard groups

The **Safeguarding Ambassadors of Kensington, Chelsea, and Westminster** represent an excellent model of co-production in making safeguarding personal. This unique group comprises individuals from prominent service user groups who are deeply committed to preventing abuse and neglect. They play a crucial role in raising awareness of safeguarding issues that impact the wellbeing of local residents, empowering the communities within the Bi-borough to confidently respond to abuse and neglect. All awareness-raising resources are co-produced with the Safeguarding Ambassadors and include a variety of video materials designed to help everyone understand a range of safeguarding topics, as well as detailed information on what happens after a safeguarding concern is reported:

- Safeguarding Ambassadors - Safeguarding Adults Executive Board
- Safeguarding Ambassadors Videos - Safeguarding Adults Executive Board
- Leaflet Library - Safeguarding Adults Executive Board

Crime is an action or an instance of negligence that is deemed 'injurious to the public welfare or morals or to the interests of the state and that is legally prohibited'.

6.2 Specific Crimes That Relate to Abuse and Neglect

- **Corporate Manslaughter and Corporate Homicide Act 2007** is where a company's actions, or inactions can lead to a person's death.
- **Criminal Justice Act 1988** includes Common Assault.
- **Criminal Justice and Courts Act 2015** sec 20-25: offences involving ill treatment or wilful neglect
- **Domestic Abuse Act 2021** extended the controlling or coercive behaviour offence to include ex-partners and family members who do not live together; extended the offence of disclosing private sexual photographs and films with intent to cause distress to cover the threat to disclose such images; and created a new offence of non-fatal strangulation or suffocation of another person. The Domestic Abuse Act 2021 also created a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse.
- **The Domestic Violence, Crime and Victims Act 2004** created the offence of causing or allowing the death or serious physical harm of a child or vulnerable adult. A person can be found guilty of this offence if they were a member of the same household and had frequent contact with the adult.
- **Fraud Act 2006** includes criminal liability for fraud and obtaining services dishonestly.
- **Hate crime** legislation addresses offences motivated by hostility towards protected characteristics, including race, religion, sexual orientation, disability, and transgender identity.
- The **Crime and Disorder Act 1998** and the **Criminal Justice Act 2003** provide for harsher penalties for aggravated offences and mandate courts to consider prejudice as an aggravating factor in sentencing.
- **Mental Capacity Act 2005** creates an offence of ill-treatment or wilful neglect of a person lacking capacity by anyone responsible for that person's care. Unpaid Carers are not required to meet any specific care standards, however if the wilfully neglect or mistreat the person they care for, they can be prosecuted under s44 of this Act. Other Criminal Laws may also apply regarding financial abuse, physical assault, domestic abuse.
- **Mental Health Act 1983** including ill treatment or neglect of mentally disordered patients within hospital or nursing homes or otherwise in persons custody or care and unlawful sexual

intercourse with patients/residents suffering mental disorder. The offences against those with a mental disorder are split into three categories:

1. offences against a person with a mental disorder impeding choice, sections 30–33. This covers individuals whose mental functioning is so impaired at the time of the sexual activity that they are unable to refuse.
2. offences against those who have the capacity to consent to sexual activity but have a mental disorder which makes them vulnerable to inducement, threat or deception, sections 34–37.
3. offences by care workers against those with a mental disorder, sections 38–41.

- **Modern Slavery Act 2015** Section 52 duty to notify Secretary of State about suspected victims of slavery or Human Trafficking.
- **Medicines Act 1968** including unlawfully administering medication, injuriously affecting the composition of medicinal products.
- **Offences Against the Persons Act 1861** including grievous bodily harm with intent, grievous bodily harm, chokes /suffocates/strangles, unlawfully applies drugs with intent to commit indictable offence, poisoning with intent to endanger life/cause Grievous Bodily Harm or with intent to injure, aggrieve or annoy and assault occasioning actual bodily harm.
- **Public Order Act 1986** including affray, fear or provocation of violence, intentional harassment, alarm or distress, and harassment/alarm or distress.
- **Protection from Harassment Act 1977** including conduct amounting to harassment, injunctions against harassment, and course of conduct that causes another to fear.
- **Sexual Offences Act 2003** considers several offences designed to protect some of society's most vulnerable adults who have a mental disorder. The Act introduced several offences committed by care workers.
- **Serious Crime Act 2025** created the offence of controlling or coercive behaviour in an intimate or family relationship.
- **Theft Act 1968** including dishonest appropriation of property, robbery, burglary dwelling house, blackmail.

The Police have a statutory/legal responsibility to National Crime Recording Standards (NCRS) that once they are told about a crime or suspect one may have occurred (unless credible evidence suggests otherwise), irrespective of how it has been disclosed, there is a duty to then record that crime. That does not mean that on every occasion the police would automatically investigate and/or pursue a criminal justice outcome for that offence. See: Policy guidance on the prosecution of crimes against older people | The Crown Prosecution Service

Cuckooing or forced home invasion is where the home of a vulnerable person is taken over by an individual or a group. This can be for a variety of reason including facilitating sex work, dealing, storing or taking drugs, a place to live or to abuse the vulnerable person. It is also connected to 'mate crime' where someone is befriended with the intent to exploit them and County Line Drug Trafficking. See:

- Preventing and Disrupting Cuckooing Victimisation: Professional Toolkit | School of Law | University of Leeds
- Crime and Policing Bill: child criminal exploitation, cuckooing (home takeover) and coerced internal concealment factsheet - GOV.UK

Cultural capability is important for people working with diverse groups and ensures the effective communication and understanding across cultures. It is important that workers should not make assumptions, are aware of unconscious bias and used concerned curiosity. There are

several resources to support workers including: CFAB | Cultural Family Life Library There are three primary components:

- **Awareness**: Understanding one's own cultural biases and perspectives.
- **Knowledge**: Gaining information about different cultures, including values, beliefs, and practices.
- **Skills**: Developing the ability to communicate effectively and empathically with individuals from different cultural backgrounds: Cultural competence - Definition and Explanation - The Oxford Review - OR Briefings

6.3 Letters D-F

Data - see NHS England Digital Safeguarding Adults Collection (SAC) for relevant data trends over multiple years.

Defensible decision making is providing a clear, thought through rationale for any decision(s) made. This should be based on current legislation, practice and agreed tools to make an informed decision and should explain why the decision was made at that time.

Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Domestic abuse is the behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

- A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive.
- Behaviour is "abusive" if it consists of any of the following:
  - Physical or sexual abuse.
  - Violent or threatening behaviour.
  - Controlling or coercive behaviour.
  - Economic abuse.
  - Psychological, emotional, or other abuse.

It does not matter whether the behaviour consists of a single incident or a course of conduct.

- Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to acquire, use, or maintain money or other property, or obtain goods or services.
- For the purposes of this Part A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child). Two people are personally connected to each other if any of the following applies - they are, or have been, married to each other; they are, or have been, civil partners of each other; they have agreed to marry one another (whether or not the agreement has been terminated); they have entered into a civil partnership agreement (whether or not the agreement has been terminated); they are, or have been, in an intimate personal relationship with each other; they each have, or there has been a time when they each have had, a parental relationship in relation to the same child; or they are relatives.

Domestic Abuse Related Death Reviews (DARDR) formerly Domestic Homicide Reviews is carried out where a person has died because of abuse, violence or neglect by a relative, intimate partner or member of the same household. They were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004), Carried out by Community Safet Partnerships to ensure that lessons are learnt when a person has died because of domestic abuse, either by homicide or suicide.

Domestic Abuse, Stalking and Harassment and 'Honour' Based Violence (DASH) is a risk identification checklist used to help workers s identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Duty of Candour/ Whistleblowers A whistle blower is an employee, a former employee or member of an organisation who reports misconduct to people or organisations that have the power and presumed willingness to take corrective action.

Enquiry establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken. Previously this may have been referred to as a 'referral' (pre-Care Act 2014).

Enquiry Lead is the worker within each agency who leads the enquiry described above.

Enquiry Officer is the member of staff who undertakes and co-ordinates the actions under Section 42 (Care Act 2014) enquiries.

Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it is unlawful to treat someone.

Ethical International Recruitment - the Home Office allows professionals to come to a job in the UK working with the NHS, NHS supplier or adult social care to address shortages in the health and social care sector. There is a list of workers who can help boost workforce capacity, bring in additional skills and expertise, and help to provide a more diverse workforce that is more representative of those needing care and support. However, it can lead to safeguarding and quality issues and can raise market concerns. In some cases, it can enable exploitation of workers including people trafficking and modern-day slavery.

All workers are expected to have a Certificate of Sponsorship**.** See: International recruitment to adult social care: A guide for councils | Local Government Association

Executive functioning skills are the mental processes that allow people to manage daily tasks, plan, focus and regulate emotions. It is key in considering capacity under the Mental Capacity Act 2005.

Female Genital Mutilation (FGM) is often performed for cultural, religious, or social reasons within certain communities. However, it has no health benefits and can cause long-term complications such as infections, chronic pain, childbirth complications, and psychological trauma.

Forced Marriage is a serious violation of human rights and can have devastating consequences for the individuals involved. It often involves physical, emotional, and psychological abuse. Safeguarding measures are crucial to protect those at risk, and collaboration between law enforcement, social services, and community organisations is vital to provide comprehensive support and intervention.

6.4 Letters G-M

UK General Data Protection Regulation (GDPR) is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the UK. The GDPR

sets out the principles for data management and the rights of the individual, while also imposing fines that can be revenue-based: Data protection: The UK's data protection legislation - GOV.UK

Herbert Protocol is a national scheme which encourages carers to compile useful information which could be used in the event of a person going missing.

Human Rights Act Human Rights Act 1998 sets out that:

- People can defend their rights in UK Courts.
- Compels public organisations and the people who work for them such as Social Workers, Doctors teachers to treat everyone equally, with fairness, dignity and respect and uphold human rights.
- Protects everyone in the UK regardless of citizenship.

Inter-Authority Safeguarding or Cross-Authority Arrangements refers to inter-authority arrangements for Safeguarding Adults Enquiry and Protection Arrangements. See: ADASS Out-of-Area Safeguarding Adults Arrangements Protocol - ADASS (October 2025).

Independent Domestic Violence Advisor (IDVA) - Adults who are the subject of domestic abuse may be supported by an IDVA. IDVAs provide practical and emotional support to people who are at the highest levels of risk. Workers should consult with the adult at risk to consider if the IDVA is the most appropriate person to support them and ensure their eligibility for the service.

Independent Mental Capacity Advocate (IMCA) - Established by the Mental Capacity Act (MCA) 2005. IMCAs are mainly instructed to represent people who lack capacity where there is no one else, such as family or a friend, who can support and represent them independently. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

Independent Mental Health Advocate (IMHA) Under the Mental Health Act 1983 certain people known as ‘qualifying patients’ are entitled to the help and support from an Independent Mental Health Advocate. If there is a safeguarding matter whilst the IMHA is working with the adult at risk, consideration for that person to be supported by the same advocate should be given.

Independent Sexual Violence Advocate (ISVA) are trained to provide support to people in rape or sexual assault cases. They help victims to understand how the criminal justice process works and explain processes, for example, what will happen following a report to the police and the importance of forensic DNA retrieval.

Local Authority Designated Officer (LADO) – this is the person to notify in each Local Authority when there are allegations against staff or volunteers who work with **children.** Some local authorities have designated people to notify where there are allegations against staff or volunteers who work with adults.

LGBTQIA+ is an acronym used to refer collectively to lesbian, gay, bisexual, transgender, queer (or questioning) intersex, asexual, and more. These terms are used to describe a person's sexual orientation or gender identity.

Making Safeguarding Personal (MSP) is about person centred and outcome focussed practice. It is how professionals are assured by adults at risk that they have made a difference to people by acting on what matters to people and is personal and meaningful to them.

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders (MAPPA-eligible offenders) under the provisions of sections 325 to 327B of the Criminal Justice Act 2003.

Mate Crime is when a vulnerable person is befriended with the intention of exploiting them. This could include financial, physical or sexual exploitation.

Multi Agency Safeguarding Hub (MASH) is one model where information is shared, concerns are risk assessed, and decisions made about how concerns are taken forward. The MASH is a partnership of agencies, who are often co-located, that have a duty to safeguard adults and have agreed to share information they hold on adults at risk. Their shared vision for adult safeguarding is to work in an integrated way to improve information sharing and outcomes for adults at risk of abuse, harm, or neglect. In 2025 a new protocol was produced to support the interface between Police and Adult Social Care Safeguarding Adult services. See: Safeguarding and multi-agency working

Multi-Agency Safeguarding Reflective Practice Forum Purpose: A platform for all Safeguarding Adults Board staff to share and learn from safeguarding experiences. Benefits:

- Enhanced Collaboration: Encourages open communication and cooperation among different agencies, leading to more cohesive safeguarding strategies.
- Shared Learning: Provides an opportunity for partners to share insights, experiences, and best practices, fostering a culture of continuous improvement.
- Improved Outcomes: By reflecting on past cases and learning from them, agencies can develop more effective interventions, ultimately improving outcomes for vulnerable adults.
- Professional Development: Offers a space for staff to develop their skills and knowledge, enhancing their professional growth and competence in safeguarding.
- Supportive Environment: Creates a supportive network where staff can discuss challenges and successes, promoting a sense of community and shared responsibility.

Mental Capacity Act 2005 provides a legal framework for acting and making decisions on behalf of people who lack the capacity to make particular decisions for themselves. The Act includes that:

- a person must be assumed to have capacity unless it is established that they lack capacity.
- a person is not to be treated as unable to decide unless all practicable steps to help them to do so have been taken without success.
- a person is not to be treated as unable to decide merely because they make an unwise decision.
- an act done or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Mental Capacity Assessment. The Act says that:

- '*…a person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or*

disturbance in the functioning of the mind or brain. Further, a person is not able to make a decision if they are unable to:

- Understand the information relevant to the decision; or
- Retain that information long enough for them to make the decision; or
- Use or weigh that information as part of the process of making the decision; or
- Communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Key points:

- Mental capacity is time and decision-specific This means that an adult may be able to make some decisions at one point but not at other points in time.
- Their ability to decide may also fluctuate over time.
- If an adult is subject to coercion or undue influence by another person, this may impair their judgement and could impact on their ability to make decisions about their safety. Thus, an adult could be put under pressure, for example in domestic abuse situations, that they lack the mental capacity to make the decisions about their safety.
- Causative Nexus – the 'because of' test. If the adult cannot make a decision, is this because of an identified disturbance / impairment of the mind or brain?
- Executive functioning – consider if the adult can both express coherent answers and also put into effect the actions outlined in their answer.

Workers must satisfy themselves that the adult has the mental ability to make the decision themselves, if not, it is best to err on the side of caution, identify the risks and consider support or services that will mitigate the risk. Preventing the person from isolation can be a protective factor. Involving an advocate could assist in such circumstances.

The Care Act 2014 Section 68 requires that a local authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of an adult safeguarding enquiry or SAR where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate individual to help them. Advocacy support can be invaluable and may be provided by an IMCA or another appropriate advocate.

If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

See: Oversight regarding people who are detained: Guidance for leaders and managers: Prevention of ill treatment in places where people are deprived of their liberty – National Preventive Mechanism

Mental Health Act 1983 (amended 2007) and Mental Capacity Act 2005 - Practitioners can struggle to determine which legislation to use but there are important differences to the powers under each act, and the practitioner should always consider the least restrictive option. If an individual lacks capacity to consent to treatment for their mental disorder in hospital, then powers under the mental health act should be used and overrides the MCA.

The MCA is decision and time specific and follows five key principles to support practitioners in carrying out the assessment however the practitioner should always assume capacity unless it is provided otherwise. The Mental Health Act is used to ensure that people who need treatment for serious mental disorder receive this treatment, even against their wishes, if there are sufficient risks to their own health or safety or risks to the safety of other people.

Key areas under the Mental Health Act to consider:

- Section 127(1) and (2) state it is an offence for any staff member of a hospital or care home to ill-treat or wilfully neglect an inpatient or outpatient who is receiving treatment for a mental disorder. It is also an offence for a Guardian or other person who is caring for a mentally disordered person in the community.
- Section 135– a warrant may be granted to allow for the search and removal of a person to a place of safety.
- Section – 136 gives the Police powers to removed someone to a place from safety from a public place.

The MCA Code of Practice makes it clear that all professionals should seek to use the MCA to make decisions if that is possible rather than using the MHA. (Code of Practice chapter 13 introduction). See:

- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice - GOV.UK
- NHS England » Guidance to support implementation of the Mental Capacity Act in acute trusts for adults with a learning disability

6.5 Letters N-T

Natural Justice is part of a general duty to act fairly. There are 2 key principles to natural justice:

1. No-one should be judge in their own cause: There should be no actual bias, or the appearance of possible bias. This is sometimes summed up as "Justice must not only be done but must be seen to be done."
2. Hear the other party too: No-one should be judged without a fair process, in which they get to hear and respond to the evidence against them.

No Recourse to Public Funds - A Safeguarding enquiry and any subsequent actions can be made regardless of a person's immigration status. Schedule 3 of the Nationality, Immigration and Asylum Act 2002 does not prevent the local authority from undertaking a safeguarding enquiry and taking any necessary action to stop abuse or neglect when a person does not have lawful status. See:

- NRPF Network | Adult safeguarding
- Support options for people with NRPF | NRPF Network

Online harm

Online harm refers to any behaviour or content online that can cause physical or emotional harm to individuals, or that can be illegal. This can include a wide range of activities, from cyberbullying and harassment to the spread of misinformation and illegal content like child sexual abuse imagery: Understanding and reporting online harms on your online platform - GOV.UK

Open-mindedness ensures that partners approach adult safeguarding work with the aim of being open minded, concerned to avoid bias, considering all relevant evidence. Not accepting wishful thinking and other factors that threaten to compromise the evidence and making best judgements and decisions based on the most up to date evidence.

Ordinary residence means the local authority where a person is normally resident in. It broadly determines which local authority is responsible for meeting a person's care and support needs under the Care Act 2014.The test for adults with care and support needs, is the local authority in which the adult is ordinarily resident will be responsible for meeting their eligible needs. For

carers, the responsible local authority will be the one where the adult for whom they care for is ordinarily resident.

Out of area safeguarding - There will be occasions when the enquiry carried out by one authority relates to the actions or responsibilities of another, or other agency e.g. HR or complaints processes. Both local authorities and any other relevant agency (for example an NHS ICB or providers) would need, at an early stage to agree, at the most appropriate management level, the roles and responsibilities of each agency/organisation.

Where the nature of the allegation gives rise to a concern that the alleged abuse or neglect may be linked to systemic issues affecting:

- An NHS commissioned organisation, the ICB is accountable for the effective oversight and management of healthcare risks (where they do not fall under local authority assurance, e.g. safeguarding), including risks within independent healthcare providers as per the National Guidance on Quality Risk Response and Escalation in Integrated Care Systems.
- A whole organisation, there needs to be an early discussion between the local authorities (and any other relevant agency/organisation) with the possibility that this will lead to the local authority with s42 responsibilities carrying out a whole service investigation – with involvement of relevant partners as appropriate or necessary. This could include the relevant ICB, CQC (as the regulator), and the police if indicated.

There is an expectation that commissioners from both authorities and the NHS will be involved in any whole service investigation if the NHS commissioned or provided a service.

Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. See: What is PALS (Patient Advice and Liaison Service)? - NHS

Person/organisation alleged to have caused harm is the person/organisation suspected to be the source of risk to an adult at risk.

Procurement is the specific function to buy or acquire services which commissioners have duties to arrange to meet people's needs, to agreed quality standards, providing value for money to the public purse.

Public Interest Test refers to the test used under data protection legislation when deciding whether the public interest in disclosing information to protect a vulnerable adult justifies interfering with another individual's right to privacy.

Registered Intermediaries (RI) play an important role in improving understanding of the justice process for people who have communication difficulties. They help people to understand the questions that are put to them and to have their answers understood, enabling them to achieve best evidence for the police and the courts.

They have been facilitating communication with vulnerable witnesses in the criminal justice system in England and Wales since 2004.

Special measure includes practical and emotional support to victims and witnesses (either for the defence or for the prosecution) provided by the Witness Service. Support is available before, during and after a court case to enable adults and their family and friends to have information about court proceedings and could include arrangements to:

- Visit the court in advance of the trial.

- Consider the use of screens in court proceedings.
- The removal of wigs and gowns.
- The sharing of use of intermediaries and aids to communication.

If the person alleged to have caused harm is a young person or has a mental disorder, including a learning disability, and they are interviewed at the police station, they are entitled to the support of an 'appropriate adult' under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice. This service is now provided by commissioned services, funded through MOPAC. See: Appropriate Adult provision | London City Hall

There is an automatic referral to victim support services for all victims of crime whether they are deemed vulnerable or not, but care should be taken (within any protection plan) to ensure this has been offered.

Regulated Provider is an individual, organisation or partnership that carries on activities that are specified in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Right Care, Right Person (RCRP) is an operational model aimed at ensuring that the right emergency agency responds when there are concerns about someone's mental health, instead of the police being the default first responder. This is to ensure that individuals are supported by the right person, with the right skills, training and experience to best meet their needs at the right time. The Metropolitan Police Service (MPS) responds to health-related calls. See: MPS RCRP Policy - Final - Management Board Approved.docx

For partners to challenge a decision made under RCRP:
- Urgent – call 999 to speak to operator.
- Non urgent – contact via email: MetCCMailboxRightCareRightPersonProject@met.police.uk

The All Agencies Welfare Concerns Pan London Guidance outlines procedures and roles and responsibilities of staff that can be adopted in the event that there are concerns raised for the welfare of a person who is open to their service. The guidance, developed in consultation with partner organisations across London, including the MPS, provides a framework for considering risk and determining the most appropriate person or organisation who can help seek assurance that an individual is safe and well. It is the responsibility of local partner organisations to adopt this policy as they see fit to reflect local partnership arrangements.

Safeguarding Adults Manager (SAM) is the person who manages, provides guidance and has oversight of safeguarding concerns that are raised to the local authority.

Sexual Assault Referral Centres (The Havens) are sexual assault referral centres (SARCs) in London for people who have been raped or sexually assaulted within the past 12 months. If the assault took place more than 12 months ago, the Haven could provide information and signpost people to other organisations. If a person has reported the rape or assault to the police, first they will organise the visit to the Haven See: About us | The Havens

The Haven also takes self-referrals from people who do not wish to report to the police.

Referrals are also accepted from professionals in London such as GPs, sexual health clinics and A&E departments. This service is available 24 hours a day, seven days a week. Adults are only offered appointments through consent and direct initial contact following referrals. Havens

also offer follow-up medical and counselling care, including full health screening for sexually transmitted infections, a pregnancy test and emergency contraception.

Learning from Patient Safety Events (LFPSE) is the new national system for recording patient safety events. It provides two services:

- Recording a patient safety event.
- Access data about recorded patient safety events.

See: NHS England » Learn from patient safety events (LFPSE) service

System Quality Groups - Integrated Care System (ICS) System Quality Groups Chaired by Integrated Care Boards (ICBs) System Quality Groups provide a strategic forum to facilitate engagement, intelligence-sharing, learning and quality improvement across the ICS footprint. They play a key role in quality risk management within the Integrated Care System; helping to identify concerns and risks, diagnosing, and developing actions/improvement plans to mitigate and respond to risks, and overseeing implementation.

Types of adult safeguarding enquiries and who might lead them

Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect	Police
Domestic abuse (serious risk of harm)	Police chair the MARAC process and are supported by the MARAC coordinator and IDVAS
Anti-social behaviour (e.g. harassment, nuisance by neighbours)	Community safety services/local Policing (e.g. Safer Neighbourhood Teams).
Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)	Landlord/registered social landlord/housing trust/community safety services
Bogus callers or rogue traders	Trading Standards/Police
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department. Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (e.g. Local Authority, NHS ICB)
Fitness of registered service provider	CQC
Patient Safety Incident Response Framework (PSIRF)	Investigation by relevant NHS Provider
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2005 Deprivation of Liberty Safeguards (DoLS)	CQC, Local Authority, OPG/Court of Protection
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	HSE/CQC/Local Authority
Misuse of enduring or lasting power of attorney or misconduct of a court appointed deputy	OPG/Court of Protection/Police

Inappropriate person making decisions about the care and wellbeing of an adult who does not have mental capacity to make decisions about their safety, and which are not in their best interests	OPG/Court of Protection
Misuse of Appointeeship or agency	DWP
Homelessness	Rough Sleeping Team
Cuckooing	Police, Community Safety Officer, Housing
Faith Organisations	Police/Adult Social Care
Sexual Exploitation	Police/Adult Social Care
Online Harm	Police

Trafficking and Smuggling are the two most common terms for the illegal movement of people. Trafficking and smuggling are however very different. In human smuggling, the person will pay someone to help them enter the country illegally; after which there may no longer be an ongoing connection between the smuggler and the adult, although there may be a heightened risk of further abuse through debt bondage and other factors.

Trafficked victims are coerced or deceived by the person arranging their relocation, which can be a legal route across an international border, or within inside the U.K. The trafficked person is denied their human rights and is forced into longer-term exploitation where the abuser will continue to attempt to control the individual victim.

- Modern slavery victims: referral - GOV.UK
- NSA 2025 - Modern Slavery and Human Trafficking - National Crime Agency

Training:
Training and continuous professional development for health professionals:
Maintaining knowledge in safeguarding is vital for all public servants, particularly in the ever-changing landscape of health and social care.

All workers are encouraged to engage in local multi-agency training, usually supported by SABs. For NHS employees, safeguarding is a key topic in statutory and mandatory training.

NHS organisations should have a training strategy in place and ensure that any training product meets the standards of the UK Core Skills Training Framework. NHS England provides safeguarding training modules via the eLearning for Healthcare platform: Safeguarding Adults - elearning for healthcare

Many NHS organisations have incorporated these modules into their mandatory training systems.

Most NHS employees will undertake Level 1 and Level 2 training, being required to refresh their knowledge and learning at least every 3 years. Other staff, particularly clinicians, will be required to undertake and maintain learning at Level 3 and above, dependent on role.

The ‘Adult Safeguarding; Roles and Competencies for Healthcare Staff’ intercollegiate document (published by the Royal College of Nursing on behalf of several royal colleges and professional associations) provides non-statutory guidance for nursing and other health care staff to identify and develop the necessary knowledge, skills, competence, and behaviours to help ensure that adults at risk are appropriately safeguarded. The guidance sets out minimum

training requirements along with education and training principles designed to support the acquisition of knowledge, skills, and competency in the field of adult safeguarding, at various levels proportionate to an individual health care employee's role: Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing

In October 2024, the Royal College of GPs published their own Safeguarding Standards for use across General Practice: RCGP safeguarding standards for general practice

These standards cover safeguarding principles across the life course from infancy, childhood to adulthood and the learning requirements for Levels 1-3. The standards are relevant to the resources and context of general practice and are related to the role of GPs and general practice staff who provide universal health services to the whole population. GPs who are contracted to undertake the additional role of Named GP would be expected to meet the Level 4 competencies as outlined in the intercollegiate document published by the RCN.

Oliver McGowan Mandatory Training is the government's preferred training for adult social care and health staff. It is named after Oliver McGowan, a young man whose death shone a light on the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability.
See: Oliver McGowan Training Hub

See: Good practice in safeguarding training | Quick guides to social care topics | Social care | NICE Communities | About | NICE

Trauma informed practice is an approach by health and social care workers s grounded in the understanding that trauma can impact on people's psychological, social, biological and neurological development. It is seeing beyond the person's behaviours to 'what this person needs' rather than 'what is wrong with this person'.

There are six key principles:
- Safety - The physical, psychological, and emotional safety of people and staff is prioritised.
- Trustworthiness - organisation's policies and procedures are transparent, building trust among staff, people accessing services and the public.
- Choice - people are supported in shared decision-making, choice, and setting goals.
- Collaboration - all experiences are recognised and valued.
- Empowerment - Efforts are made to share power and give people involved a strong voice in decision-making, both individually and organisationally.
- Cultural consideration (as above).

6.6 Letters U-Z

Victim Support is a national charity, which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime, which includes information, emotional and practical support. Help can be accessed either directly from local branches or through the Victim Support helpline. Help and support - Victim Support

Victims Code the Code of Practice for the Victims of Crime is a practical guide for victims to understand what they can expect from the criminal justice system if they have been a victim of crime. It sets out the minimum level of service that victims should receive in England and Wales: The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK

VAWG Violence Against Women and Girls. See:
- Tackling violence against women and girls
- Tackling Violence Against Women and Girls | London City Hall

Vital interest a term used in the General Data Protection Regulation (GDPR) to permit sharing of information where it is critical to prevent serious harm or distress, or in life-threatening situations. See: Data protection: The Data Protection Act - GOV.UK

Vulnerable Adult Witnesses the Youth Justice Criminal Evidence Act 1999 include that people have a:
- Mental disorder.
- Learning disability, or
- Physical disability.

Intimidated Witnesses', section 17 of the Youth Justice Criminal Evidence Act 1999 define those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of:
- The nature and alleged circumstances of the offence.
- The age of the witness.
- The social and cultural background and ethnic origins of the witness.
- The domestic and employment circumstances of the witness.
- Any religious beliefs or political opinions of the witness.
- Any behaviour towards the witness by the accused or third party.

Also falling into this category are:
- Complainants in cases of sexual assault.
- Witnesses to specified gun and knife offences.
- Victims of and witnesses to domestic violence, racially motivated crime, crime motivated by reasons relating to religion, homophobic crime, gang related violence and repeat victimisation.
- Those who are older and frail.
- The families of homicide victims.