

Appendix to the suggested framework to support practice and reporting in relation to the duty to carry out safeguarding adults enquiries

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Appendix 1

Where/how do the six key safeguarding adults principles come into play in decision-making around the S42 duty to make enquiries?

What did participants in the LGA/ADASS workshops (November 2018) emphasise as important?

Safeguarding Adults Principle	What has this principle got to do with decision-making within the S42 duty?	What will help to support this?
<p>Empowerment</p>	<p>People should be involved at all stages of a safeguarding concern.</p> <p>In answer to a question: <i>How important is it that they talk to you about how they help? Right from the start?</i> a person using services said:</p> <p><i>“It is important they involve me as to how they can help. If it is worrying me, then best to let me know from the start. I would want to be ‘quietly involved’.”</i>¹</p> <p>When someone declines support, empowerment is not about walking away but rather supporting an informed decision in the context of presenting risks and weighing the person’s wishes against the duty of care.</p>	<p>Making the right information available in the right way to inform and involve the person from the beginning. Making sure that, when asked the approach they want to take, the person has the right information on which to base their decision.</p> <p>Using language that is understandable and avoiding jargon.</p> <p>Supporting the person so that they have a competent and confident voice.</p> <p>Having the right person to support the individual - whoever the person feels is right for them.</p> <p>Accessibility of advocacy support (including within MASH and triage arrangements)</p> <p>In cases where the person declines support, staff need to be supported and competent/confident to know where the level of risk and legal responsibilities indicate that doing nothing is not an option.</p>

¹ A comment from conversations with several people at 5 different services across Cheshire East; adults with learning disabilities and physical disabilities.

Safeguarding Adults Principle	What has this principle got to do with decision-making within the S42 duty?	What will help to support this?
<p>Prevention</p>	<p>‘It is about working together to reduce the chances of something happening; that’s what it’s all about!’²</p> <p>People can be supported to keep themselves safe without an enquiry under S42. This is a sign of success not failure.</p> <p>Information and data needs to capture this activity and its outcomes locally to demonstrate effective early intervention and prevention alongside the SAC data.</p>	<p>Establish local mechanisms for recording safeguarding concerns, activity and outcomes where the S42 duty is not met, and safeguarding actions are taken under powers rather than duties. This facilitates understanding where local risks and issues are and where to target early intervention and prevention.</p> <p>Establish a shared understanding across organisations about provider quality concerns and safeguarding concerns. There needs to be clarity locally about routes for dealing with and <i>recording</i> the range of these concerns.</p> <p>Working proactively with all providers to pre-empt situations where a decline in care quality could result in abuse or neglect. Offering support to providers to identify and deal with the underlying problems.</p> <p>Build in a system of learning across the multi-disciplinary team to support this area of practice.</p> <p>Work with local community groups to raise awareness about people’s rights to protection against abuse and neglect and identify pathways for concerns to be raised.</p>

² Observation from participant attending one of the S42 workshops (November 2018)

Key Safeguarding Adults Principle	What has this principle got to do with decision-making within the S42 duty?	What will help to support this?
<p>Partnership</p>	<p>“We need multi-agency agreement and collaboration from concern to outcome”.</p> <p>Be clear about information sharing. Not undertaking an enquiry under S42 does not preclude sharing information.</p> <p>Initiating an enquiry under S42 is sometimes seen as a ‘passport’ to a multi-agency discussion. This should not be necessary and can usefully take place at the preliminary stage of assessing a concern and considering the most effective response.</p> <p>The Care Quality Commission has developed clear guidance about circumstances in which notifications must come from providers to CQC. This is clear regarding medication errors and says that these should only be notified where there is a degree of harm to the individual(s). This work will support system wide learning and greater clarity about the nature of safeguarding concerns and enquiries under S42 and quality issues.</p>	<p>Strong partnership between commissioning and contracting teams, supporting shared understanding and more consistent responses for effective outcomes.</p> <p>Strengthening this partnership through protocols with providers. When the local authority ‘causes’ a provider to make enquiries, it is made clear what is being asked of them. Local information and data needs to be capable of showing the impact of this work on safeguarding.</p> <p>Developing a shared understanding and conversations about the appropriate route for dealing with situations. Partners know what to refer into the local authority and, when they do so, they are clear as to which route will be taken to address the concerns.</p> <p>Share tools to support decision-making across sectors. For example, the Care Quality Commission plans to develop scenario-based advice for providers on notifications. This will be helpful across local authority areas in shared conversations about what is a concern or an enquiry under S42.</p>

Key Safeguarding Adults Principle	What has this principle got to do with decision-making within the S42 duty?	What will help to support this?
<p>Protection</p>	<p>“Making Safeguarding Personal is not an excuse to walk away”³</p> <p>If a person declines safeguarding support and/or a S42 enquiry that is not the end of the matter. Empowerment must be balanced with Duty of Care and the principles of the Mental Capacity Act must come into play. Best practice in working with risk must be considered (see under Empowerment, above)⁴ Protection and safety must be balanced with wellbeing.</p> <p>Whatever the decision about undertaking an enquiry under the S42 duty, the objective is to understand if there is any risk to the person and, if so, to support the person to reduce it if possible. Staff need to be clear on what they are doing if they don’t undertake a S42 enquiry. They need to record this or it won’t be clear that individuals, about whom an enquiry under S42 is not carried out, have nevertheless been ‘protected’ (i.e. the risk has been reduced).</p>	<p>Have a clear local understanding about what will lead to an enquiry under S42 and how to record that decision.</p> <p>Be equally clear in recording actions outside an enquiry under the S42 duty, which may include:</p> <ul style="list-style-type: none"> • Pass to quality assurance team – for specific targeted interventions or as part of a wider care service surveillance • Care Act (2014) Assessment (S9) • Carers Assessment (S10) • Referral to other agency (GP, Police, Other LA, Acute Health, MH, Domestic Abuse Services etc.) • Formal Complaint • Advice & Information⁵ • Any other actions

³ Observation from participant attending one of the S42 workshops (November 2018)

⁴ <https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/working-risk>

⁵ LB Bexley presentation S42 workshop, LGA/ADASS, November 28, 2018

Key Safeguarding Adults Principle	What has this principle got to do decision-making within the S42 duty ?	What will help to support this?
Proportionality	<p>“We will always acknowledge when safeguarding duties apply but the recommendation and decision to close will also evidence the principle of Proportionality, the least intrusive response appropriate to the risk presented”.⁶</p>	<p>Having clarity in policies and procedures (locally or regionally) about the range of support options outside safeguarding services and activities that could be used to reduce risk or harm.</p> <p>Having a decision-making tool that assists people who are referring a concern to see the different levels of risk of harm and the route for support which would be most likely and appropriate.</p> <p>Monitoring and reporting on the outcomes for people who receive support outside of an enquiry under the S42 duty, to ensure that these are positive and effective. This is also important in the context of accountability (see next section).</p>

⁶ Devon County Council presentation S42 workshop, LGA/ADASS, November 28, 2018

Key Safeguarding Adults Principle	What has this principle got to do with decision-making within the S42 duty?	What will help to support this?
<p>Accountability</p>	<p>“...data collection is important to me as someone could be seriously hurt without looking at the wider picture to stop abuse”.⁷</p> <p>Within this principle the practice and the recording of making decisions on S42 enquiries come together.</p> <p>Accountability means:</p> <ul style="list-style-type: none"> • being able to explain how an issue has been addressed; • accounting for actions taken; • accepting responsibility for actions and outcomes; • understanding mutual roles across organisations • reporting regularly and openly on the above • acting to address problems 	<p>Transparency and openness about the process, approach and understanding and recording why the approach that was taken supports accountability.</p> <p>Having a comprehensive assurance framework that enables the SAB to triangulate information and test out whether the system is working as it should.⁸ This would include:</p> <ul style="list-style-type: none"> • Case file audits • Monitoring outcomes for people • Feedback from people who have had safeguarding support • Internal audit • Benchmarking and peer review against other authorities in the region • Discussions across the region to understand the differences and the issues (as in Yorkshire and the Humber)

⁷ A comment from conversations with several people at 5 different services across Cheshire East; adults with learning disabilities and physical disabilities.

⁸ The MSP outcomes framework and examples of audit tools available will support this <https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal>

Appendix 2

Legal Literacy

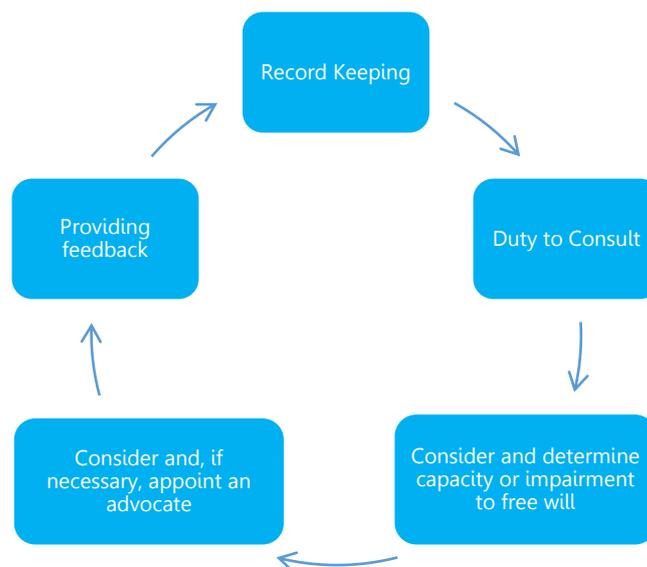
Core Message One

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.

Each matter must be decided on the facts of that specific case, taking into account the duties in legislation, regulations and guidance. As these are public law decisions practitioners must also be confident that they can demonstrate, in Court if necessary, that they have:

- Upheld principles that decision-making is **lawful, reasonable and fair**
- Protected against breaches of the adult's human rights and advanced the principles of the Equality Act 2010
- Ensured that all decisions respect autonomy and that where there is reasonable cause to believe a person lacks capacity that all decisions are made with regards to the duties set out in the Mental Capacity Act 2005. Practitioners also need to be mindful of external pressures than can impair free will, and
- Met obligations under the Data Protection Act 2018 and regulations.

The diagram below illustrates a process for sound decision-making⁹. It is important to remember that all safeguarding decisions are public law matters that can be challenged -by the adult concerned, their representative or by the person accused of causing harm - through a complaint or judicial process.



⁹ This diagram is from Fiona Bateman's presentation to the LGA/ADASS workshops in November 2018

For an enquiry to be conducted under S42 there must be “reasonable cause to suspect” that an adult covered by the scope of the legislation is suffering, or at risk of suffering, abuse or neglect. In many cases this may be achieved through initial, information gathering to establish the facts, in other cases more detailed exploration may be necessary. This should involve the adult concerned and requires the use of professional judgment to weigh up all available evidence (proactively looking for corroborating information) obtained from a proportionate review of case records and other relevant enquiries.

Appendix 3

Why are there significant differences in the proportion of concerns dealt with within the S42 duty to make enquiries? Reflections from the workshops (LGA, November 2018)

It was never the intention of the Care Act (2014) to impose a rigid and prescribed set of processes on local authorities for the protection of adults against abuse and neglect. Indeed, one of the major criticisms of practice under the preceding 'No Secrets' guidance was that it was too process driven and did not have the flexibility to respond fully to the wishes of the adult concerned.

"We're doing safeguarding work and activity in different ways. That might be alright. We should accommodate differences in the ways we support people to manage risk"¹⁰

It was clear from the workshops that staff take different approaches in terms of how they respond to the duty to conduct safeguarding enquiries in individual circumstances. However, the degree of inconsistency and uncertainty supports an argument for suggesting a way of achieving greater consistency and confidence going forward. The term used to describe how the advice in this paper might be used was as 'scaffolding' to support practice. The suggested way of interpreting the relevant aspects of the Care and Support Statutory Guidance (DHSC,2018), including being explicit in putting into practice the six safeguarding adults principles, is one part of that scaffolding.

Arrangements for first contact with the local authority

There is a range of organisational structures and processes across the country for receiving and acting on safeguarding concerns.

Almost half of local authorities have a triage process for evaluating concerns initially¹¹ and NHS Digital have calculated that about 50% of concerns go no further than this stage. In many councils, concerns will go to a generic team (usually one which deals with all enquiries about social care and support) who will determine whether it is a safeguarding matter and therefore whether it should be referred on. For instance, in many areas, concerns that relate to care quality will be referred to the team dealing with care contracts and commissioning rather than being treated as a safeguarding concern.

The skill sets within these teams vary. Some include qualified social workers but others do not. Some of these teams will gather information, usually by obtaining other information from their records and by telephoning or emailing the relevant people who can help establish the facts. The information gathering may go no further than this or it may be referred on to another team for further work. How this information is recorded also varies. Some will be reported as enquiries under S42(2), others as concerns and some may not be reported at all within safeguarding.

¹⁰ Observation from a participant attending one of the decision-making workshops in November 2018

¹¹ Safeguarding Adults Collection, Survey of Local Definitions 2018, NHS Digital, November 2018

In some areas the concern will be received by a Multi-Agency Safeguarding Hub (MASH) and recording practices also vary within these. This may result in a higher number of concerns being recorded in some areas which, in turn, affects the proportion of concerns that become enquiries under S42(2).

In other areas concerns go directly to a specialist safeguarding team in the local authority without being triaged by a 'first contact' team.

The variety of organisational and staffing arrangements for first receipt of a safeguarding concern is highlighted as a contributing factor to the variations in recording and reporting decision-making practice.

Views of the person concerned and the extent to which (and how/at what point) these influence decision-making

The principle of shared decision-making, involving people in clinical or professional decisions that affect their lives, should underpin good health and social care practice. This is the bedrock of Making Safeguarding Personal. Conversations with service users in Cheshire East generated comments including:

“It is important that I know what is happening to me, no decision about me, without me”

“It is certainly important to have control, be respected and listened to. I would want a worker to be pleasant and respectful and chat to me - not go off on their own agenda.”

This is reflected in the Care and Support Statutory Guidance (DHSC, 2018)¹² which states that *“policies and procedures should assist those working with adults how to develop swift and personalised safeguarding responses and how to involve adults in this decision making”*. The guidance assumes that adults have capacity to take part in decision-making but that where the adult has a “substantial difficulty” in being involved that a suitable person or advocate must be found to support them¹³.

The Care and Support Statutory Guidance (DHSC, 2018) states *“The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult’s well-being and work together to that shared aim¹⁴.”* Participants at the workshops supported the principle of getting the views of the adult from the outset and that, ideally, this should be done by the person referring the concern ie checking with the adult that they agreed to or were aware of the referral. Some authorities are unwilling to accept a referral from a third party unless this has been done.

Participants at the two workshops were asked how much influence they thought the views of the adult concerned have on a decision to undertake an enquiry under S42(2). Responses to this included:

¹² Paragraph 14.52, Care and Support Statutory Guidance, DHSC, October 2018

¹³ Paragraph 14.54, Care and Support Statutory Guidance, DHSC, October 2018

¹⁴ Paragraph 14.93, Care and Support Statutory Guidance, DHSC, October 2018

“It [the concern] may be closed at the request of the service user, but it would still be a S42 enquiry in the first instance”

“The Mental Capacity Act guidance and principles and risk assessment are key to decisions as to how far to accept the wishes of the person at face value”.

There seemed to be a general consensus that, although obtaining the views of the adult was of prime importance in determining what outcomes should come from a safeguarding enquiry, this should not be the overriding factor in determining the process of that enquiry i.e. it would be for the authority to determine, taking all the circumstances into account, the most appropriate way to conduct an enquiry under S42(2), which could include a process outside of safeguarding such as a care review. Some of the factors that influenced this view were about ensuring that any response is proportionate to the circumstances and a lack of clarity about what the added value was of conducting an enquiry under S42(2) compared with other options to assist the adult.

Participants were also asked their views about whether an enquiry under S42(2) should be carried out if the adult concerned did not want this. There was more confidence in addressing this issue, reflecting the principles underpinning Making Safeguarding Personal (MSP) about placing people at the centre of decision-making. It is important to understand that MSP does not mean walking away from someone who is suffering abuse or neglect but who is reluctant to support a safeguarding intervention. A stronger relationship may have to be established in order to create trust and to give time for the adult to think about their options. Participants said that other factors would have to be weighed against an adult’s opposition to an enquiry being made. These included coercion by another person, the level of risk to the adult or to others, public interest and whether a crime had been committed.

The views of the adult are central to determining the desired outcomes in a case but should not be the overriding factor in determining the process.

How should the six safeguarding adults principles¹⁵ be employed in the context of the S42 duty to make enquiries?

It was clear from the LGA/ADASS workshops that the six safeguarding adults principles set out in the Care and Support Statutory Guidance (DHSC, 2018) are well known to practitioners but that some are more explicitly influential on decision-making than others.

Many participants referred to Proportionality in determining the best way to respond to a concern. One workshop participant said they “would record proportionality but probably not the others”

There were also indications from the workshops that Making Safeguarding Personal and the Empowerment principle are embedded in practice, although this may simply be referred to by practitioners as a person-centred approach.

The other four principles – Prevention, Protection, Partnership and Accountability – were not prominent in discussions at the workshops. Participants said that they bring

¹⁵ Paragraph 14.13, Care and Support Statutory Guidance, DHSC, October 2018

the six safeguarding adults principles into play in decision-making but many struggled to say how or evidence in what way and for what purpose they do so.

The Care and Support Statutory Guidance (DHSC, 2018) states that all of these principles must underpin decision-making¹⁶. These are set out in Section Three of this paper. Being explicit about applying principles supports transparency and clarity about the rationale for decision-making and evidences individualised responses.

Interpretations of what constitutes a safeguarding enquiry

Section 42 of the Care Act (2014) sets out the criteria which would result in a duty for the local authority to make “*whatever enquiries it thinks necessary*”. The Care and Support Statutory Guidance (DHSC, 2018) clarifies what the enquiry is intended to achieve:

“The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult¹⁷.”

Section 42 does not define what an enquiry is. The Care and Support Statutory Guidance (DHS, 2018) says:

“An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action¹⁸.”

The guidance therefore describes a broad range of activity that would constitute an enquiry and / or information gathering that precedes a decision to initiate an enquiry under S42(2).

In the context of perceived ambiguities and a lack of clear and explicit guidance, local authorities have to some extent developed local definitions of what constitutes an enquiry under the S42 duty, leading to very different recording and reporting practices across the country.

For example, it is clear that there is inconsistency in how local authorities opt to record information gathering that is carried out to determine whether the statutory criteria for S42(1) are met. (*Not all these approaches are supported within the suggested framework in this paper.*) The workshops (LGA, November 2018) included indications that:

- For some it is a matter of scale. If the enquiries to gather information are extensive then they are reported as an enquiry under S42(2) but if they are minimal and short then they remain as concerns.
- In many cases information gathering will establish that the incident was minor, or that the issue has been dealt with and resolved and no further action is needed. Some local authorities would report this work as an enquiry under S42(2) whereas others would not.

¹⁶ Paragraph 14.92, Care and Support Statutory Guidance, DHSC, October 2018

¹⁷ Paragraph 14.78, Care and Support Statutory Guidance, DHSC, October 2018

¹⁸ Paragraph 14.77, Care and Support Statutory Guidance, DHSC, October 2018

- A degree of support offered at the stage of information gathering can resolve the issue. In that case it may not be reported as an enquiry under S42(2) even though a safeguarding concern has been resolved.
- Some participants at the workshops said that their local authorities would not identify the S42 duty to make enquiries until there has been a conversation with the person concerned.
- Some authorities opt to report all work that looks into safeguarding concerns, as part of an enquiries under the S42(2) duty.
- In Yorkshire and the Humber a detailed analysis of case studies by all local authorities in the region found that enquiries reported as being within the S42(2) duty, ranged from minimal responses to telephone enquiries, resolution at early enquiry stage and right through to a multi-agency enquiry.

Approach to establishing the statutory criteria for a safeguarding enquiry

The evidence, from the survey carried out by NHS Digital and observations at the workshops in November 2018, is that all local authorities are using the criteria set out in Section 42(1) (Care Act, 2014) to determine whether a safeguarding enquiry must be undertaken. In theory, this would mean that all concerns where there is reasonable cause to believe that these meet the statutory criteria for S42(1) would be reported as enquiries under the S42(2) duty. However, there are perceived ambiguities in the Care and Support Statutory Guidance (DHSC, 2018) as set out above. This leads to different approaches to applying the guidance. Professional judgements vary as to what is best dealt with through an enquiry under the S42(2) duty and what could be best dealt with through a process outside of safeguarding, for example, a new care assessment and care plan.

Local authorities report a relatively small number of enquiries into cases that do not meet the S42(1) criteria. These enquiries are usually reported as 'Other' safeguarding in the SAC returns. The most common reasons for this are that the person concerned is dead; or does not appear to have a care and support need; or where there is a pattern of concerns; or there is a matter of public interest. It was also clear from workshop discussions (LGA, November 2018) that some local authorities report some situations of self-neglect and domestic abuse as an 'Other' enquiry.

In Yorkshire and the Humber the Regional ADASS group have conducted a stocktake on progress in Making Safeguarding Personal and identified very significant variances, across the fifteen local authorities in the region, in decision-making about enquiries under S42(2). Workshops were held to try and identify what lay behind these differences in practice and it was decided to carry out a 'deep dive' exercise. Sixteen scenarios, based on real cases, were considered by representatives from all the local authorities¹⁹.

This exercise demonstrated that even in a region where a lot of work had been done to agree principles for data collection, and where common procedures were shared

¹⁹ Workshop slides presented by Y&H Programme Director at LGA/ADASS workshops, November 2018

across several local authority areas, there was still a wide divergence of opinion on whether the statutory criteria under S42(1) had been met or not.

The case studies in Appendix 5 show how the framework set out in this paper can be used in practice. Specific judgements may still vary but the framework has been piloted on a number of cases in a region and this indicated a shift towards more consistent decision-making.

The application of a range of ‘thresholds’ in decision-making

An assessment of the level of risk of harm is a critical factor in determining whether there is reasonable cause to suspect that the statutory criteria for S42(1) are met and any subsequent activity.

“The first priority should always be to ensure the safety and well-being of the adult.”²⁰

Most local authorities set out examples of harm and risk to show different levels of severity and to indicate what action might be appropriate. This is usually in the form of a matrix that is referred to as a ‘threshold’ document or as a ‘decision-making tool’

Over 80% of local authorities responding to the SAC Survey by NHS Digital in 2018²¹ stated that they have thresholds in place for adult safeguarding decisions. Decision-making tools have also been adopted regionally in some areas to increase consistency of response across local authority areas.

Concerns have been expressed that the use of thresholds can lead to a mechanistic or tick-box approach assessment that is inconsistent with a Making Safeguarding Personal approach. For the person involved the ‘test’ of meeting a ‘threshold’ of risk might appear inappropriate and be a barrier to achieving safety and well-being. With that in mind, it is preferable to have a decision-making tool rather than a threshold document – that is, something that assists in decision-making and not a document that determines a decision.

It has not been possible within the scope of this framework to analyse in detail the types of thresholds guidance being used across the country and the extent to which they inform decisions about the S42 duty or decisions about when to refer concerns into the local authority.

Threshold documents are probably best used in offering examples to guide those who are not specialists in safeguarding to help them understand whether they need to raise a concern with the local authority and what kind of action may follow, rather than to set down clear lines about who can or cannot access safeguarding support.

²⁰ Paragraph 14.95, Care and Support Statutory Guidance, DHSC, October 2018

²¹ Safeguarding Adults Collection, Survey of Local Definitions 2018, NHS Digital, November 2018 - INSERT HYPERLINK

Given the variance in practice across the country, these tools do not seem to have achieved consistency in decision-making, at least in whether or not an enquiry under the S42(20) duty is indicated, even where common policies are shared.

Further consideration will be given to this area of guidance and practice in considering (in workshops and a briefing during 2019) where concerns require referring into a local authority because they need a safeguarding response. This will reference work underway in the Care Quality Commission which aims to support greater clarity on identification of safeguarding issues that need to be referred to the regulator as safeguarding concerns by providers.

Appendix 4.

What does the national data tell us?

The data identify a wide range in the numbers of concerns submitted by local authorities, and the number of these that progress to an enquiry under the S42(2) duty (known as the 'conversion rate' of concerns to enquiries).

Concerns raised during 2017-18 and the reported route taken to offering a response and support

There were 394,655 safeguarding concerns raised during 2017-18, an increase of 8.2% on 2016-17. A total of 150,070 adult safeguarding enquiries were reported as starting during the year. Of these, 131,860 were enquiries under S42 (87.9% of the total), and there were 18,210 *Other* safeguarding enquiries.

The ratio of total enquiries (S42(2) plus *Other*) to concerns gives a 'conversion rate'. This combined figure gives an overall conversion rate during 2017-18 for England of 38%; that is, for every 100 concerns that were raised there were 38 Section 42 and *Other* enquiries that were started.

The range of conversion rates varied across all the different local authorities from 3.9% to 100%. Eight local authorities had a 100% conversion rate, ie all their concerns were recorded as becoming enquiries. Regionally, the conversion rate varied from 31.0% in the West Midlands to 45.9% in the North East.

Some commentators²² have sought to establish what a 'good' conversion rate should be by using this data, but this is not a reliable indicator of the quality of decision-making or the effectiveness of the response. Data should not simply be used to draw general conclusions but is better used to understand the differences in practice at local level that result in these variances i.e. as a 'can opener' to ask pertinent questions about practice rather than as the basis on which to draw general conclusions.

(See the presentation on the approach the East of England region took to analysing a relatively low conversion rate of concerns to S42 enquiries)²³

There was a prevalent view at the workshops (LGA, November 2018) that by focusing on practice there is more likely to be an improvement in outcomes. As one participant in the workshops said, "*Responding appropriately and proportionately is more important*" A service user from Cheshire East commented: "*The most important thing to me is getting the right help*".

Does it matter whether enquiries are classified and reported differently?

*"It is important to record data so that abuse is stopped"*²⁴

²² A Patchwork of Practice, Action on Elder Abuse, December 2017

²³ Workshop slides presented by Claire Bruin at S42 workshops, LGA, 2018

²⁴ A comment from conversations with several people at 5 different services across Cheshire East; adults with learning disabilities and physical disabilities.

The data is important. It has been a catalyst for this work. There is an important principle of Accountability that must be satisfied. This exists at an individual level in relation to the support provided to an adult at risk of abuse and neglect, and it also exists in relation to the work of Safeguarding Adults Boards, the statutory duties of local authorities and the overview by the Department of Health and Social Care.

The data reflects inconsistencies in recording and reporting practice in relation to the S42(2) duty to carry out safeguarding adults enquiries. This inconsistency follows from differences across local authorities in interpreting the Care and Support Statutory Guidance (DHSC, 2018). If consistent interpretation of the guidance is supported and developed, consistent reporting should follow. A way forward in supporting that consistency is suggested in this framework.

All those enquiries carried out under the S42(2) duty generate information through the SAC. This supports accountability. However, at the same time local authorities and SABs should collect supplementary, local data and information to support understanding of those situations which do not progress to an enquiry under S42(2) and to improve local monitoring of the quality of safeguarding activity.

Appendix 5

Case studies which include factors that divide opinion on whether or not the criteria set out in S42(1) Care Act (2014) are met.

Whilst a consistent framework is offered in terms of the factors that determine whether a S42 (2) duty to make enquiries exists this cannot take away the need for professional judgements, based on individual circumstances, about which situations meet the criteria set out in S42(1) of the Care Act (2014) and which do not.

The framework set out in this paper supports the view that there is a duty from the outset which starts with S42(1) information gathering to inform a decision as to whether that duty will continue into a statutory S42(2) enquiry. Only if it is established that there is reasonable cause to suspect that the three criteria in S42(1) are fulfilled is the duty under S42(2) to make enquiries triggered. Only then will it be reported as a S42(2) enquiry to NHS Digital in the SAC.

The following case studies include factors where opinion is often divided (particularly in respect of S42(1) (b); whether the person is *experiencing, or is at risk of, abuse or neglect*. Concerns about medication errors and about service user on service user 'abuse' are also amongst those that divide opinion.

What is important here is that the framework set out in this paper is taken account of and that the judgement is made against the core principles and tools provided in the legislation and associated guidance. There must be transparency and accountability for the decision against that background. Not everyone will agree on each, specific decision, but there will be greater consistency if decisions are taken using the same tools.

These case studies illustrate the level of transparency required and how the decision fits with available guidance.

Case Study 4 - Peter

Case outline

The situation was referred as a safeguarding adults concern by a day centre to the local authority on the day on which the incident took place.

The adult at risk is Peter, a 26-year-old male with severe autism and learning disabilities who attends day care on three days per week. The person alleged to have caused harm (PACH) is another service user. The allegation is one of physical abuse. Both services users were travelling to the day centre and were sat together as usual. The PACH reached over to Peter and pinched him on the left arm.

The bus was immediately stopped, and staff separated both service users to different seats. Distraction techniques were used. Staff advised the PACH that their actions were not appropriate. Having reached the day centre, Peter and the PACH were kept apart by their 1:1 members of staff. Peter was initially distressed but soon calmed down. He was checked for injuries and he had a red bruise with the imprint of three fingers from contact. This was recorded on a body map.

Peter's mother has been informed of the incident, advised of actions taken to minimise risk, including them being kept apart by staff members. She is happy with the measures put in place. Peter's mother is consenting to this being addressed through safeguarding adults procedures and is likely to contribute where needed

Suggested decision-making in this case, reflecting the approach set out in this paper

If the criteria set out in Section 42 (1) are applied and 'reasonable cause to suspect' is considered, Peter:

- (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 (*there are physical marks and measures are still in place to protect him*)
- (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (*It is judged that members of staff on a 1:1 basis need to monitor and keep Peter and the PACH apart*)

Reasonable cause to suspect

The presentation of this case supports a view that Peter is at risk because he has physical marks from the incident, and it is felt that measures need to be in place to protect him from further similar incidents.

Following the framework set out in this paper, the S42 (2) duty to make enquiries is triggered and Section 42 (2) will follow:

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."

Information gathering indicates that:

- Initial actions have been necessary straight away to minimise risk, including keeping the two individuals apart.
- There has been communication with Peter's mother, engaging her in understanding that this is a safeguarding concern and seeking her consent and contribution to address it as such.
- The incident has been recorded.

Further enquiries under the Section 42 (2) duty will be needed in line with the purpose and objectives of an enquiry as set out in the Statutory Guidance (including in paragraphs 14.78, 14.93 and 14.94, DHSC, 2018).

Initial actions have been taken but further conversations and support are needed to secure sustainable protection planning. Whilst immediate safety is secured a number of the objectives in paragraph 14.94 are not fulfilled. This will be done within the Section 42 (2) duty to make enquiries. Consideration of this situation against these aspects of the Care and Support Statutory Guidance (DHSC,2018) will support a

decision as to whether the local authority is sufficiently assured that a provider's response has been robust enough to deal with a safeguarding issue, or whether a S42 (2) enquiry is needed (see paragraph 14.69, Care & Support Statutory Guidance (DHSC, 2018))²⁵.

14.78 The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult...

14.93 Local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult. The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult's well-being and work together to that shared aim. At this stage, the local authority also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.

14.94 The objectives of an enquiry into abuse or neglect are to:

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

Case study 5 - Mr Wilson

Referred by Care home (Team Leaders)

Case outline – Mr Wilson's medication had been changed from Madopar to Co-Bendaloper. The last dose of Madopar should have been on the night of 14 August.

²⁵ 14.69 When an employer is aware of abuse or neglect in their organisation, then they are under a duty to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and CCG where the latter is the commissioner. Where a local authority has reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect, then it is still under a duty to make (or cause to be made) whatever enquiries it thinks necessary to decide what if any action needs to be taken and by whom. The local authority may well be reassured by the employer's response so that no further action is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action (for example, referral to CQC, professional regulators).

The Co- Bendaloper should have commenced on the morning of 15 August. However, the Madopar had not been stopped on the Medicines Administration Record (MAR) or removed from the medicines trolley. The team leader administering medication that morning gave both Madopar and Co-Bendaloper and did so again at lunchtime.

On carrying out the medication audit after lunch, this error was noted.

The GP was contacted, and the GP stated that Mr Wilson should be fine as both medicines are short acting and any complications would have arisen already. The advice was to monitor and continue with the Co-Bendaloper dose for the rest of the day and to contact the GP again if there were any concerns.

The local authority receiving the referral of this concern telephoned the care home deputy manager who advised that this error had been an oversight and due to the error, she is in the process of carrying out a random audit to check that no further errors have been noted. At this stage none has been found. The error that occurred was in regard to a change in Mr Wilson's medication for Parkinson's Disease. The error led to him being given his old medication as well as his new medication.

The home had immediately contacted the GP who advised on the consequences (as above) and that it was alright to continue the medication as prescribed going forward. Mr Wilson was asked how he felt; he said he felt no different and that his capabilities with his mobility/ balance had not been impacted. Mr Wilson agreed that a safeguarding concern could be raised but didn't want any fuss.

Applying the framework

The below sets out one rationale by one local authority for making a judgment about whether this situation meets the statutory criteria set out in S42(1). It is not the only possible conclusion as to whether the criteria are met but it does show a clear rationale for deciding one way or the other.

Factors such as local procedures on medication errors and safeguarding will play a part in decisions. (In some instances, the framework presented in this paper may lead to revisiting local procedures). *National developments including those being developed by CQC may also impact upon a more consistent reading of these situations involving medication errors (and upon local procedures)*. An associated framework to support considering what constitutes a safeguarding concern will aim to further clarify the position on concerns such as medication errors during 2019/20).

The following judgment about whether the criteria in S42(1) are met is based on the local context:

Local procedures in the local authority area state that where two or more consecutive medication errors occur involving the same adult then this is a safeguarding matter. In this context, the local authority decides that the criterion in S42(1) (b) that the adult *is experiencing, or is at risk of, abuse or neglect*, is met. As part of establishing reasonable cause to suspect that all three criteria are met, the local authority considers the information gathered from the care home, which indicates:

- more than one medication error involving an adult with care and support needs (due to Parkinson's Disease)
- that the adult is in receipt of care and support and is reliant on staff to administer his medication so unable to protect himself.

The fact that it happened twice (in the morning and then again at lunchtime) is enough in *this* local authority area to meet s42 (1) (b) and consequently the local authority should discuss with the home the need to make enquires and find out how the correct medication will be dispensed and by whom. Therefore, their decision is that the S42(1) duty continues to a S42 (2) enquiry²⁶.

The local authority may make the enquiries or might 'cause' or 'require' others to undertake them. ('The local authority, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under section 42(2) to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary'. (Paragraph 14.100, Care and Support Statutory Guidance (DHSC, 2018))

Decisions need to be taken about what action is necessary and by whom to address the concerns under activity within the Section 42 (2) duty enquiries. Paragraph 14.94 of the Statutory Guidance states that the objectives of an enquiry are to:

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

Activity needs to reflect the six key safeguarding adults principles and might include:

- checking with the GP, information received from the care home and asking about any previous concerns (same resident or other medication errors/ concerns) gain assurance regarding impact on the resident and clarify recommended timeframe within which the home will need to monitor the resident.
- checking local authority records about any previous medication incidents or medication related concerns

²⁶ It is acknowledged that other local authorities may not have come to the same judgement in this case (ie that Mr Wilson had suffered abuse or neglect) but would have opted to mitigate the risk of future medication errors by actions outside of S42. In reality, many of these actions would have been very similar to those carried out under S42(2) in this case study.

- checking CQC inspection reports, share concerns with CQC and commissioners, inform them and the care home that the s42 (2) duty has been triggered and enquiries are being made to decide what action is necessary.
- considering action taken by the home to involve the adult and address the immediate risks to the adult/others
- checking the views, wishes and expressed outcomes of the adult
- ensuring the adult/their representative are fully involved
- consider advocacy under the statutory duty (Care Act (2014) Section 68) to support the adult during the enquiries
- considering the need for assessment/reassessment of the adult's needs (Care Act (2014) Section 9).

The enquiry will determine whether action needs to be taken and by whom. There may be no further action required (in which case the case can be closed to safeguarding) or further actions may be required by the local authority and/or others.

'One outcome of the enquiry may be the formulation of agreed action for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement'. (Care and Support Statutory Guidance (DHSC, 2018) Paragraph 14.110)

In relation to the adult, this should set out:

- what steps are to be taken to assure their safety in future
- the provision of any support, treatment or therapy including on-going advocacy
- any modifications needed in the way services are provided (for example, same gender care or placement; appointment of an OPG deputy)
- how best to support the adult through any action they take to seek justice or redress;
- any on-going risk management strategy as appropriate
- any action to be taken in relation to the person or organisation that has caused the concern

(Care and Support Statutory Guidance (DHSC, 2018) Paragraph 14.111)

In this case this might include the care home formulating a plan for this and other residents to prevent the error in the future; a root cause analysis establishing the causes of the error; a review of staff training and recording processes; an apology to the resident.

The local authority would determine if the resident is in need of an assessment/review (Section 9, Care Act (2014)) and is satisfied with the outcomes. The local authority would inform resident and partner agencies that the s42 (2) duty has been met or, if not, what further enquiries are needed.

Case Study 6 - Julie

This case study concerns domestic abuse and contains a level of complexity about whether the statutory criteria under S42(1) are met. It illustrates how, dependent on the information that emerges, the decision might be made one way or the other.

Case outline

Julie is 35. She lives with her husband of 10 years. They have no children. She goes to see her GP and tells the GP she is depressed and anxious and would like some medication to help. She confides in the GP that her husband refuses to give her any money and won't allow her friends to visit or Julie to leave the house. Julie appears to be suffering with low moods and speaks of an increased dependence on alcohol. Julie further discloses emotional, physiological, physical, financial abuse and coercion.

The GP prescribes anti-depressants and a referral to Talking Therapies. Julie agrees for the referral to be made. The psychological therapist decides to call the local authority as she thinks that this is a safeguarding adults concern.

Decision-making in this case, reflecting the approach set out in this paper

Scenario One: In carrying out the S42 (1) duty it might be established that there is reasonable cause to believe that Julie:

- (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.

The conclusion might be reached that the reported domestic abuse has had such a significant impact on Julie's mental health, as well as on her general circumstances, that she has had to seek support because she could not recognise this as abuse, has little insight into the risks and is unable to deal with this on her own (i.e. she had been under such coercion/ control that she was effectively rendered unable to understand the GPs concerns or weigh up her options and so could not act to protect herself).

In order to come to a judgment on this, the person conducting the information gathering will need to establish Julie's capacity to understand the risks and to take action to protect herself. This must be done either in conversation with Julie or, should it not be safe to speak to her directly, with her GP.

Within this perspective there could be reasonable cause to suspect that the three criteria in S42(1) are met and therefore it is necessary to continue to a section 42(2) duty to make enquiries in order to decide what action is necessary and by whom to address the concerns.

Where the local authority proceeds to make those enquiries and uses these to inform decisions on actions then that should be reported under S42(2).

Any form of conversation /enquiry that agrees what action is needed to keep the person safe is a S42(2) enquiry. In this case this might include:

- Exploring the extent of the abuse and level of risk (to Julie and/or others) alongside Julie. This might include completing a MARAC²⁷ DASH²⁸ risk assessment tool and possible referral to a MARAC
- Exploring Julie's rights and options and who / what is available to help/ support
- Contingency plans in case the risk escalates
- Empowering Julie to reach a point where she has insight into her situation and knows how to seek help and take steps to deal with it.

The enquiry here will require a risk assessment alongside Julie to look at what is going on, the level of risk and any actions that might possibly mitigate risks.

Scenario Two: An alternative perspective on whether the S42 duty should continue to a S42(2) enquiry:

It might be the case that (through conversations within the gathering of information to establish if the three criteria are met) it is demonstrated that Julie does have insight into the coercion and control, the abuse and the level of risk and is therefore capable of understanding the concerns and weighing up her options.

In this scenario it might be assessed that S42(1) (c) is not met because **she is able to protect herself** and this includes that she is capable of seeking the necessary support, armed with information and advice. She might still be offered support, but this might not be recorded under the S42(2) enquiry duty. Risk would be assessed as part of information gathering to establish whether the three statutory criteria are met and support offered through prevention and advice/information (S2 and S4 Care Act (2014) duties).

Conversations within information gathering to establish whether the three statutory criteria are met might have taken in the following but because Julie's situation did not meet the criteria the risk is assessed and the advice is offered through prevention rather than through safeguarding enquiry. This might include:

- Exploration of the type, nature, level of abuse Julie is experiencing and whether any children or other adults with care and support needs live within the household; this may include conducting a MARAC DASH risk tool and discussions about a MARAC referral if appropriate

²⁷ Multi Agency Risk Assessment Conference (where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan.)

²⁸ The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009

- Explanation of her right to live free from abuse and that there are steps she can take to protect herself from abuse;
- Offer of a safe space for Julie and ways she can report if she is in immediate danger or the abuse escalates;
- Offer a referral to IDVA service;
- Consideration of whether Julie is able to understand this information, weigh up her options and act to protect herself.

Whether or not the S42(2) duty to make enquiries is triggered some of the same conversations and actions will take place. One route is not in or of itself more effective than the other.

It is for SABs, police and local authorities to be clear about effectiveness and outcomes whichever route is followed.

Application of the six safeguarding adults principles that should underpin all adult safeguarding work are set out in Section Three and in Appendix 1. These might be reflected as follows:

Empowerment – involving Julie and possibly others whom she trusts and who can support her. Best practice might engage an independent domestic violence advocate or potentially a family group conference to involve and engage other family members in exploring needs, risks and potential support as part of both the enquiry and the ongoing actions. Empower Julie with information about options.

Protection – enquiries are made, and action planned to protect and empower Julie. The level of risk is assessed alongside Julie so that she can have better insight into the level of risk.

Prevention - Proactive support at this stage might stop escalation of control/harm

Proportionality - the risk is assessed alongside those involved and this informs a proportionate response.

Partnership – work is undertaken in partnership with Julie and if possible other members of her family/support network as well as with professionals and support workers who can contribute.

Accountability - the rationale for the decision to undertake an enquiry (and then later decisions about actions coming out of the enquiry) are clearly recorded.