RBSAB

ROCHDALE BOROUGH
SAFEGUARDING ADULTS BOARD

Professional Decision Making in Response to a Safeguarding Concern

TITLE	Title: Version:	Professional Decision Making in Response to a Safeguarding Concern 3
WRITTEN BY	Written by:	Fiona Love-Roberts Social Work Professional Lead and Jane Timson Head of Safeguarding and Practice Assurance, Rochdale Adult Care
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Introduction

Safeguarding means protecting an adult's right to live safely, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect. However, identifying when safeguarding referrals should be made is not always clear cut.

This guidance has been compiled for RBSAB membership agencies and Adult Care in order to order to give some clarity to when a safeguarding concern should be raised with Rochdale Council's Adult Care Service, to ensure that the concern is investigated at the appropriate level and to give guidance to professionals on how to proceed.

The Care Act 2014

From April 2015 the Care Act put adult safeguarding on a legal footing and made it a legal requirement for local authorities to make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and, if so, by whom. 'Making Safeguarding Personal' is shifting the focus of adult safeguarding work towards a person centred approach, and working towards outcomes that the person wants to help them manage the risk of abuse and/or neglect.

The Care Act 2014 states that six key principles must underpin all adult Safeguarding work, these are:

- **Empowerment** - the presumption of person led decisions and informed consent
- **Prevention** - it is better to take action before harm occurs
- **Proportionality** - proportionate and least intrusive response to the risk presented
- **Protection** - support and representation for those in greatest need
- **Partnership** - local solutions through services working with their communities
- **Accountability** - accountability and transparency in delivering safeguarding

Care Act 2014 – Section 42 Definitions

'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:'

In the context of the legislation, adult safeguarding duties apply to *any* adult (over the age of 18) who:

***(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.*

This guidance explains the processes involved in making a decision about whether a safeguarding concern received regarding an adult, who appears to be at risk of harm or is being harmed, is progressed as a formal Section 42 Safeguarding Enquiry or whether the concern can be more proportionally addressed by other means.
When determining a decision, consider the following:

- Was harm caused, how serious was the harm or abuse / risk of harm or abuse - the consequence / impact
- How often has it the risk of abuse or harm occurred - history /context
- How many adults at risk were exposed or could have been exposed to the harm or abuse - vital interest or potential organisational abuse
- What is the likelihood of the abuse or harm reoccurring? - frequency

What is poor practice?

If a person is totally dependent on others' assistance to meet their basic needs, continual poor practice can lead to serious harm or death. This may require further enquiries.

Poor practice when identified can be dealt with by other means such as a care home investigating the issues identified or by being passed to the commissioner of the service to investigate and address. Alternatively, it can be addressed by teams completing Care Act Assessments or reviews.

Useful elements in deciding if poor practice has occurred, which does not require consideration for a safeguarding adult section 42 enquiry response, are to ascertain if the concern:

- is a "one off" incident to one individual
- resulted in no harm
- indicated a need for a defined action

Incidents which indicate that poor practice is impacting on more than one adult, or that poor practice is recurring and is not a "one off", must result in a formal s42 enquiry being started. Section 42 enquiries must involve the Integrated

Commissioning Directorate where relevant. These incidents can be good indicators of more widespread, organisational abuse and commissioning services are best placed to manage these concerns.

Sometimes a “one off” incident is an indication of a lowering of standards by health or care providers. Early indications of poor practice must be challenged and can be addressed using other systems, such as commissioners’ quality assurance processes; care and support reviews; complaint investigations; or human resources systems. All of these will ensure that the issue is properly addressed, recorded, resolved and monitored. All reported incidents or complaints about poor care in a regulated setting should be sent to the Integrated Commissioning Directorate.

Integrated Commissioning Directorate will collate records of poor practice concerns and keep the safeguarding adults lead informed of any escalating concerns about individual agencies. They will be responsible for addressing any identified organisational abuse.

Examples of poor practice and safeguarding concerns

Poor practice concerns will can be dealt with by assessment and care management intervention or the poor practice procedure	**Safeguarding concerns which initiate a section 42 enquiry.**
Person does not receive the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed continence pads on one occasion.	Recurring event, or is happening to more than one adult. Harm: pain, constipation, loss of dignity and self-confidence, skin problems.
Person, who is known to be susceptible to pressure ulcers, has not been formally assessed with respect to pressure area management, but no discernible harm has arisen.	Person has not been formally assessed, advice not sought with respect to pressure area management, or care plan not followed resulting in avoidable significant tissue damage.
Person does not receive recommended assistance to maintain mobility on one occasion	Recurring event, or is happening to more than one adult resulting in reduced mobility resulting in loss of mobility confidence and independence
Appropriate moving and handling procedures not followed or staff not trained and competent to use the required equipment, but person does not experience harm.	Person is injured, or common non-use of moving and handling procedures make this very likely to happen.
Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs	Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being, or calls are being missed to more than one adult resulting in missed medication and meals, put at risk of harm including neglect.
Person has fallen and sustained an injury. Risk assessment in place and was followed.	Person has fallen and sustained an injury, risk assessment not in place or was not followed.

Safeguarding levels of harm

Level 4 - Critical - serious harm has been caused, high suspicion of a crime

Level 3 - Harmful - harm has occurred, consideration as to whether a joint investigation with police is required or not

Level 2 - Low Risk - where there is little or no harm caused. Identified risk but require further information gathering.

Level 1 - Poor Practice - isolated incident, no harm - low risk

Information Gathering stage

When a safeguarding concern is received by Adult Care, a decision needs to be made as to what action should be taken. At this point more information may need to be gathered to ascertain exactly what has happened. This will allow a full picture to be gathered and ensure that correct decisions are made. It will allow professionals to decide whether the concern requires a more formal course of action (Section 42 enquiry) or whether other more proportionate actions can take place.

This 'information gathering stage' can take many different forms and includes:

- Asking for more information and clarification from the person who has raised the concern.

- Does the person have care and support needs? Are they at risk of harm?
    - As a result of their care and support needs are they unable to protect themselves?

- Is the person **currently** experiencing, or at risk of abuse or neglect? If the abuse or neglect was in the past and is not current, a s42 enquiry is **not** appropriate. Other mechanisms, such as the formal complaint process, should be used to address the concern. (For more information see the ' Historic Serious concern investigation protocol')

- It is important to contact the Adult to ascertain how they view the concern and identify from their perspective whether they believe they have been harmed and what outcomes they want to achieve.

- If the service user is in a provider service, it is appropriate to ask the service to complete the 'information gathering' form, as long as this would not compromise the Adult or interfere with the potential s42 enquiry.

- The individuals Mental Capacity should be assessed to determine if the individual has the ability to take part in a safeguarding enquiry.

- Talk with family if this is appropriate about the concern and establish their involvement and how they could contribute to the potential protection plan.

- If it is ascertained that the individual does not have capacity to take part in a safeguarding enquiry, ascertain who will advocate and whether a formal advocate needs appointing.

- Gather information from relevant health professionals who may have involvement with the individual.

- Has the harm been caused by a person in a position of trust (i.e paid carer, volunteer) If so, the care organisation will need to follow their own disciplinary process to investigate the incident and they will need to risk assess whether this requires a referral into Allegation Management framework in Adult Care. (see separate Allegation Management process)

Timescales
All safeguarding concerns should be reviewed on the day of receipt to address any immediate safeguarding and protection issues.

The decision to progress to a formal Safeguarding enquiry should take no longer than 2 working days. Where 'information gathering' is required to identify the correct proportionate response this should not unnecessarily delay the decision to progress to a s42 enquiry.

If a decision is made to progress to a formal s42 enquiry, then a multi-agency strategy meeting should take place as soon as possible, within 2-3 days.

Who is responsible?
Each service will have their own duty system arrangements where concerns will be actioned.

A Safeguarding Adult Manager (SAM) is responsible for the decision to progress the concern to a s42 Enquiry. The appointed SAM is responsible for allocating an Enquiry Practitioner and progressing to a strategy meeting.

It is essential that the rational for any decision making is recorded on the appropriate case management system (ie ALLIS).

A practitioner guide providing examples of levels of harm and the appropriate response required (ie poor practice or serious concern) can be found in appendix A.

Physical Abuse

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1/ Poor Practice	**Level 2**	**Level 3**	**Level 4**
Staff error on one occasion causing little or no harm, e.g. skin friction mark due to ill-fitting hoist sling	Isolated incident involving vulnerable adult on vulnerable adult not resulting in harm	Inexplicable marking or lesions, cuts or grip marks on a number of occasions	Inappropriate restraint. Withholding of food, drinks or aids to independence
Adult does not receive recommended mobility assistance on one occasion not resulting in harm	Inexplicable very light marking found on one occasion.	Vulnerable adult on vulnerable adult incident where there is a power imbalance being used to cause harm / exploitation	Inexplicable fractures/injuries
Appropriate moving and handling procedures not followed on one occasion not resulting in harm	Adult at risk attends casualty, minor injury unit, GP surgery with minor injury and doubtful explanation, wants treatment but no other action. Health professional checks previous history but no previous concern has been recorded	Adult at risk is injured through common flouting of procedures	Assault, injury, death
Isolated incident of carer falling asleep at night on duty remains a disciplinary/management issue Environmental hazards including maintenance	Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care, therapy does not on one occasion receive required timely medical attention.	Predictable and preventable incident between two vulnerable adults where injuries have been sustained or emotional distress caused – the staff fails to prevent.	Grievous bodily harm/assault leading to permanent or substantial injury or death including Female Genital Mutilation.

Medication

<table>
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<tr><td>Level 1</td><td>Level 2</td><td>Level 3</td><td>Level 4</td></tr>
<tr><td rowspan="3">Adult does not receive prescribed medication (missed/wrong dose) on one occasion - no harm occurs</td><td rowspan="3">Medication administration records are inaccurate</td><td>One medication error where significant harm occurs</td><td>Deliberate misadministration of medications</td></tr>
<tr><td>Recurring missed medication or administration errors that cause no harm</td><td>Covert administration without medical authorisation.</td></tr>
<tr><td>Missed medication or errors that affect more than one adult which may or may not result in harm</td><td>Pattern of recurring errors or an incident of deliberate misadministration that results in ill health or death.</td></tr>
</table>

Sexual Abuse

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1	**Level 2**	**Level 3**	**Level 4**
Isolated incident when an inappropriate sexualised remark is made to an adult with capacity and no distress is caused	Isolated incident of low level, unwanted sexualised attention/touching directed at one adult by another, whether or not capacity exists. No harm or distress	Sexualised attention between two service users where one lacks capacity to consent	Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent.
	Two people who lack capacity engaged in a sexual activity or relationship. No distress to either	Verbal sexualised teasing or harassment.	Being made to look at pornographic material against will / where valid consent cannot be given.
		Recurring sexualised touch or masturbation without valid consent	Sex without valid consent (rape)
		Being subject to indecent exposure	Female Genital Mutilation.
		Contact or non-contact sexualised behaviour which causes distress to the person at risk.	Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user

Psychological and Emotional Abuse

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<tr><td>Level 1</td><td>Level 2</td><td>Level 3</td><td>Level 4</td></tr>
<tr><td rowspan="5">Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but little or no distress caused.</td><td rowspan="5">Resident in a warden complex reports that s/he finds the warden overbearing and intrusive.</td><td>Isolated taunts or verbal outbursts which cause distress</td><td>Emotional blackmail e.g. threats of abandonment / harm</td></tr>
<tr><td>The withholding of information to dis-empower</td><td>Frequent and frightening verbal outbursts</td></tr>
<tr><td>Treatment that undermines dignity and damages esteem</td><td>Denial of basic human rights/civil liberties, over-riding advanced directive, forced marriage, modern slavery</td></tr>
<tr><td>Denying or failing to recognise an adult’s choice or opinion</td><td>Prolonged intimidation / victimisation</td></tr>
<tr><td>Adult at risk is intimidated and bullied and they are frightened to talk about why</td><td>Vicious / personalised consistent verbal attacks</td></tr>
</table>

Financial or material Abuse

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1	**Level 2**	**Level 3**	**Level 4**
Money is not recorded safely or properly.	Failure to meet agreed contribution to care by family/attorney	Adult not routinely involved in decisions about how their money is spent or kept safe -capacity in this respect is not properly considered	Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards
		Adult's monies kept in a joint bank account – unclear arrangements for equity of interest	Personal finances removed from adult's control without lawful authorisation.
		Adult denied access to his/her own funds or possessions, other than in the context of properly authorised decision-making on behalf of an incapacitated adult and in his/her best interests	Fraud/exploitation relating to benefits, income, property, last will and testament
		Failure to meet agreed contribution to care by family/attorney results in failure to provide personal allowance and/or jeopardises the placement	Theft of money or property

Self – neglect

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Neglect and acts of omission

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1/Poor Practice	**Level 2**	**Level 3**	**Level 4**
Missed home care visit on one occasion - no harm occurs	Inadequacies in care provision leading to discomfort - no significant harm e.g. left wet on one occasion	Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs	Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure wounds, malnutrition, loss of independence / confidence
Adult is not assisted with a meal/drink on one occasion and no harm occurs	No access to aids for independence on one occasion and no harm occurs	Vulnerable adult who is susceptible to pressure ulcers is not formally assessed	Adult at risk is known to mental health services and assessed as high risk of suicide – timely response not made to report of possible suicide and harm or emotional distress occurs
Care plan does not address assessed needs / or is not followed on one occasion and no harm occurs	Care plan not followed and no harm occurs	Care plan does not address risk of harm i.e. i) Management of behaviour to protect self or other ii) Liquid diet because of swallowing difficulties	Failure to arrange access to life saving services or medical care

Discriminatory abuse

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Consider the need for criminal investigation.
Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.</td></tr>
<tr><td>Level 1/Poor Practice</td><td>Level 2</td><td>Level 3</td><td>Level 4</td></tr>
<tr><td rowspan="3">Incident of teasing, rude, insulting, or belittling manner on one occasion, motivated by prejudicial attitudes towards an adult’s individual differences and little or no distress is caused</td><td rowspan="3">Isolated incident of care planning that fails to address an adult’s specific diversity associated needs for a short period</td><td>Recurring taunts (Hate Crime)</td><td>Being refused access to essential services</td></tr>
<tr><td>Inequitable access to service provision as a result of diversity issue</td><td>Denial of civil liberties e.g. voting, making a complaint</td></tr>
<tr><td>Recurring failure to meet specific care/support needs associated with diversity</td><td>Hate Crime resulting in injury/emergency medical treatment or fear for life</td></tr>
</table>

Organisational abuse

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1/Poor Practice	**Level 2**	**Level 3**	**Level 4**
Lack of stimulation/ opportunities to engage in social and leisure activities over a short period of time and no harm occurs	Adult at risk is discharged from hospital without adequate discharge planning but no harm occurs - needs to be addressed as a quality issue	Adult at risk whose personal plan of care stipulates that they should have two staff supporting them is supported by one member of staff on several occasions or one occasion and harm occurs	Widespread consistent ill treatment
One off incident of low staffing due to unforeseen circumstances	More than one incident of low staffing levels, no contingencies in place, no harm caused	Repeated incidents of low staffing resulting in harm to a person	Low staffing levels which results in serious injury or death to more than one person (corporate manslaughter)
Service design where adults living together are inappropriate	Lack of stimulation/ opportunities to engage in social and leisure activities over a short period of time and no harm occurs	Adult at risk dignity is undermined e.g. lack of privacy during support with intimate care needs	Over medication and/or the use of inappropriate restraint in the management of behavior
One off incident of failure to adhere to care regime (positioning) no harm occurs	Adult at risk whose personal plan of care stipulates that they should have two staff supporting them is supported by one member of staff on one occasion and no harm occurs	Rigid/inflexible routines	Staff misusing their position of power over service users

Mate Crime and Hate Crime

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1	Level 2	Level 3	Level 4
			.

Domestic Abuse

Lower level concerns		Harmful	Critical
Could be addressed via an agency's internal processes / procedures, care and support assessment. Integrated Commissioning Directorate be notified of all lower level concerns involving commissioned services to enable quality monitoring		Safeguarding concerns which initiate a section 42 enquiry. Consider the need for criminal investigation. Integrated Commissioning Directorate/CCG/ GMP/CQC or other partners to be included in Strategy actions as appropriate.	
Level 1	Level 2	Level 3	Level 4
			.

Whole Service Investigations

A whole service investigation is an investigation which involves a number of individuals in the same establishment who are considered to be at risk. This will usually be led by the Rochdale Council's Integrated Commissioning Directorate in line with the RBSAB multi-agency policy and procedures and the joint Rochdale Council and HMR CCG Escalation Plan and Accountability Framework for Care Provision in Heywood, Middleton and Rochdale.

The decision to undertake a Whole Service Investigation can be difficult and may be as a result of poor practice coming to light rather than specific safeguarding concerns.

Guidance on the type of concerns which might trigger a Whole Service Investigation is included at Appendix 2: Whole Service Investigations: Criteria for Consideration

Case Examples

Case example 1

Mrs Smith receives the wrong medication from care staff on 1 occasion. There is no harm to her. This is an isolated incident (it hasn't happened before) she is the only person to receive the wrong medication. The tablets are now in a marked blister-pack so the likelihood of reoccurrence is minimised.

A Safeguarding Concern does not need to be raised but the care home need to follow their own internal procedures due to poor practice in this case.

Case example 2

Mrs Smith has been given the wrong medication by care staff. There is no harm to her but this has happened before to her and others and there are concerns that this could happen again and/or lead to her/others being at risk of harm.

Concern reported to Adult Care Service in addition to any action required by the Care Provider

This is a level 3 concern so a Section 42 enquiry should be initiated AND the strategy meeting should include the Integrated Commissioning Directorate and others to address the poor medication management?

Case example 3

Mr Brown, a service user, hits Mr Singh, another service user. Mr Singh is not injured or harmed. This is the first time that Mr Brown has acted in this way.

The Registered Manager speaks to Mr Singh who is not upset by the incident, carries out a risk assessment and takes appropriate steps to manage the risk of this

from happening again. A concern is raised with Adult Care but does not need to progress to a s42 Enquiry.

The Concern needs to be passed to Integrated Commissioning team to record.

Case example 4
Mr Brown, a service user hits Mr Singh, another service user. Mr Singh is not injured but was distressed and this has happened several times before to Mr Singh and other residents and there are concerns that someone is going to be seriously hurt or injured.

The Registered Manager reports the safeguarding concern to Adult Care Services. This is a Level 3 concern and therefore a S42 Enquiry is needed. ICD need to be involved.

Case example 5
Miss Johnstone lives alone in poor housing conditions. She does not like to throw away anything and her home is full of newspapers and household rubbish which impedes her mobility and restricts her access to only one room where she cooks, sleeps and carries out personal care tasks. There is evidence of vermin infestation. Although physically frail she has mental capacity and understands the risks to her health from her chosen lifestyle and refuses to allow any services into her home.

A Section 42 safeguarding enquiry should be considered at this point, however agencies should try to engage with her to risk assess and offer services/support as appropriate. Following RBSAB Self-Neglect Guidelines, agencies should hold a multi-agency meeting to consider the risks to Miss Kennedy / others and coordinate how they work with Miss Kennedy.

Case example 6
Miss Johnstone lives alone in poor housing conditions. She does not like to throw away anything and her home is full of newspapers and household rubbish which impedes her mobility and restricts her access to only one room where she cooks, sleeps and carries out personal care tasks. There is evidence of vermin infestation.

She is physically frail, has some cognitive impairment and fluctuating mental capacity. At times she appears to understand the risks to her health from her chosen lifestyle and refuses to allow any services into her home. There are additional concerns that local children have been targeting her home for some time throwing objects at her house and shouting abuse and she has been seen outside her home in a distressed state.

A safeguarding concern is raised with Adult Care Services. This should be progressed to a s42 Enquiry.

Appendix 2

Whole Service Safeguarding Investigations: Criteria for Consideration

Please note that this practice guidance is for guidance only and is not exhaustive:

The presentation of concerns might result from:

- Investigation into the care of one person which then indicates that the practices within the service may be putting other vulnerable people at risk
- A whistle blower within the service
- A poor CQC review outcome
- Reports from commissioners undertaking quality monitoring
- Reports or complaints from service users, professionals or family members and friends
- An accumulation of volume of safeguarding concerns over a period of time

The common thread is a significant breach of CQC's "Fundamental Standards" (2016). Problems may emerge as:

- Poor hydration / nutrition
- Widespread neglect of other basic needs such as medical care, medication and hygiene
- Lack of dignity and respect
- Poor care planning
- Poor risk assessment and / or management
- Lack of person centred approaches
- Ignorance of health and safety, including moving and handling
- Dirty environments

- A high number of medication errors
- Pressure ulcers (Grade 3 and 4) where there are concerns that neglect may have occurred.

Underpinning these is often a lack of clear leadership, concerns about staff competence and a culture of poor practice. Occasionally, there may be members of staff who plan to exploit these environments, in these cases patterns of theft, sexual assault or physical assault may emerge.