Making decisions on the duty to carry out Safeguarding Adults enquiries

Suggested framework to support practice, reporting and recording

Making Safeguarding Personal

CONTENTS

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Section 1 Introduction and purpose

This paper has been produced by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). It is based on work at two LGA/ADASS workshops (facilitated by Making Connections, Isle of Wight Ltd) in November 2018.

The purpose of this paper is to offer support in making decisions about whether or not a reported safeguarding adults concern requires an enquiry under the Section 42 (S42) duty of the Care Act, 2014[1]. It offers a framework to support practice, recording and reporting, in order to impact positively on outcomes for people and the level of accountability for those outcomes.

The paper considers both day to day practice and the recording and capturing of data and information that flows from that practice. The paper considers the core aspects and principles for robust decision-making alongside how to report on this.

Accountability and assurance are crucial. Accountability means, in part, being clear about how and why a particular approach is taken. This is best achieved through transparent and consistent decision-making and practice that can show this is derived from the Care and Support Statutory Guidance (DHSC, 2018) and the relevant legal framework, including the Human Rights Act (1998), the Mental Capacity Act (2005) and the Care Act (2014) . This framework will support practice and outcomes for people that are fair, lawful and reasonable. It can also give confidence and empower staff. This framework offers a way of achieving that clarity.

The core aspects and principles set out in this paper are based on the Care Act 2014 and the Care and Support Statutory Guidance (DHSC, 2018)[2]. It also draws on the following sources:

a) Presentations and contributions from 120 representatives of Safeguarding Adults Boards at two workshops held in November 2018.

b) A workshop exercise in Yorkshire and the Humber in which staff from all the local authorities looked at 16 cases and assessed what action they would take in their area.

c) Returns to NHS Digital for the Safeguarding Adults Collection (SAC) and to the voluntary survey of local authorities completing the SAC. (51% of authorities completed the survey.)

d) Conversations with several people at five different services across Cheshire East; adults with learning disabilities and physical disabilities. A group conversation and two individual conversations held with the professional lead for adult safeguarding for Cheshire East. (Service user comments recorded in the text are derived from these conversations).

e) Feedback from a group of critical readers who provided a view on an initial draft of thoughts and issues emerging from a) to d) above. They are listed in the acknowledgements at the end of this report.

[1]This duty (to make safeguarding enquiries) is referred to throughout as the S42 duty

[2] Care and Support Statutory Guidance, DHSC, 2018

Some of the information from the workshops held in November 2018 is available on the Making Safeguarding Personal section of the LGA website.[3]

The Care and Support Statutory Guidance (DHSC, 2018) offers considerable support in interpreting the Section 42 duty. However, it is clear from conversations within a) to e) above, that practitioners perceive some ambiguity in that guidance. These ambiguities are reflected in this paper (including in Appendix 3 where they are set out in more detail).

Recording and reporting activity is important. Improving the quality and consistency of reported safeguarding activity was a catalyst for this work. Data is best used as a 'can opener' to ask pertinent questions about practice but some commentators[4] have drawn general conclusions from published data about the extent to which people are protected. Public perceptions are influenced by such analyses.

Although the workshops held to support this work reflected numerous examples of excellent practice and outcomes for people, not all this work is currently reflected in the Safeguarding Adults Collection (SAC)[5] data return or in other publicly available information. Data submitted to the SAC should be supplemented with local information and data to support understanding and monitoring, including of those situations which do not progress to an enquiry under S42.

This paper provides a collective view (from a group from the following backgrounds: practitioner; leader; manager; data professional; educator; expert by experience; a lawyer) on the most helpful way to interpret the Care and Support Statutory Guidance (DHSC, 2018), drawing attention to specific points. It sets out a clear position to offer greater clarity, consistency and confidence in practice decisions and in reporting.

This paper will connect with a further piece of work being undertaken during the Autumn/Winter 2019, focusing on safeguarding adults concerns. This will facilitate conversations and development of practice on the kinds of circumstances that indicate the need for a safeguarding response and those that might be addressed through alternative routes, outside of safeguarding processes. This will aim to support the appropriate referral of concerns to local authorities and greater understanding of what constitutes a safeguarding adults concern across the range of sectors and organisations.

[3] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

[4] A Patchwork of Practice, Action on Elder Abuse, December 2017

[5] Safeguarding Adults, England, 2017-18, Experimental Statistics – NHS Digital, November 2018 https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf

Section 2 Definition and core messages

What is a Section 42 enquiry?

This is set out in Section 42, Care Act (2014)[6]

The Section 42 duty requires consideration of the following criteria under Section 42 (1) and (2) of the Care Act (2014):

S42 (1)

Whether there is "reasonable cause to suspect" that an adult

i. has needs for care and support
ii. is experiencing, or is at risk abuse or neglect, and
iii. as a result of their needs is unable to protect themselves

S42 (2)

iv. Making (or causing to be made) whatever enquiries are necessary
v. Deciding whether action is necessary and if so what and by whom

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 (points i.-iii. above).

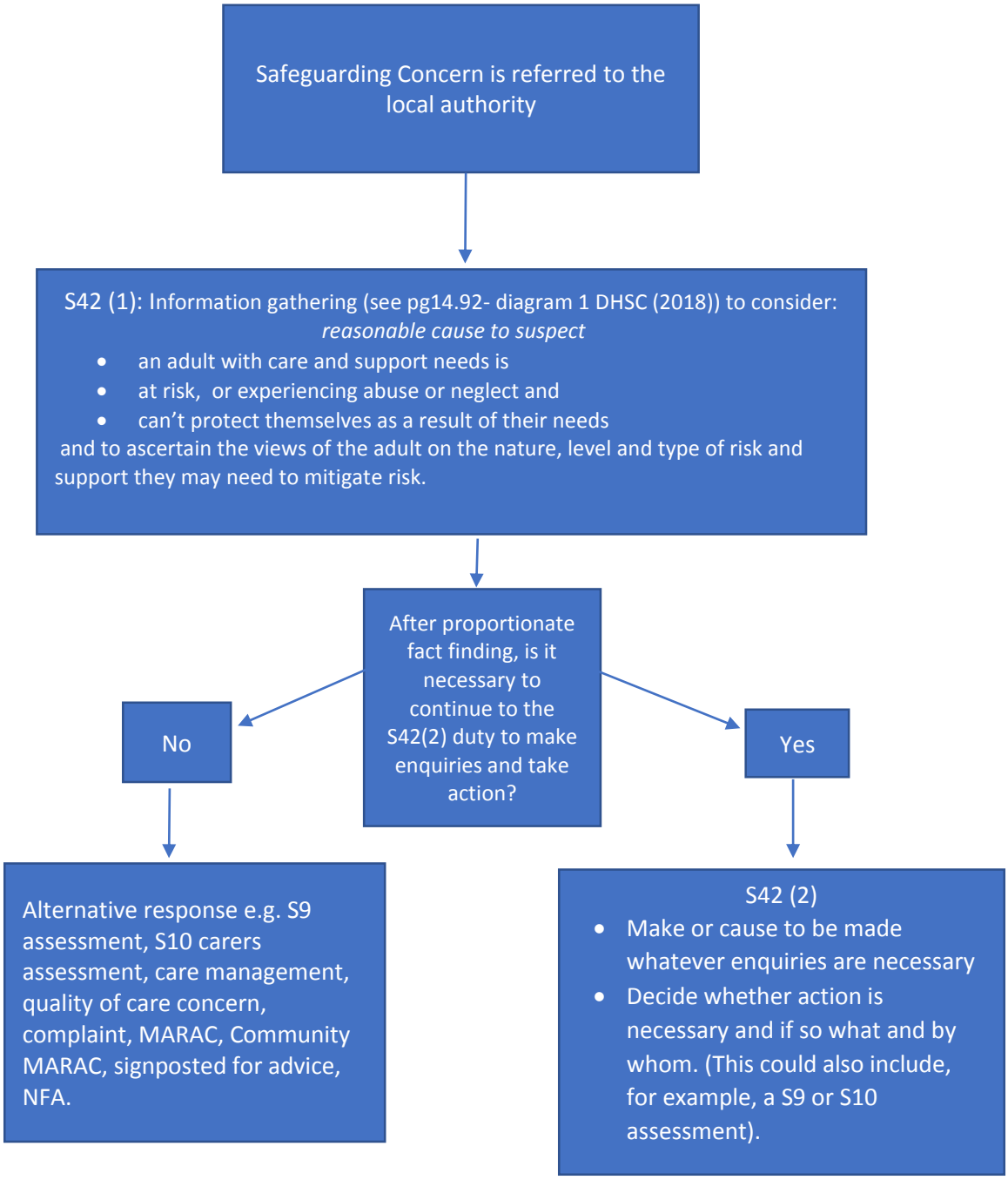
What has commonly become known as the 'three-point test' set out in S42(1), is covered in points i. to iii. above. In this framework we refer to these as the **statutory criteria** for decision-making[7]. These criteria and working out whether there is "reasonable cause to suspect" that these are met, inform any decision identifying a duty to make enquiries. The local authority is responsible for that public law decision as to whether or not to proceed with the duty to make enquiries under S42 (2).

The last two points (iv. and v. above) under S42 (2) support an understanding that activity attached to that duty is required - to inform the decision on what action needs to be taken and by whom.

The following flow chart illustrates this.

[6] *(1) This section applies 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.
(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.

[7] This is to avoid any inference that an individual must 'pass a test' or 'reach a threshold' to get safeguarding support.



The objectives of a S42 enquiry into abuse or neglect are set out in paragraph 14.94 of the Care and Support Statutory Guidance (2018):

- 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

The duty to make enquiries under S42(2) is not a prescriptive process in the way it was before the Care Act (2014) but consists of activity to inform decision-making and the actions to be taken. This might include new care assessments or care plans - or to take no action at all. (Paragraphs 14.110 and 14.111 of the Care and Support Statutory Guidance (DHSC, 2018) provide more detail on the formulation of agreed action, which is the outcome of an enquiry. An illustration of how this applies in practice is set out in Case Study 4 (Mr Hastings) in Appendix 5).

Summary of the core aspects of a suggested framework for decision-making and reporting

S42 is the environment within which we operate when a safeguarding concern comes in to the local authority (LA). It ensures support to keep people safe who may be at risk of or experiencing abuse/neglect. That support may be required within the S42(2) duty to make enquiries or outside of it.

Information gathering is done under the duty described in S42(1), and if the criteria in this part are met then the enquiry & decision on what action to take (including taking no action) will follow under the duty to make enquiries described in S42(2).

Where there is reasonable cause to suspect that points i.-iii. above are met then the S42 (1) duty continues with the duty to make enquiries. Points iv. and v. under S42 (2) indicate activity that is required in connection with that duty ie to make enquiries to inform the decision on what action needs to be taken and by whom.

A S42 (2) enquiry will take many forms by conforming to the six key safeguarding adults principles and Making Safeguarding Personal[8].

From the start, robust information gathering (including that set out in 14.92 (Care and Support Statutory Guidance, DHSC, 2018) will establish whether there is reasonable cause to suspect that the three statutory criteria for a S42 enquiry are met (S42 (1)). Depending on the findings, this activity may or may not be reported ultimately as within a S42(2) enquiry.

From a prevention point of view, conversations within this early information gathering can themselves make a valuable contribution in informing and empowering people to keep themselves safe.

Although the points above are numbered, this is not a linear process. The decision-making needs to be dynamic. Practitioners might change their mind as information unfolds about whether or not the situation meets the statutory criteria for undertaking an enquiry under the S42(2) duty.

There is no fixed point during the early phase of an enquiry when a practitioner must determine how to report activity within the SAC return[9]. It may be that this is

[8] Paragraphs 14.13-14.15, Care and Support Statutory Guidance, DHSC, 2018

[9] Guidance on the SAC return is available at https://digital.nhs.uk/binaries/content/assets/legacy/pdf/0/m/sac-guidance-2018-19-v1.pdf

determined, and therefore recorded and reported as a S42(2) enquiry, after the practitioner has already done part of it. Reporting and recording reflect practice decisions.

Information gathering to determine whether the criteria in S42(1) have been met, must be recorded robustly to evidence/support the LA decision whether to progress to a S42 enquiry (S42(2)) or not. In the event that there is no S42(2) duty to make enquiries, the practitioner must still consider and record how any identified risk will be mitigated (including through communication with partner agencies) and how that will be communicated to the adult concerned and the person accused of causing harm.

How decisions are reported will depend on the conclusion as to whether there is reasonable cause to suspect that the situation meets the three statutory criteria. (S42(1)). At that point, in line with the reporting requirements of NHS Digital reflected in the (Safeguarding Adults Collection (SAC)[10], there are three options for reporting the activity:

1. as a safeguarding enquiry under the S42 (2) duty (where there is reasonable cause to suspect that the three statutory criteria are met).
2. as an 'Other'[11] safeguarding enquiry using the local authority's powers but not under the S42 (2) enquiry duty.
3. as not requiring any further action under adult safeguarding (although support might be offered through other powers). Such cases will remain reported as a safeguarding concern. The decision that the duty under S42 is not met must be properly recorded in local practitioner records and show how any residual issues/ risks will be addressed or prevented.

Safeguarding Adults Boards are encouraged to set up local ways of reporting and analysing activity related to safeguarding adults concerns that do not meet the duty to carry out a S42(2) enquiry, so that they can assure themselves of the types of concerns being received, the responses made and the outcomes for the adults concerned.

[10] https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf

[11] This is a voluntary element of the SAC but authorities are encouraged to record such activity. 'Other' safeguarding adults enquiries are reported within the SAC where an adult does not meet all of the Section 42 criteria but the council considers it necessary and proportionate to use its powers to make enquiries.

Core messages within this framework

There is clear indication of 'struggle', inconsistencies, ambiguities and disconnect across local authority areas. This was expressed at the workshops and elsewhere[12]. Current wide variation in practice and decision-making is reflected in the SAC data (as set out in Appendix 4). Taken together, this provides a rationale for offering a common approach going forward.

This paper is not intended as guidance to prescribe exactly what must be done but is offered as support to improve practice. It is being written in the spirit of empowering practitioners to make consistent decisions and to be confident in the rationale for those decisions (which is rooted in the legal framework and guidance). Data recording can then flow from this and reflect practice and outcomes more clearly and more consistently.

Appendix 5 highlights that 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 appendix offers examples of situations which may divide opinion, but which nevertheless offer a clear rationale for the decision made.

It is proposed that the following core messages, might be adopted to support shared understanding, consistency and accountability in this area of practice and reporting. They build on the definition and summary framework set out above.

Messages relating to shared values and principles[13] derived from the statutory framework

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.[14]

Two Specifically, 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 Care and Support Statutory Guidance (DHSC,2018). This introduces a duty to promote wellbeing and to adopt a flexible approach, focusing on what matters most to the individual.[15]

[12] See examples of local discussions and attempts to establish greater consistency in understanding and practice presented at the workshops, November 2018

[13] Principles referred to here include: Human Rights Act (1998) principles; the six statutory principles for safeguarding adults, alongside Making Safeguarding Personal (Care and Support Statutory Guidance, 2018 14.13-14.15) and the five core principles of the Mental Capacity Act, 2005. (see section 3 of this framework, below)

[14] See also Appendix 2 and the workshop (November 2018) slides provided by Fiona Bateman. This includes activity described in section 3 of this paper to assess whether there is a "reasonable cause to suspect" and whether the three statutory criteria are met. It also includes following Mental Capacity Act principles and guidance.

[15] Care and Support statutory Guidance, para 1.1, DHSC, 2018

Three The six statutory safeguarding adults principles[16] (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 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).

Four 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. This requirement is clearly set out in the Care and Support Statutory Guidance (DHSC, 2018)[17].

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.

Messages that suggest a shared and common interpretation of the Care and Support Statutory Guidance, (DHSC, 2018). The aim is to achieve greater consistency in applying the S42 duty in practice.[18]

Five Before a decision can be made that no S42 (2) duty to make enquiries exists, a judgement must be made as to whether there is 'reasonable cause to suspect' that the three statutory criteria are met. That is, whether this would be (in the context of the Human Rights Act, 1998) a lawful interference in someone's private life. This would include questioning what it is about the presentation and the context that supports a view that this individual (or other individuals) is at risk. This is activity under S42 (1), Care Act, 2014.

Six Alongside establishing 'reasonable cause to suspect', information needs to be gathered to establish whether the three statutory criteria in S42 (1) are met.

From the point at which the three statutory criteria (and alongside this an understanding that there is "*reasonable cause to suspect")* are met then there is a

[16] Paragraph 14.13, Care and Support Statutory Guidance, DHSC, 2018 – **Empowerment, Prevention, Proportionality, Protection, Partnership** and **Accountability.**

[17] Paragraphs 14.52 and 14.54

[18] See below and in section 3 and appendix 5 where case studies apply this interpretation

duty under S42 (2) to undertake an enquiry. All activity from that point will constitute an enquiry under the S42 (2) duty and be reported as such.

Seven The decision-making and activity that relate to the Section 42(2) duty to make safeguarding enquiries is not a linear or hierarchical process with separate and discrete stages and timescales. The decision-making needs to be dynamic. Practitioners might change their mind as information unfolds about whether there is reasonable cause to suspect that the situation meets the three statutory criteria or whether some alternative action is necessary to mitigate risk.

Messages relating to recording and reporting on decision-making and outcomes for people

Eight In respect of how activity is reported within the SAC return, it is important to clarify there is no fixed point during the early phase of an enquiry when a practitioner must determine how to report activity within the SAC return[19]. It may be that this is determined and therefore reported as a S42 (2) enquiry after the practitioner has already done part of it.

Nine It is important to remain open to reviewing the decision. For example, it is acceptable to say that initially the decision was for a care management response outside of the safeguarding process but then further down the line to conclude that there is evidence of abuse or neglect. (This point is illustrated with the case of Mrs Smith. See Section 3 below.)

Ten It is recommended that the SAC data (alongside local data and other forms of information such as audits, peer reviews, feedback from adults themselves and staff) be used by Safeguarding Adults Boards to ask questions and to seek necessary assurances about the effectiveness of practice and outcomes[20]. Local information must reflect those situations which do not progress to an enquiry under the S42(2) duty.

Aspects of the data and other available information should be used as a 'can opener' to ask questions rather than attempting to draw generalised conclusions.

[19] Guidance on the SAC return is available at https://digital.nhs.uk/binaries/content/assets/legacy/pdf/0/m/sac-guidance-2018-19-v1.pdf

[20] 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

The following case study illustrates how these core messages relate to good practice, especially in the application of the six safeguarding adults principles

Case study 1 – Mr and Mrs Lewis

The following situation was referred in by the daughter of an 80 year old man.

Case outline – Her father was showing signs of early dementia. He lived with his wife at home. They were both now in a position where they were unable to look after themselves. They were both frail and struggling with mobility. Her father was adamant that he was fine and that there was nothing wrong with him.

The daughter, however, was clear that he was not the same man that she had come to know as her father. She said that he had refused to attend a memory clinic appointment, which was made for him a few months previously and the clinic had said that they could do anything until he gave his consent.

The daughter advised that her mother has told her that he shouts at her and the daughter said that she was getting more and more worried that his temper may turn physical.

A week before the referral of these concerns by his daughter, Mr Lewis purchased a bed from cold callers at the house. This bed cost him nearly £5,000 - they did not need a new bed as they had not long purchased a new mattress for their existing bed. It was out of character for him to spend a large amount of money like this.

The daughter had contacted the bed company and they had promised to get back but have not done so as yet. In the meanwhile, the bed had been delivered and the old bed taken away. The daughter had rung the bank and the cheque had been cancelled but there were still concerns around her father being bullied into buying it.

All of this was making Mrs Lewis very poorly and she was finding day-to-day life unbearable. The daughter lives two and a half hours drive away but tries to get to see them at least once a month.

Suggested application of core aspects of the above framework to inform a decision about whether to carry out a S42 (2) enquiry:

In carrying out the S42 (1) duty

There is reasonable cause to believe that Mr Lewis and/or Mrs Lewis:

(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.

There is potential financial abuse from a possible rogue trader. This needs to be discussed with the trading standards department and police as others may be at risk. In addition, there is the risk of possible abuse of Mrs Lewis. Mr Lewis's own capacity to understand important information about his own health and wellbeing is in doubt as well.

There is reasonable cause to suspect that S42(1) is 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 (once S42(1) is met) that agrees what is the action needed to keep the person safe **is** a S42 enquiry. In this case this might include identifying the need for:

- Information and advice about how to stay safe from rogue traders, money management- e.g. information about the roles and responsibilities of Lasting Power of Attorney;
- Action to investigate and prosecute rogue trading;
- Advice from primary health professionals on recognising/ managing symptoms of dementia, home adaptations and fall reduction support and interventions;
- Support from specialist, community agencies to reduce social isolation and to support both adults to understand and reduce the risks and to know how to report concerns;
- A S9 or a S10 assessment (Care Act (2014).

Timescales for reporting that this has been completed must be clear.

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

Application of the six safeguarding adults principles that should underpin all adult safeguarding work are set out in section 3 (below) and in Appendix 1. These might be reflected (alongside principles of the Mental Capacity Act, 2005) in working with this family as follows:

Empowerment – initially the daughter of the person is involved, and her views sought. Best practice might engage an advocate or potentially a family group conference to involve and engage all family members in exploring needs, risks and potential support as part of both the enquiry and the ongoing actions.

Protection – enquiries are made, and action planned to protect the two adults in the household concerned and also others from the doorstep trader.

Prevention - Others in the neighbourhood may be protected from potential harm from the doorstep traders early on before abuse/neglect and any further harm comes about. The tensions in the situation between the husband and wife may be impacted on before this escalates (as the daughter has indicated she fears it might) through both the enquiry and ensuing actions.

Proportionality - the risk is assessed alongside those involved and public interest considerations are also a factor. This informs a proportionate response.

Partnership – work is undertaken in partnership with the family. There is engagement of police and trading standards (in respect of the doorstep traders and purchase of the bed). Also, with health colleagues in respect of the frailty of both the husband and wife and how a positive impact can be made on their health, safety and wellbeing.

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

Paragraphs 14.110 and 14.111 (Care and Support Statutory Guidance, DHSC, 2018) set out the need for clarity about the outcomes of the enquiry and any agreed action plan formulated as a result of the enquiry.

What might need to be addressed to support acting on these messages?

An ADASS Advice Note has been developed making recommendations to DASSs in order to support communicating and implementing this framework. It suggests key points for the attention of Directors of Adults Social Services (DASSs) in order to ensure that this framework and principles is reflected in local protocols and practice. It suggests that DASSs should review whether the following are in place as support for putting the framework into practice. Wider ownership of these actions will strengthen practice.

1. Seek assurance that decision making regarding safeguarding enquiries reflects the statutory guidance and legislation, using the framework to support this.
2. Seek assurance that people are not disadvantaged where their circumstances are not considered as part of a statutory S42(2) enquiry. Is there clear information on *all* routes for addressing safeguarding concerns and the outcomes? Is everyone being protected, including where support falls outside of a S42(2) enquiry?
3. Consider the impact of arrangements at the 'front door' on decision making regarding safeguarding enquiries (see appendix 3 of the framework)
4. Offer of support and development opportunities to staff in interpreting the legal framework and legal requirements (including statutory principles) and in making the necessary professional judgements.
    a. For example: Enable decision-making about enquiries under S42 to be a focus for reflective practice and case discussion[21]. Make use of the

[21] The workshops held in Yorkshire and the Humber provide a model for how regional discussions can be conducted – see Appendix 3.

MSP briefing on risk for SABs to support making judgements about whether there is sufficient justification to make enquiries. https://www.local.gov.uk/briefing-working-risk-safeguarding-adults-boards

b. For example: Enable and support local and regional conversations to establish shared ownership of this framework for decision making. Work in the Yorkshire & the Humber region offers an excellent template for this (see Appendix 3 of the framework). The summary of the framework, the case studies included in the framework and in the appendices, will support these conversations.

5. Check that local safeguarding adults procedures fully reflect the spirit of the Care Act (2014) and are not simply a reuse of old *'No Secrets'* based process-led ideas and approaches, without significant change.
6. Pay attention to the language used about safeguarding. Language should convey the principles that are at the heart of good practice. Be aware that the language used can run counter to those principles. Use Appendix 1 of the framework to promote understanding of how core principles translate at the front line. Consider the suggestions in the framework for a shift in terminology away from terms such as 'threshold' or 'three-point test'.
7. Seek assurance that practice is not driven by IT systems and reporting processes that are designed on a linear flow of information. Decision-making is not a linear process in practice. Data needs to flow from practice rather than practice being driven by IT /reporting systems. Provide support /development to staff to guard against this.
8. Consider how local information and data could supplement information available from the Safeguarding Adults Collection (SAC). It should include for example, audits; peer reviews; feedback from/about individuals who have received safeguarding support; feedback from conversations amongst practitioners. This will support broader assurance that people are safeguarded through prevention and early intervention as well as through statutory S42(2) enquiries.[22]
9. Discuss with the Independent Chair of the Safeguarding Adults Board how the Board can promote understanding and use of the framework and require assurance from partners that the framework is being used locally and achieving improvements in practice.

Section 3 Developing a common understanding of the duty to undertake a section 42 enquiry

The statutory framework; core principles

[22] 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

A human rights framework

The Care Act (2014) provides a legal basis for safeguarding adults from abuse or neglect within the context of broader reforms. These introduced a duty to promote wellbeing and to 'adopt a flexible approach that allows for a focus on which aspects of wellbeing matter most to the individual concerned'[23]. The suggested approach in this paper needs to be seen within the context of these broader aspirations of the Care Act (2014) and the need to act in accordance with human rights legislation.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) sits firmly within the Care and Support Statutory Guidance (DHSC, 2018). [24] It means that safeguarding adults:

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety

The importance of Making Safeguarding Personal for people who may be in need of safeguarding support was underlined repeatedly by adults in Cheshire East[25] including:

"I want to be involved as if there is a set plan, I can be involved in tweaking it. Everyone is individual and I'd rather be involved to say what works/what not works for me".

However, Making Safeguarding Personal does not mean 'walking away' if a person declines safeguarding support and/or a S42 enquiry. That is not the end of the matter. Empowerment must be balanced for example, with Duty of Care and the principles of the Human Rights Act (1998) and of the Mental Capacity Act (2005). Best practice in working with risk must be considered.[26] The need for balance on this issue is illustrated elsewhere within the Care Act (2014), in Section 11, where it is explicit that although the local authority duty to carry out a needs assessment (S9) may be removed if the adult does not consent, this does not apply where the adult is experiencing or at risk of abuse or neglect. S11 (2) (b)'.[27]

In the event that there is no duty under S42 to make enquiries, the practitioner must still consider how any identified risk will be mitigated and how that will be communicated to the adult concerned and the person accused of causing harm.

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[23] Paragraph 1.1, Care and Support Statutory Guidance, DHSC, 2018

[24] Paragraphs 14.14 and 14.15

[25] Comment from conversations (as a follow up to the workshops in November 2018) with several people at 5 different services across Cheshire East; adults with learning disabilities and physical disabilities.

[26] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/working-risk offers support in balancing apparently conflicting principles

[27] **Care Act, 2014, S 11 Refusal of assessment**

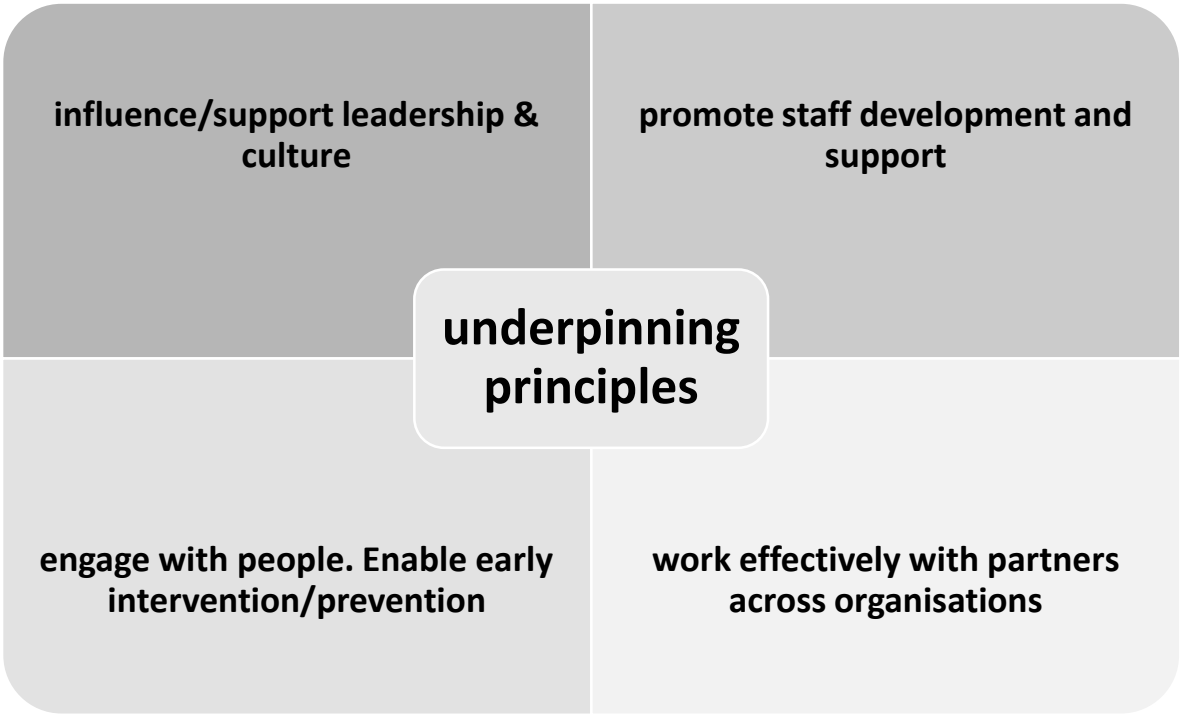
(1)Where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment (and section 9(1) does not apply in the adult's case).

(2)But the local authority may not rely on subsection (1) (and so must carry out a needs assessment) if—

(a)the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or

(b)the adult is experiencing, or is at risk of, abuse or neglect.

This framework builds on a range of resources in the Making Safeguarding Personal (MSP) programme[28]. This diagram illustrates how a number of different strands link together to contribute to making safeguarding personal.



Development under all these headings is needed to support best practice in working together with people and across the partnership:

- to identify safeguarding concerns
- to share information to establish which of these requires a S42 enquiry
- to identify alternative effective responses where a S42 duty is not indicated but some other action is needed
- to prevent circumstances from escalating to the point where a S42 duty is triggered
- to support staff in making legally literate decisions
- to develop cultures and leadership that enable and support responses that reflect human rights and safeguarding adults principles.

The core resource for Safeguarding Adults Boards (LGA/ADASS, 2017)[29] highlights the importance of measuring the difference that MSP makes for people. This is essential as part of the assurance role of Safeguarding Adults Boards. It must include qualitative and quantitative information, both regarding enquiries under S42(2) and in those situations where that duty to make enquiries is not triggered.

"What's important is that something is done about the situation."

[28] www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/resources

[29] www.local.gov.uk/making-safeguarding-personal-safeguarding-adults-boards

"People just want to know that we acknowledge this is something that is important to them and something will happen"[30].

Six key principles underpin all adult safeguarding work

These should inform the ways in which professionals and other staff work with adults. Recording needs to reflect explicit consideration of how all of these principles influence decision-making. The case study in section 2 (above), and those elsewhere in this framework and the appendices, demonstrate how these principles are applied in practice. The principles provide a framework for ensuring that a range of responses is considered to reflect individual circumstances. They are set out in the statutory guidance to the legislation.[31]

Empowerment

People being supported and encouraged to make their own decisions and informed consent.

Prevention

It is better to take action before harm occurs.

Proportionality

The least intrusive response appropriate to the risk presented.

Protection

Support and representation for those in greatest need.

Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability

Accountability and transparency in delivering safeguarding.

All six safeguarding adults principles must be at the heart of practice in order to deliver flexible responses around the needs and wishes of the person.

Appendix 1 sets out in detail how each of these principles relates to decision-making in the context of the S42 duty and what will help to support that in practice and in recording and reporting. Appendix 3 sets out in more detail the comments from the workshops about the use of principles in decision-making.

Discussion at the workshops (LGA, November 2018) reflected particularly on the significance of Proportionality and Empowerment but recording needs to reflect explicit consideration of how all these principles influence decision-making.

For this reason, the principle of **Accountability** is particularly significant in safeguarding. It brings together conversations about both practice and recording in making decisions.

[30] Observations from participants attending one of the S42 workshops in November 2018

[31] Paragraph 14.13, Care and Support Statutory Guidance, DHSC, 2018

'…data collection is important to me as someone could be seriously hurt without looking at the wider picture to stop abuse'.[32]

Accountability is about:

- reporting
- being able to explain how something has been approached
- accounting for actions
- accepting responsibility for actions and outcomes and understanding mutual roles
- having transparency and openness about the process/approach and understanding and recording why a particular approach was taken.

An assurance framework for this is important in order to be clear what is happening in the range of responses. For example, Devon County Council lists its assurance framework as including:

- ❖ internal audit,
- ❖ peer review against other authorities in the region;
- ❖ conversations across the region to understand the differences and the issues and,
- ❖ assuring and monitoring decision-making by completing monthly practice quality reviews.

Support in interpreting the Care and Support Statutory Guidance (DHSC, 2018) towards greater consistency in establishing where the S42 duty applies

The Section 42 duty requires consideration of the following criteria under Section 42 (1) and (2) of the Care Act (2014):

S42 (1)

Whether there is "reasonable cause to suspect" that an adult

i. has needs for care and support
ii. is experiencing, or is at risk abuse or neglect, and
iii. as a result of their needs is unable to protect themselves

S42 (2)

iv. Making (or causing to be made) whatever enquiries are necessary
v. Deciding whether action is necessary and if so what and by whom

This paper suggests a consistent way of interpreting the Care and Support Statutory Guidance (DHSC, 2018), reaching a shared understanding that from the

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

point at which the 'three statutory criteria (i.-iii. above) (and alongside this an understanding that there is 'reasonable cause to suspect'*)* are met then there is a duty under S42 Care Act (2014) to undertake an enquiry. All activity from that point will constitute an enquiry under the S42(2) duty.

This activity may take many forms. Decisions as to how to respond and what form an enquiry takes should be tailored to meet the needs of the individual. Application of the six statutory safeguarding adults principles supports practice to achieve this.

Paragraph14.93[33]

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.

Reasonable cause to suspect' and the three statutory criteria must be considered by the local authority, as set out in S42 (1) Care Act, (2014), in deciding whether there is a duty to make enquiries.

There needs to be consideration of whether there is sufficient justification for the local authority to make enquiries into a person's private life (in the context of the Human Rights Act,1998) in order to discover what supports a view that the three criteria are met and, if so, that an enquiry is necessary. This is what is meant by exploring whether there is **'***reasonable cause to suspect'.* This links to the principle of proportionality (ie the least intrusive response appropriate to the risk presented).[34] This involves weighing up what is known about the level of risk and the person's understanding of that. It isn't simply about 'walking away' if the person declines safeguarding support. Public interest considerations need to come into play too.

Records need to reflect that the information gathering at this stage is necessary to address whether the situation meets the criteria set out in S42 (1).

Consideration of these criteria includes ascertaining (usually through contact with the adult or, if they lack capacity, their representative/ advocate) whether the individual understands the risk faced and/or whether, because of their care and support needs, they are unable to protect themselves. (See the final point in the diagram below).

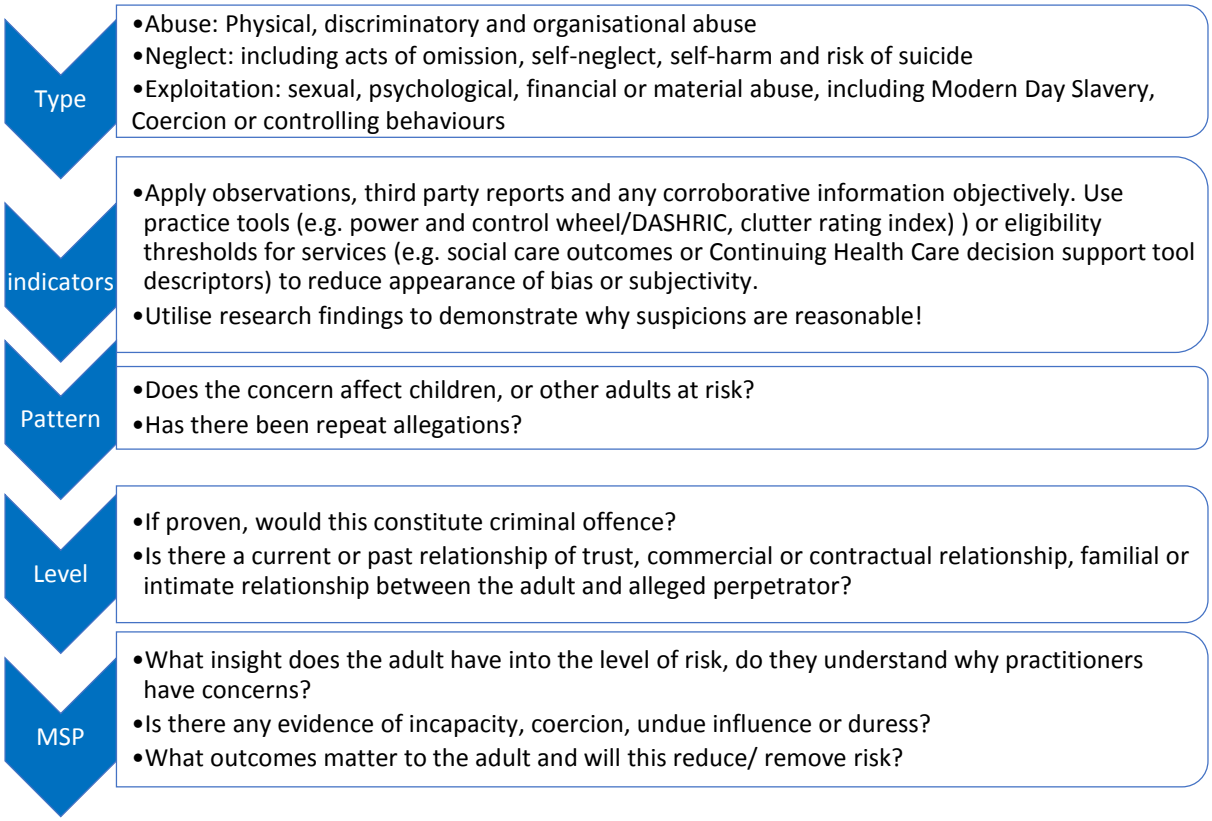
Information gathering (to ascertain whether the statutory criteria in S42(1) are met) must take place in order to decide whether activity within the duty to make enquiries under S42(2) is triggered and is consistent with the rights of the person. Where those

[33] Paragraph 14.93, Care and Support Statutory Guidance, DHSC, 2018

[34] Paragraph 14.13 and 14.92, Care and Support Statutory Guidance, DHSC, 2018

points are considered to be met then actions in connection with the S42(2) duty are required.

The diagram below sets out factors that might be considered in making the necessary judgements about 'reasonable cause to suspect' and whether the situation reflects the three statutory criteria.



This builds on factors for consideration set out in the Care and Support Statutory Guidance (DHSC, 2018)

Paragraph14.99
It is important, when considering the management of any intervention or enquiry, to approach reports of incidents or allegations with an open mind. In considering how to respond the following factors need to be considered:

- the adult's needs for care and support
- the adult's risk of abuse or neglect
- the adult's ability to protect themselves or
- the ability of their networks to increase the support they offer
- the impact on the adult, their wishes
- the possible impact on important relationships
- potential of action and increasing risk to the adult
- the risk of repeated or increasingly serious acts involving children, or another adult at risk of abuse or neglect
- the responsibility of the person or organisation that has caused the abuse or neglect

- research evidence to support any intervention

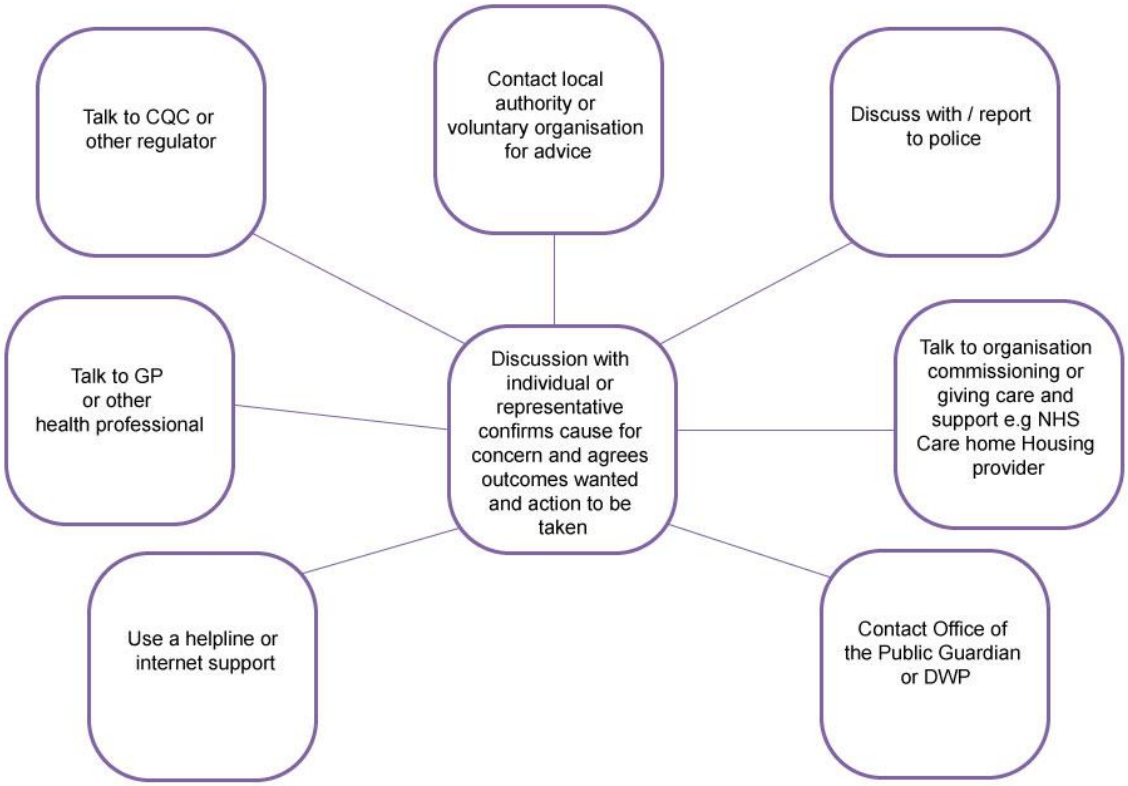
When does information gathering (to establish whether the three statutory criteria are met) end and a S42 enquiry begin?

Where the local authority satisfies itself that the three statutory criteria are not met, activity may be similar but just not carried out under adult safeguarding process or a S42(2) enquiry. From the outset, activity like that set out in paragraph 14.92, (DHSC 2018) -see diagram below, will begin to fulfil the objectives of an enquiry as set out in paragraph 14.94 (whether or not that activity is ultimately reported as a S42(2) enquiry).

There is complexity around where information gathering (to establish whether the statutory criteria are met) ends and actions as part of the early stages of a duty to make enquiries (including conversations) begin. Although these elements are numbered (above), this is not a linear or hierarchical process with separate and discrete stages and timescales. The decision-making needs to be dynamic. Practitioners might change their minds as information unfolds about whether the situation meets the statutory criteria for a S42 (2) enquiry. .

It may be that initially information gathering indicates that there is not a S42 duty to make enquiries but that later down the line, as early enquiries are made, then more is found out and the decision is revisited to say it does now meet the criteria set out in S42 (1). Alternatively, the reverse might apply. (See for example the Mrs Smith case study, below).

The diagram below is from paragraph 14.92 of the Care and Support Statutory Guidance (DHSC, 2018). It illustrates conversations that might form part of both information gathering to establish whether the three criteria are met *and* within S42 enquiries. This should be experienced as 'seamless' practice by the individual concerned.



14.92 "If the issue cannot be resolved through these means or the adult remains at risk of abuse or neglect (real or suspected) then the local authority's enquiry duty under section 42 **continues** until it decides what action is necessary to protect the adult and by whom and ensures itself that this action has been taken"[35].

Note: the use of the word ***"continues"*** conveys the meaning that local authorities must be satisfied that there is not a reasonable cause to suspect that the three statutory criteria are met before determining that they are not under a duty to make enquiries. In addition, these early enquiries (once it is established that the criteria are met) are already part of fulfilling the Section 42 duty, S42 (2). Equally, such conversations may form part of establishing reasonable cause to suspect that the three statutory criteria are met.

The following case study supports understanding about the way in which information gathering and the decision to make enquiries under S42 (2) is not always a linear process. As information comes to light the decision may be reviewed.

Case study 2 - Mrs Smith

Case Outline

Mrs Smith suffers from dementia and requires hoisting for all transfers. She suffered an unwitnessed fall in the lounge of her care home, resulting in a bump above her left eyebrow and two black eyes.

[35] Text from paragraph 14.92, Care and Support Statutory Guidance, DHSC, October 2018

Staff were in the lounge but dealing with another resident who required the toilet. Mrs Smith had had no previous falls. She was taken to hospital; the injury was cleaned up and a dressing placed on her forehead. Since then she has been fine and is still able to sit in the lounge.

There is now, following this incident, always a member of staff in the lounge but another staff member will be called on to watch Mrs Smith whenever she is in the lounge.

Mrs Smith lacks capacity to give her views, but her son has stated that he is satisfied with the outcome and does not want the matter investigated further.

Applying the framework to this case study

At the heart of the decision about whether a S42 (2) enquiry is indicated is robust information gathering.

In this case, the criterion, of those set out in S42(1), that is perhaps most likely to cause debate in making a judgement, is whether Mrs Smith is *experiencing, or is at risk of, abuse or neglect,*

The framework set out in this paper supports a view that information gathering must elicit enough detail to decide whether the situation meets the criteria for a safeguarding enquiry ie that there is reasonable cause to suspect that the three criteria in S42(1) are met. Part of this will be a decision about whether the fall was as a result of neglect. If that activity concludes that it does meet the criteria, then there will be an enquiry under the S42 (2) duty in order to consider what action needs to be taken and by whom. If not, then there may be other actions but not under the S42 (2) duty to make enquiries. This would include a report to CQC and a record of the incident in the context of this provider. This enables any pattern of similar future concerns to be picked up.

This may at first appear to be a one-off accident. It may be concluded from initial information that prompt action was taken in obtaining medical attention and that ongoing supervisory measures were put in place as a result of this first indication that Mrs Smith needed a higher level of supervision. The conclusion may be that therefore this did not constitute neglect and did not meet all three statutory criteria for a S42 (2) enquiry.

However, further information gathering may change that view, for example if the hospital visit, or a visit to the GP found that Mrs Smith had a urinary tract infection due to dehydration. This may offer a stronger rationale for considering neglect and a S42 (2) enquiry. The possibility of a preventable underlying health issue, impacting on her stability may indicate the need for further enquiries under S42 (2) including into hydration policy and practice.

The fact that the family do not want this to be progressed is a factor to be taken into account in making decisions but in a care setting, public interest considerations will be significant and the importance of the safety of all residents must be discussed with the individual/their family.

This illustrates that information gathering to ascertain whether the three statutory criteria are met may lead to an initial judgment, but that obtaining further information may change that judgement. This will influence whether or not the situation is ultimately reported under the S42(2) duty to make enquiries.

A framework is offered here, and this does not dictate whether the judgment will be made one way or the other. Rather it offers tools and principles that can be used in making such judgements.

Suggested shared understanding of terminology

A shared set of terms to describe activity will support clarity and consistency.

The terminology must reflect that there is a flow of activity; *not* a linear or hierarchical process with separate and discrete stages.

In this paper the following terminology is suggested for wider adoption. This supports the interpretation of the available guidance that is suggested here.

Information gathering is activity that takes place to determine whether the situation meets the three statutory criteria. This might well include some of the conversations indicated in paragraph 14.92 of the statutory guidance (see diagram above).

Three statutory criteria is suggested as an alternative to 'three point-test'. This is in line with the terminology within the statutory guidance (DHCS, 2018) and avoids any implication that an individual needs to get through a test or pass a threshold in order to receive support to address risk, abuse or neglect in their life..

Early enquiries reflects the initial activity that forms part of carrying out the S42 duty. This might *also* include activity and conversations reflected in the diagram within 14.92 of the statutory guidance.

Recording. This is what practitioners write down to evidence decision-making and actions.

Reporting in the context of S42 decision-making is how the decision is classified for data collection.

The use of the term **'preliminary enquiry'** has been variously used elsewhere to describe activity both to find out whether a situation meets the three statutory criteria *and* that which constitutes the early stages of activity within the S42 duty to enquire. This can lead to confusion and it is probably more helpful to avoid using this term.

It is suggested that it might be helpful too in supporting consistent understanding and practice in the context of the Care and Support Statutory Guidance (DHSC, 2018) if the term **'formal' enquiry'** were to be avoided even though this term does appear in the statutory guidance as follows:

> Paragraph14.77
>
> An enquiry is the action taken or instigated by the local authority in response to a concern that abuse, or neglect may be taking place. 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 action. Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views, wishes, and any immediate action has taken and the reasons for those actions[36].

[36] Paragraph 14.77, Care and Support Statutory Guidance, DHSC, October 2018

This part of the guidance is clear about the need for a range of responses dependent on the individual circumstances; that an enquiry can take many forms "from a conversation … right through to a much more formal multi-agency plan or course of action." This is reinforced in paragraph14.93 of the statutory guidance, where it 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 views and wishes which will often determine what next steps to take." This all reinforces the six safeguarding adults principles and Making Safeguarding Personal.

S42 imposes a duty to enquire where there is reasonable cause to suspect that the three statutory criteria are met. All aspects and forms of enquiry are significant. There is no hierarchy. It is not the case that a S42 (2) duty to enquire is only present where enquiries and planning are complex and multiagency. The Care and Support Statutory Guidance (DHSC, 2018) uses the term 'formal' in the context of the range of potential activity that might constitute an enquiry. This is helpful and consistent with the above. It is perhaps less helpful to use the term 'formal enquiry' as this has led some to understand that only a complex and formal plan might constitute a S42 (2) duty. This appears inconsistent with the meaning conveyed in paragraphs 14.77 and 14.93.

The case studies in section two and three illustrate good practice in information gathering to ascertain whether the three criteria are met, as well as in applying the six safeguarding adults principles.

Section 4 What are the key issues that need addressing to improve consistency in reporting safeguarding activity?

Core messages in Section Two include those relating to reporting and recording.

Core Message Eight

In respect of how activity is reported within the SAC return, it is important to clarify there is no fixed point during the early phase of an enquiry when a practitioner must determine how to report activity within the SAC return[37]. It may be that this is determined and therefore reported as a S42 enquiry after the practitioner has already done part of it.

Information needs to be gathered to ascertain whether or not the three statutory criteria are met. Information gathering may involve quite a bit of interaction before there can be a decision about whether or not the situation is one of abuse or neglect and whether or not there was harm to the individual. As set out above, the information gathering and early part of enquiries will take in some of the same conversations.

How this is reported will depend on the conclusion as to whether or not the situation reflects the three statutory criteria. At that point there are three options for reporting the activity:

[37] Guidance on the SAC return is available at https://digital.nhs.uk/binaries/content/assets/legacy/pdf/0/m/sac-guidance-2018-19-v1.pdf

1. As a safeguarding enquiry under the S42 duty where the three criteria are met.

2. As an 'Other' safeguarding enquiry using the local authority's powers but not under the S42 duty. (For example, where the authority chooses to carry out a safeguarding enquiry even though the adult concerned does not have care and support needs or may be able to protect themselves. This may be because of the severity of the case or because there is a public interest aspect to the case.)

3. As not requiring any further action under adult safeguarding processes (although support might be offered through other powers). Such cases will remain reported as a safeguarding concern. The decision that the duty under S42 is not met must be properly recorded in local practitioner records and show how any residual issues/ risks will be addressed.

Some situations (such as that of Joyce below) may be resolved very quickly and not involve a lot of activity. In such cases, the information gathering may have established at an early stage that there is reasonable cause to suspect that the three statutory criteria have been met. However small the enquiry may be it should be reported as being under the S42 duty if there is reasonable cause to suspect that the statutory criteria are met.

Case Study 3 - Joyce[38]

Joyce had concerns about her neighbour, who had "borrowed" money and not repaid it. She said she didn't want "anything to be done" as the neighbour was "very kind" and visited her regularly.

Joyce said that she would like to speak with her neighbour on her own, but she wasn't sure how to start the conversation. It was an opportunity to help her develop resilience. The practitioner provided Joyce with some coaching about how she might start the conversation and what she wanted to get out of it.

Joyce was then able to talk with her neighbor who was initially defensive but, after a day or so, he reflected on what Joyce had said and he visited her again to apologise for putting her in the position where she didn't feel able to refuse his request.

Although Joyce reported that her relationship with her neighbour was "a bit fragile", he is still visiting her and hasn't asked her for money. Joyce said that she felt she was listened to and that professionals wouldn't do anything without her permission.[39]

[38] https://www.local.gov.uk/sites/default/files/documents/Making%20Safeguarding%20Personal%202013-2014%20-%20Case%20Studies.pdf

[39] Individuals like Joyce may sometimes need independent advocacy. This may form part of the actions that flow from a S42(2) enquiry. Care Act statutory guidance (paragraphs 7.4/7.24) is clear that an independent advocate should be arranged where appropriate for adults who have "substantial difficulty" being involved as the subject of a safeguarding enquiry or safeguarding adult review. This responsibility sits alongside

Conversely, in the light of information gathered and enquiries made, the practitioner may conclude that, although there was a lot of activity involved, they are satisfied that the activity did not come within the S42 duty to make enquiries as it did not meet the three statutory criteria. Such activity does not need reporting in the SAC unless it should be reported as an 'Other' safeguarding enquiry. This is a voluntary element of the SAC but authorities are encouraged to record such activity. 'Other' safeguarding adults enquiries are reported within the SAC where an adult does not meet all of the Section 42 criteria but the council considers it necessary and proportionate to use its powers to make enquiries.

Any response to a concern comes under the broad S42 duty. The duty is there to ensure we act to protect people who may be at risk of or experiencing abuse or neglect. It is there to support keeping people safe through flexible responses that respond to their individual circumstances.

The initial information gathering takes place within that broad S42 duty and informs a decision to filter a particular situation in or out of a S42 enquiry. The decision may lead to reporting under any of the three options set out above. None is of more significance or value than the others. The important thing is that the individual is supported, and abuse or neglect is addressed and/ or prevented. Activity reported under options 2 and 3 above can be just as significant in keeping an adult safe as that which takes place within a S42 enquiry.

Differing arrangements at the 'front door' of local authorities can hinder progress towards consistent decision-making and reporting. Factors include the range of skill and experience of 'first contact' staff; the range of professionals involved in these teams; whether or not there is a Multi-Agency Safeguarding Hub (MASH) arrangement; the range of triage systems; whether care quality issues are dealt with initially by commissioners; who gathers information on whether the three statutory criteria (S42 (1) are met; the role of generic/locality based teams or specialist safeguarding teams in carrying out enquiries. (This is explored in more detail in Appendix 3.) Inconsistencies in practice will be reflected in reporting.

We would encourage Safeguarding Adults Boards to set up local ways of reporting and analysing activity related to safeguarding adults concerns that do not meet the duty to carry out a S42 duty, so that they can assure themselves of the types of concerns being received, the responses made and the outcomes for the adults concerned.

The LGA/ADASS workshops (November 2018) considered challenges that have been made[40] as to whether some people may be disadvantaged by not having their circumstances treated as an enquiry under a S42 duty (ie. that they may not receive the necessary help and support through other means). By having clear information on *all* routes for dealing with concerns *and* the outcomes we can be clear and confident that all concerns are dealt with properly and people are being protected, including where support falls outside of an enquiry under S42.

responsibilities to provide advocacy set out elsewhere, including in the Mental Capacity Act (2005) and in the Mental Health Act (1983; 2007).

[40] A Patchwork of Practice, Action on Elder Abuse, December 2017

Section 5 Further Information

There are several supporting documents that give more detail on the issues covered in this paper or provide more background or context. These can be found on the Local Government Association website with other Making Safeguarding Personal resources. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

Appendix 1 sets out a table showing what the workshops (LGA/ADASS, 2018) identified as significant to support putting the principles into practice in the context of S42 decision-making**.**

Appendix 2 sets out advice on ensuring legal literacy in decision-making.

Appendix 3 sets out the main factors that account for the significant differences across localities in the proportion of concerns that become safeguarding enquiries.

Appendix 4 sets out what the national data tells us about safeguarding activity.

Appendix 5 sets out three case studies which include factors that divide opinion on whether or not the criteria set out in S42(1) Care Act (2014) are met.

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