A FRAMEWORK FOR MAKING DECISIONS ON THE DUTY TO CARRY OUT SAFEGUARDING ADULTS ENQUIRIES

Advice Note

July 2019

This Advice Note has been developed for ADASS members. It relates to the above framework developed on behalf of ADASS and LGA. Related cross sector work will follow which considers the circumstances that constitute a safeguarding 'concern.' The aim across the two pieces of work, is to support consistency in appropriate referral of, and responses to, safeguarding adults concerns and ultimately good outcomes for people.

What is it that the local authority needs to make a decision about?

The Care Act 2014, Section 42 (2) requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of those care and support needs is unable to protect him/herself against the abuse/neglect or the risk of it (see Care Act 2014, S42(1)).

A S42(2) enquiry establishes whether any action needs to be taken to prevent or stop abuse or neglect, and if so, what and by whom.

The local authority is responsible for this public law decision as to whether or not to carry out a statutory, s42(2) enquiry. It works alongside individuals and partner agencies in gathering information connected with S42(1) to support that decision and in carrying out S42(2) enquiries.

Purpose

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

Prior to the Care Act (2014) many councils operated thresholds consistent with eligibility thresholds in their understanding of where their safeguarding duties lie. The Care Act (2014) introduced a responsibility to make, or cause to be made, enquiries for any adult in need of care and support (not just those whose needs met eligibility thresholds) who might be at risk of or experiencing abuse or neglect.

The Care Act (2014) distinguishes statutory enquiries known as S42 enquiries (and set out in S42(2) of the Care Act (2014)) from early conversations and information gathering, which might lead to responses other than those statutory S42(2) enquiries.

The Care Act (2014) sets out clear criteria in S42(1) which, if met, must trigger a statutory enquiry (S42(2) to take place. The proportionate conversations and information gathering that take place in finding out whether the criteria in S42(1) are

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

met (and therefore whether a statutory enquiry is triggered) sometimes themselves offer protective and preventive value.

The framework builds on a range of resources produced by the Making Safeguarding Personal (MSP) programme[2]. It supports best practice in working together with people and with partners across sectors to work through the implications, options and most appropriate responses to deliver the outcomes that people want. It promotes transparency so that there can be clarity that, whether concerns are addressed through a statutory S42(2) enquiry or outside of that, people's safety and wellbeing are addressed.

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). People must not simply be abandoned in situations where, for example, there is significant risk and support is declined and/or coercion is a factor.

The framework is consistent with Care Act (2014) principles, including Making Safeguarding Personal (MSP). It advocates a common approach, whilst retaining flexibility to respond to individual needs and preferences. It underlines the significance of safeguarding support both within and outside of statutory (S42(2) enquiries and the need to record and report on all this activity. It is firmly rooted in the legal framework and statutory guidance. This supports practice and outcomes for people that are fair, lawful and reasonable.

The framework does not prescribe exactly what must be done but is offered as support to enhance practice and consistency. It aims to empower practitioners to make consistent decisions and to be confident in the rationale for those decisions. Recording should flow from this, reflecting consistent practice and outcomes.

Appendix 5 highlights that, a consistent framework to support determining whether a statutory S42 (2) duty to make enquiries is triggered, does not remove the need for professional judgement. A focus on individual circumstances is needed to decide whether a situation meets the criteria set out in S42(1) of the Care Act (2014). The appendix offers examples of situations which may divide opinion, but where there must be a clear rationale for the decision, based on the legal context.

Context and rationale for this framework

There is clear indication of 'struggle', inconsistencies and ambiguities across local authority areas in making decisions about the duty to carry out safeguarding enquiries. This was expressed at national workshops that informed the framework and is reflected in appendix 3 to the framework. Current wide variation in practice and decision-making is reflected in the Safeguarding Adults Collection (SAC) data (set out

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

in Appendix 4 of the framework). This provides a rationale for developing a common approach.

Recording and reporting of activity is important. The need to improve 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[3] have drawn general conclusions from published data about the extent to which people are protected. Public perceptions are influenced by such analyses. Broad and robust information about all safeguarding activity is needed to challenge such conclusions.

Although the workshops that informed this framework reflected numerous examples of excellent practice and outcomes for people, not all this work is currently reflected in the Safeguarding Adults Collection (SAC)[4] data return or in other publicly available information. Local information and data are needed to support understanding and monitoring of those situations which do not progress to an enquiry under S42 (2).

The Care and Support Statutory Guidance DHSC (2018) offers considerable support in interpreting the Section 42 duty. However, it is clear from conversations at national and regional workshops, that practitioners are interpreting this in a range of different ways. Perceived ambiguities in the legislation and guidance are reflected upon in the framework (including in Appendix 3 of the framework). Further opportunities for reflection and to consider and implement this framework are necessary locally and across regions to support a shift to more consistent understanding of that legislation and guidance, as a basis for practice and recording.

Legal context and best practice

What is a Section 42 enquiry?
This is set out in Section 42, Care Act (2014)[5]
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

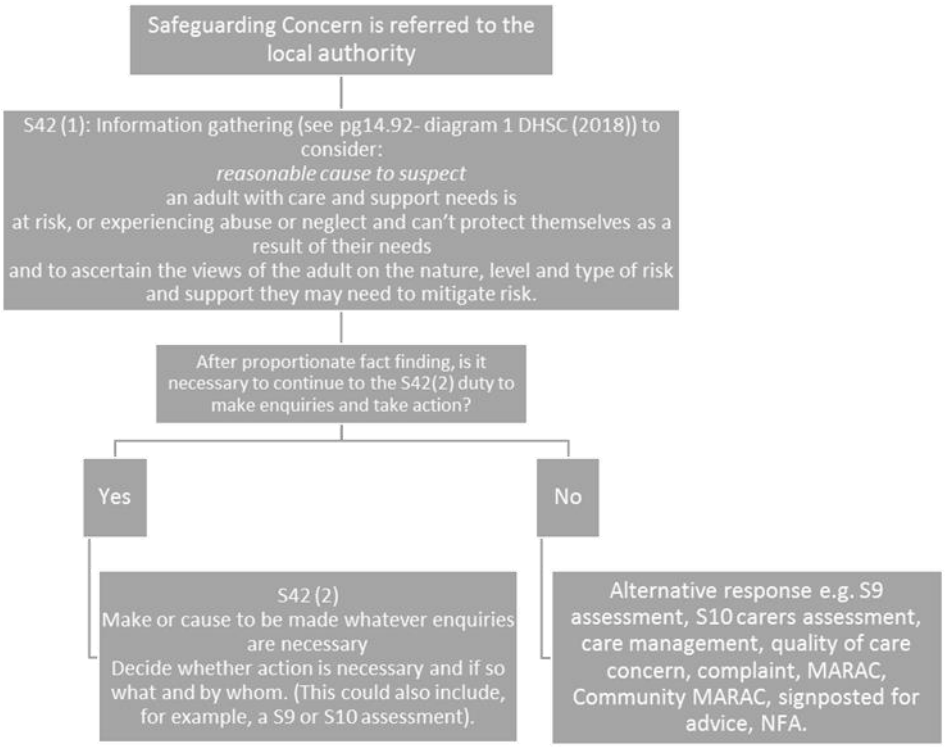
i. has needs for care and support

[3] A Patchwork of Practice, Action on Elder Abuse, December 2017
[4] Safeguarding Adults, England, 2017-18, Experimental Statistics – NHS Digital, November 2018 https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2017-18-england
[5] *(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.

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 following flow chart illustrates this.



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 statutory duty to make enquiries (S42 (2) of the Care Act (2014)). 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). The local authority is responsible for that public law decision as to whether the statutory S42 (2) duty is triggered.

The local authority and the Safeguarding Adults Board (SAB) need to find ways of recording and capturing information on early work under S42(1), which is currently not captured in the SAC, to evidence the decision making, impact. and effectiveness of safeguarding support from prevention through to intervention, resolution and recovery.

Where the decision is that the criteria do not apply and therefore the duty will not continue into S42(2), issues may still need to be addressed and/or risks mitigated under other processes and powers. This needs to be explicit and recorded. (Activity

within S42(1) includes determining whether, within a human rights context, it is fair, reasonable, lawful to 'interfere').

The statutory 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 (2018) provide more detail on the formulation of agreed action, which is the outcome of an enquiry.

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

S42 is the environment within which we operate when a safeguarding concern comes into the local authority (LA). It ensures support to keep people safe who may be at risk of or experiencing abuse or neglect. That support may be required within the statutory 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 and 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 i.e. 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[6].

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 a statutory enquiry under the S42(2) duty.

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

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[7]. It may be that this is determined, and therefore recorded and reported as a statutory 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 statutory 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)[8], there are three options for reporting the activity:

i. as a safeguarding enquiry under the S42 (2) duty (where there is reasonable cause to suspect that the three statutory criteria are met).

ii. as an 'Other'[9] safeguarding enquiry using the local authority's powers but not under the S42 (2) enquiry duty.

iii. 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 statutory 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.

[7] 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

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

[9] 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.

Suggested key points for attention of Directors of Adults Social Services (DASSs)

To ensure that **A framework for Making Decisions on the duty to carry out Safeguarding Adults enquiries** and safeguarding principles are reflected in local protocols and practice, DASSs should review whether the following are in place as support for putting this framework into practice:

i. Seek assurance that decision making regarding safeguarding enquiries reflects the statutory guidance and legislation, using the framework to support this.

ii. 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?

iii. Consider the impact of arrangements at the 'front door' on decision making regarding safeguarding enquiries (see appendix 3 of the framework)

iv. 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[10]. Make use of the MSP briefing on risk for SABs to support making judgements about whether there is sufficient justification to make enquiries.

   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.

v. 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.

vi. 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

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

front line. Consider the suggestions in the framework for a shift in terminology away from terms such as 'threshold' or 'three-point test'.

vii. 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.

viii. 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[11].

ix. 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.

[11] 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