

**A**chieving  
**C**are  
**T**ogether  
2026

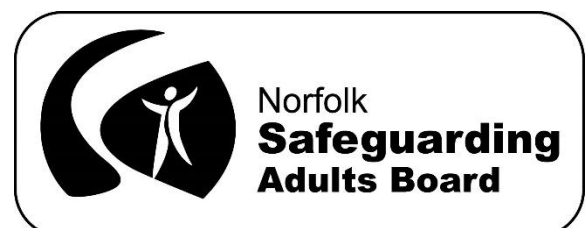
#NorfolkACT2026

# Workshop - Safeguarding Adults

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# Plan for this session (45 mins)

- 1 – Concise safeguarding concerns framework
- 2 - Carrying out an internal investigation and how that fits with s42 Care Act (safeguarding adults) enquiry

# 1 - NSAB Safeguarding concerns framework

A quick reference guide on different indicators of abuse to help all multi-agency staff and managers with decision making on what interventions are required – published 2025.

NSAB already has guidance around falls and medication errors, but the framework is more concise (3 pages long) and covers:

- General and unwitnessed falls
- Pressure areas
- Incidents between two adults who have care and support needs
- Medication errors

# NSAB Safeguarding concerns framework

## Aims to:

- Improve outcomes through better decision-making
- Create a consistent approach and shared understanding of safeguarding concerns
- Build transparent partnerships between organisations and increase confidence in the process

- The framework supports your professional judgement — every case is different
- Helps spot concerns needing safeguarding approach (abuse/neglect)
- Helps choose other routes for safety, wellbeing or quality issues
- More detail is available (e.g. NSAB guidance)
- You can still discuss with others (e.g QMOs) or use the portal

## Falls, pressure areas, incidents between adults and medication

The overall aim of the framework is to provide better outcomes for people and consistency in what is reported where. The guidance is not a substitute for professional judgement, rather it should help practitioners in identifying what concerns may require a response under the safeguarding process and support decision making when alternative routes and processes are used.

<b>Section 42 (1) Care Act 2014</b>	a) Does the adult have needs for care and support? b) Is the adult experiencing, or at risk of, abuse or neglect?
<b>Mental Capacity</b>	1. Is the person unable to make the <b>specific decision</b> when they need to? 2. Are they unable to make the specific decision because of an impairment of their mind or brain, whether as a result of an illness or other external factors such as alcohol or drug use?
<b>Making Safeguarding Personal</b>	All safeguarding activity should be person-led and outcome focused

<b>Report a safeguarding concern to the local authority</b>	<p>These are incidents of abuse/neglect that have been identified and require a specialist safeguarding response. This may result in a police-led response and/or a safeguarding enquiry under Section 42 of the Care Act.</p> <p><b>It is important to note that if the person is in any immediate danger the police must be contacted on 999 straight away.</b></p> <p>These are concerns raised that depending on the context and the case specific details that may require reporting for a specialist safeguarding response or may be managed via local management or quality concern response. These concerns will require discussion and consultation with a safeguarding professional and will require reporting to enable that discussion.</p>	<b>Action</b>	<p>Incidents at this level should be reported directly to local authority</p> <p>By telephone - on 0344 800 80 20</p> <p>Online via the NCC website or NCC Portal</p> <p>Out of hours and urgent concerns must be reported by telephone</p> <p><b>If there is any indication a criminal act has occurred and the matter is urgent, the police must be contacted.</b></p>
<b>Quality &amp; Risk management</b>	<p>In consultation with their organisational safeguarding leads, resolutions can be sought by individuals, their representatives or organisations themselves. These are concerns that have been raised with regards to the quality of care being delivered. No categories of abuse appear to have been identified.</p>	<b>Action</b>	<p>Incidents at this level do not require reporting to the local authority. However, agencies must keep a written internal record of what happened and what action was taken.</p> <p>Actions/outcomes may include advice, information, risk management, staff training or referral to other appropriate agencies.</p> <p>Where there is a concern about the actions of a person in one setting who also works in another setting, consider the <a href="#">Safeguarding Adults Data Sharing (SADS)</a> referral for information sharing</p>

## 1. General & unwitnessed falls

Report a safeguarding concern to the local authority	<ul style="list-style-type: none"> <li>• Injury/death where risk assessment / care plan not in place, or in place but not followed.</li> <li>• Previous known concerns but not addressed by organisation with or without injury.</li> <li>• Repeated incidents by same staff member but with no injury, whether the care plan followed or not.</li> <li>• Single incident, any staff member, care plan in place and followed, where there is significant injury</li> </ul>
Quality or risk management	<ul style="list-style-type: none"> <li>• Isolated incident, risk assessment in place and being followed. Appropriate care plan in place and being followed. No significant injury</li> <li>• Single incident, including agency / locum staff, with no injury and/or care plan not being followed</li> </ul>

See also NSAB – [Falls and safeguarding – guidance for providers](#) (this guidance has been designed for care providers but the principles of best practice around falls apply in any setting)

## 2. Pressure areas

Complete adult safeguarding decision guide as per **national guidance** [Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK \(www.gov.uk\)](#)

Report a safeguarding concern to the local authority  (i.e. score of 15 or above)	<ul style="list-style-type: none"> <li>• Pressure area - Person NOT risk assessed with regards to pressure ulcers risk and management and harm occurs</li> <li>• Failure to assess and provide suitable pressure relieving equipment and harm occurs</li> <li>• Failure to follow the advice of clinical specialists leading to harm/possible hospitalisation/irreparable damage/death</li> <li>• Pressure damage - Person risk assessed with regards to pressure areas, but actions not implemented and harm occurs</li> <li>• Pressure areas that have been investigated through the <a href="#">Patient Safety Incident Response Framework (PSIRF)</a> and have found to be preventable</li> <li>• Single or isolated incident of Grade 3 or 4 obtained either pre-admission or as an inpatient</li> <li>• Multiple Grade 1 and 2 pressure areas over the body that may indicate neglect.</li> </ul>
Quality and Risk Management	<ul style="list-style-type: none"> <li>• Pressure damage with no evidence of neglect or failure to provide or access adequate care or pressure relieving equipment</li> <li>• Pressure damage, person has capacity and makes an informed decision to decline treatment and pressure ulcer develops</li> <li>• Single or isolated incident of Grade 1 or 2 pressure ulcer</li> <li>• Isolated pressure ulcers where: a care plan is in place and is being followed and action taken. Other relevant practitioners have been notified and there has been full discussion with the person, their family or representative and there are no other indicators of abuse or neglect</li> </ul>

### 3. Incidents between 2 adults

<p><b>Report a safeguarding concern to the local authority</b></p>	<ul style="list-style-type: none"> <li>• Any incident resulting in intentional or intent to harm</li> <li>• Weapons or other objects are used with the intention to cause harm</li> <li>• Repeated incidents where the person lacks capacity and is unable to protect themselves</li> <li>• Victim appears fearful in the presence of other person or adapting behaviours to pacify or avoid the person</li> <li>• Failure to act on concerns and take preventative action where there is escalation of behaviours between identified individuals, leading to incidents</li> <li>• Multiple incidents where:             <ul style="list-style-type: none"> <li>○ Care plan has not or cannot be fully implemented</li> <li>○ Professional advice has not been sought or it is not clear that professional advice has been sought at the appropriate time</li> <li>○ There have been similar incidents involving this perpetrator or areas of concern.</li> <li>○ There are other indicators of abuse or neglect</li> </ul> </li> </ul>
<p><b>Quality and Risk Management</b></p>	<ul style="list-style-type: none"> <li>• Isolated incident where no harm or distress was caused</li> <li>• Both people display a dislike for each another but no abuse has occurred.</li> <li>• More than one incident where there was no impact on the person AND care plan is in place and adhered to, action has been taken to minimise the risk, other professionals have been notified, a full discussion with the person, family, representative and no other indicators of abuse/neglect</li> </ul>

### 4. Medication errors

<p><b>Report a safeguarding concern to the local authority</b></p>	<ul style="list-style-type: none"> <li>• Deliberate maladministration of medicines or failure to follow proper procedures, e.g. controlled medicines</li> <li>• Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death</li> <li>• Deliberate falsification of records or coercive/ intimidating behaviour to prevent reporting</li> <li>• Misuse of/over-reliance on sedatives to control challenging behaviour.</li> <li>• Recurring missed medicines and/or errors that result in adverse effects to one or more persons</li> <li>• A number of Incidents causing no adverse effect that are not reported by staff</li> <li>• Recurring prescribing or dispensing errors that affect <u>more than one person</u> and/or result in adverse effects to one or more persons</li> <li>• Covert administration without the person's consent or having a best interest decision recorded in the care plan.</li> </ul>
<p><b>Quality and Risk Management</b></p>	<ul style="list-style-type: none"> <li>• Any incident where the person is accidentally given the wrong medicines, given too much or too little medicines or given it at the wrong time but no adverse effect</li> <li>• Isolated incident causing no adverse effects that is not recorded by staff</li> <li>• Isolated prescribing or dispensing medical or nursing practitioner resulting in no adverse effects.</li> <li>• Prescribing or dispensing error by GP, pharmacist or other medical practitioner resulting in no adverse effects</li> </ul>

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## Using the scenarios in your groups and referring to the framework:

- Does this meet the threshold for reporting as a safeguarding concern to the local authority or not? Why?
- What immediate actions should be taken to keep the person(s) safe?
- What systemic or organisational issues might this scenario reveal?
- How should the adults and their family be involved?
- Would this scenario require notifications to other bodies?

Group  
exercise

- Scenario 1 – Betsy (pressure care)
- Scenario 2 – Daniel and Martin (incident between 2 adults)
- Scenario 3 – Pamela (medication)
- Scenario 4 – Leonard (falls)
- Scenario 5 – Hari (medication)

Feedback

## 2 - Carrying out an internal investigation and how that fits with a s42 enquiry

A safeguarding concern has been raised following a fall at a care home: Leonard is 78; he has dementia and is particularly confused at night, often unable to express himself, as well as reduced mobility. He was found on the floor at 3.45am by night staff. He has bruising to his hip and shoulder. He is unable to say what happened. Initial information suggests:

- The fall was unwitnessed
- His sensor-mat alarm did not activate
- He had been left in his room for more than two hours without checks, contrary to his night care plan
- There is inconsistent recording in the daily notes about his mobility and supervision needs

Due to concerns about possible neglect, poor monitoring, and potential system failures, a Section 42 Safeguarding Enquiry is opened by the local authority.

# Provider's role:

'Delegated Responsibilities' means the local authority can ask another practitioner or agency, including providers, to complete specific enquiry tasks. In this case the home is asked to carry out an internal investigation into the fall, focusing on how his care was delivered with reference to the care plan, equipment functioning, and staff practice.

Those findings are then shared with the allocated social worker, as the local authority keeps overall responsibility for the safeguarding enquiry – the social worker will complete the S42 enquiry and determine the overall outcome.

# Carrying out an internal investigation.

- Clarify the Questions from the Local Authority
- What do you need to do to answer them?
- Gather the evidence
- Analyse the evidence
- Safety actions
- Producing the report to share with the Local Authority
- What the Local Authority Does with the report
- Learning



# Purpose of a Section 42

A Section 42 enquiry is a statutory process to understand what happened, what the person needed, and what learning or improvements might help in future.

A substantiated outcome isn't just about blame or criticism but about ensuring we work together to strengthen safety and support for adults at risk.

Caring for adults who have needs, especially complex needs, can be challenging work and there are times when things go wrong. A safeguarding enquiry is a structured approach to understanding what happened and learning from that to prevent the harm happening again.



[Safeguarding Concerns Framework \(concise\) | Norfolk Safeguarding Adults Board](#)

St Thomas Training – [Safeguarding Know How for Provider Managers and Senior Staff | Norfolk Safeguarding Adults Board](#)

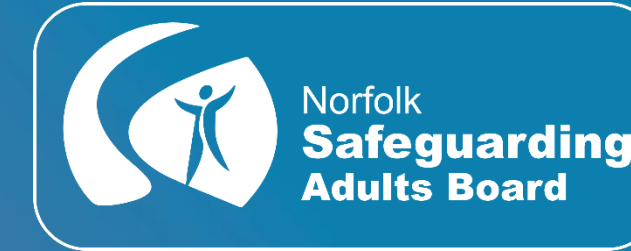
[Norfolk Safeguarding Adults Board \(NSAB\)](#)

# ACT Questions for you – in terms of **safeguarding**...

Q1: ...where are you now and what are your goals?

Q2: ...what support do you need to improve your service?

Q3: ...what would be the impact of making the improvements you want to make?



# Thank You

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