West Sussex Safeguarding Adults Board
Making Safeguarding Personal

Sector learning briefing
Learning from reviews: police

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Our sector learning briefing series

Our sector learning briefing series has been produced to share learning from our reviews, including learning reviews and Safeguarding Adults Reviews.

Each sector learning briefing is aimed at a different area of the adult safeguarding sector and draws out particularly relevant learning from our published reviews. This is not to say that there isn't wider learning to be taken from our reviews, but that the learning contained in these briefings is particularly pertinent to the sector.

These sector learning briefings are intended to be a concise exploration of key themes identified in our reviews. They will be updated with any new identified learning or themes, as needed.

The scope of this briefing

This briefing includes learning from reviews published since 2018 and is intended for use by police.

It draws primarily on learning from the following published West Sussex reviews:

Safeguarding Adult Review in respect of Matthew Bates and Gary Lewis (2018)
Safeguarding Adults Review in respect of MS (2019)
Thematic Safeguarding Adults Review (2021)
Safeguarding Adults Review in respect of DJT (2023)
Provider Learning Review (2025)
Safeguarding Adults Review in respect of Tom (2025)

Safeguarding Thresholds Guidance

All staff working with adults with care and support needs should be aware of, and regularly referring to, the Sussex Safeguarding Adults Thresholds.

These thresholds are designed to support staff, partners, and providers to decide on whether to report a safeguarding concern for an adult with care and support needs. They are intended to support professional judgement, and to provide examples of when incidents may be 'non-reportable', 'require consultation', or are 'reportable'.

> **We know from our reviews of the importance of timely and accurate reporting of safeguarding concerns, to support staff to provide the help you need, when you need it.**

Make sure you're up-to-date with your safeguarding thresholds knowledge. If, after referring to the safeguarding thresholds you are still unsure of whether a safeguarding referral is appropriate, please call 03302 228400 to speak with a social care practitioner in the Safeguarding Adults Hub.

Information sharing

When conducted appropriately, information sharing is an essential mechanism to support the safeguarding of adults with care and support needs.

Sharing information within an agreed framework and in accordance with legislation helps to:

- ensure an effective response to safeguarding concerns and allegations of abuse or neglect;
- promote efficient multi-agency working, particularly in the undertaking of safeguarding enquiries and other review processes.

Our reviews have told us that improved information sharing between agencies is likely to lead to better outcomes for adults we work with. It is particularly important that police develop good working relationships with local Care Quality Commission colleagues.

The statutory guidance to the Care Act emphasises the need to share information about safeguarding concerns at an early stage. This is key in providing an effective response where there are emerging concerns about abuse or neglect. See our information sharing resources for more information.

Multi-agency working

When working with adults with care and support needs, and particularly those with multiple and compound needs, it is essential that you engage in multi-agency working.

This means working closely and well together (i.e. collaboratively) with staff from the involved agencies. This will ensure that everybody involved in an adult's care is aware of, and understands, each other's work and views so that the adult has the best experience of a co-ordinated approach.

We have learned from our reviews that multi-agency working is important for effective risk assessment, capacity assessments, and care planning.

To support multi-agency working you should consider:

- Convening a multi-agency meeting, either in-person or virtually. This is the best way to ensure that there is effective information-sharing and communication and is the ideal opportunity to agree an action plan for the adult, or to review the care plan.

- Sharing information with the right people, at the right time. This should include sharing the adult's wishes with all involved agencies. See our information sharing resources for more information.
- Undertaking a multi-agency risk assessment. You can find a template for this in our Complex Needs Toolkit.

Concerned curiosity

The term professional or concerned curiosity, sometimes called respectful nosiness, is used to describe an in-depth interest in the adults you are working with by exploring and understanding what is happening, rather than making assumptions or accepting things at face value.

It requires skills of looking, listening, asking direct questions, and being able to hold difficult conversations. Nurturing concerned curiosity and challenge are a fundamental aspect of working together to keep adults safe from harm.

> **We've learned that staff need to be more professionally curious, and to ensure that they are making time to speak with adults alone, and away from the influence of family, friends, or carers.**

Concerned curiosity is vital in helping to identify abuse and neglect in cases where it may be less obvious. This could be in a care home, where abuse practices may be hidden from visiting staff. It could also be in an adult's own home, where they are not able to tell you about the abuse they are experiencing, as a result of domestic abuse or when a person is being coerced or controlled.

It is important that you make time and space to have a private conversation with the adult. This will provide them with a space where they are more likely to feel able to disclose abuse or neglect without repercussions from the perpetrators.

Communication with families

When we're following protocols and procedures, we can sometimes get swept up in making sure we're meeting all of our responsibilities, without considering the people at the centre of our work, who don't know, or understand, the detail of our roles and processes.

We need to be mindful that we're working with the adults, and where appropriate, their families, friends, and carers, and bringing them along on our journey. This means that we need to keep them updated at every stage of our investigations and ensure that they're clear on what to expect from safeguarding and criminal processes.

> **We've learned from our reviews that regular communication is important to people feeling heard and involved in safeguarding processes and criminal proceedings.**

If we can factor communications into our regular processes, including progress updates and closing communications, we can ensure that adults feel that we are working 'with' them, rather than that our investigations are something being 'done to' them.

Recognising and responding to self-neglect

Self-neglect can describe a wide range of situations or behaviours experienced by a person. Each circumstance is unique.

It could be someone whose personal care or health is deteriorating due to a lack of attention, or where they are not maintaining their home environment for so long that it becomes unsafe to their health or the wellbeing of others.

We know from our reviews that staff do not always recognise self-neglect as a safeguarding issue, and so do not seek the appropriate support to manage it.

There are a range of explanations and contributing factors which may lead to a person self-neglecting, including:

- Physical or mental health problems, or substance dependency
- Psychological and social factors
- Diminished social networks
- Traumatic histories and life-changing events

In Sussex we have a five-step process to working with adults who are self-neglecting. These steps are set out in the Sussex Safeguarding Adults Policy and Procedures but are also relevant for self-neglect which sits outside of safeguarding processes. The steps are:

- Identifying self-neglect and requesting a social care assessment and/or raising a safeguarding concern if the threshold is met.
- Identifying a lead agency, which may or may not be the local authority.
- Sharing information between agencies, and agreeing who will take what actions, and when.
- Arranging a multi-agency meeting with involved agencies.
- Completing a comprehensive assessment of risk.

Risk assessment in call handling

Accurate assessment of risk, and identification of significant risk at the earliest opportunity, is key to positive outcomes for adults experiencing abuse and neglect.

Risk assessment in instances where there is limited information, such as 999 call handlers, can be understandably challenging.

Learning from reviews: police

We know from our reviews that there is a need for comprehensive assessment of risk by call handlers, particularly where there have been multiple calls indicating a deteriorating situation.

Wherever possible, record-keeping needs to provide opportunities for the identification of increasing risk and the deterioration of a situation over time. Every call and piece of information gathered about an individual is another 'puzzle piece', which can be used to build a picture of the adult's situation.

The 'golden hour' in cases of suspected adult abuse

The College of Policing describe something known as the 'golden hour'. This is:

"The period immediately following the report of an offence or incident, when positive action should be taken. This may include protecting, preserving or gathering material that may otherwise be concealed, lost, damaged, altered or destroyed. Effective action during the golden hour will increase the opportunity to identify suspects, protect victims and witnesses and help to secure positive criminal justice outcomes." (*Investigation process* (2024))

Our reviews have highlighted that investigation in the period immediately after the reporting of abuse or neglect (where the criminal threshold may have been met) is likely to maximise evidence and the chance of securing convictions in court.

Wherever possible, if there are concerns that the criminal threshold for abuse and neglect may have been reached, police should be leading the investigation as soon as possible. This is likely to involve working closely alongside providers, adult social care, health services, and the Care Quality Commission.

Mental capacity

The Mental Capacity Act 2005 Code of Practice provides guidance to anyone who is working with adults who may lack capacity to make decisions, and particularly decisions about their care and treatment.

Mental capacity is defined as the ability to make a specific decision, at the time that the decision needs to be made. This can include 'daily life' decisions, such as what to wear, or daily routines, or more 'complex' decisions which have more significant consequences. This could include decisions around medical treatments, move to a care home placement, or planning a will.

We know from our reviews that staff across the partnership require a better understanding of the Mental Capacity Act and its implementation in their practice.

If you are not already confident in your understanding of the Mental Capacity Act, and how it is relevant to your practice, you should take steps to address this. Visit our Mental Capacity Act learning resources.

Additional resources

If you would like to explore any of these themes in more depth, you can refer to our learning resources:

- Our learning pathway
- Core safeguarding learning resources
- Safeguarding practice learning resources