Concern Decision Making

11

The initial planning will be a led by the Enquiry Officer at the Local Authority in partnership with the person and organisations involved

11.1 Information Gathering

This is the stage that describes how Tameside MBC will respond to a concern and make a decision as to whether or not the criteria for a Section 42 Enquiry has been met.

This will involve an Enquiry Officer at TMBC checking the information on the referral. This will include: speaking to the person and/or their representative, speaking to the referrer and/or other agencies involved. Immediate actions will be reviewed and further actions may be taken as required to address any immediate safety risks.

The information gathering stage should be commenced within 24 hours of raising the concern.

See Best Practice Guide and section 12.4 -12.11

11.2 Section 42 Decision Making

The information on the concern form along with the information gathered will enable the Enquiry Officer to determine whether the 3 point criteria has been met in Section 42 of the Care Act 2014.

Section 42 Where there is "reasonable cause to suspect" that an adult

(a) Has needs for care & 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.

Where the criteria is met a Safeguarding Enquiry will be required.

TASPB
Tameside Adult Safeguarding Partnership Board

A clear rationale for the decision must be recorded by the Enquiry Officer. This will be approved by a manger. The rationale must reflect the information gathered to ensure there is a record of evidenced based decision making.

Where the criteria is not met any alternative actions must be determined in partnership with the individual and recorded.

11.3 Examples of alternative responses

- Referral for a needs assessment under s9 of the Care Act.
- Referral for a carers assessments under s10 of the Care Act.
- Referral for DOLS assessment.
- Referral for Mental Health Act assessment.
- Referral to other risk management processes, e.g. MARAC, MAPPA,
- Referral or signposting to other agencies or support services, e.g. Police, victim support, domestic abuse support services, counselling services, GP.
- Written information and advice on how to keep safe, or how to raise a concern in the future.
- Information about how to make a formal complaint, for example, about substandard care or treatment.
- Information sharing with regulatory agencies (e.g. CQC) and commissioners to address service quality concerns.
- Service Provider to undertake appropriate internal responses, e.g. internal investigation, training, disciplinary process, audit & assurance activity.
- Concern is passed into other incident management processes, e.g. NHS Serious Incident process.
- Utilisation of the PIPOT process to address concerns about people in a position of trust who may pose a risk of harm to adults with care and support needs.
- Referral for Safeguarding Adults Review (Care Act s44).

TASPB
Tameside Adult Safeguarding Partnership Board

11.4 Feedback and Information sharing

Tameside MBC will follow general information sharing principles in terms of sharing information and feedback with other agencies. Consent from the adult should be gained, if information is shared without consent then the person should be informed of what information has been shared, who the information has been shared with and why.

The person or agency who has raised the safeguarding concern should be updated on the outcome of the concern where ever it is appropriate and safe to do so.

CQC and relevant commissioners should be informed of concerns raised regarding quality assurance issues in regulated services.

The Police should always be informed if a suspected crime has been committed via 101. If the person has died the Coroner needs to be informed at this stage.

11.5 Dealing with historic allegations of abuse or where the adult is no longer at risk.

Concerns relating to historic abuse or neglect where the person is no longer at risk will not be the subject of statutory enquiry under these procedures, but further action under different processes may be needed.

All such historic concerns will be considered to determine whether they demonstrate a potential current risk of harm to other adults and also whether they require criminal or other enquiry through parallel processes (e.g. complaints, inquests, regulatory, commissioning, health and safety investigations).

TASPB
Tameside Adult Safeguarding Partnership Board

11.6 What if a safeguarding concern is raised about an adult who has died?

One of the criteria for undertaking statutory enquiries under the Care Act S42 duty is that the adult is 'experiencing, or is at risk of, abuse or neglect'. This is written in the present tense, so this is therefore a matter of professional judgement as the legislation and the guidance does not clarify this. When making decisions in regards to Safeguarding enquiries when someone has died please consider the following;

- Where a safeguarding concern arises and there is a decision made to refer the concerns to the local authority, but in the time taken to pass the safeguarding concern to the local authority and for the concern to reach the appropriate decision maker in the local authority, the person has died. The local authority should still apply the statutory criteria against the time the safeguarding concerns arose, in which case if the criteria is met then the enquiry duty is triggered.
- The starting point should be that if the criteria in s42(1) were met at any point during the period from when the abuse occurred or the risk of it arose to when the decision is being made then the presumption should be that there will be an adult safeguarding enquiry.
- If the S42 decision was made before the adult died, then the enquiry process should continue.
- If the person died before and abuse or neglect was suspected as a contributory factor, then consideration could be given to a non-statutory enquiry. If there is a possibility that other people with care and support needs may be at risk then there will need to be assessments to determine if statutory duties apply, including S42 enquiry duties.
- There may be public interest matters where an enquiry might promote public confidence in the services involved.
- Factors that may lead to a reversal of the presumption might include that there were no apparent risks to others, no questions to be addressed about the actions of any agencies involved, or if there was going to be another process that might provide sufficient scrutiny such as a Safeguarding Adults Review (SAR), taking account that the aims of an enquiry and a SAR are different.

There are also other things to consider after someone dies, which include:

- Does the information indicate that a criminal offence may have occurred? Where a criminal offence has or may have occurred then a referral should be made to the police.
- Is there a need to secure documentation?
- Does the Coroner need to be involved?
- How do we involve families?
- Who else may be affected?
- In cases where an adult has died or suffered serious abuse or neglect, and where there is concern that agencies should have worked more effectively to safeguard the adult, there is a statutory requirement for the Safeguarding Adults Board to undertake a Safeguarding Adults Review under S44 of the Care Act.
- Are there other processes that need to be followed, i.e. Serious Incidents, etc.

In such circumstances a safeguarding planning meeting is advisable, to consider all of the issues and agree a plan as to how the enquiry should proceed, identify lead agency/s, etc and a safeguarding outcome meeting may also be needed to concluded the enquiry, determine the outcomes, identify learning etc.

Where a decision is made not to undertake enquiries when a person has died, then this decision should be made by a local authority manager who will have consulted with the relevant partner agencies and the decision is recorded and shared with those that need to know.

In cases where an adult has died or suffered serious abuse or neglect, and where there is concern that agencies should have worked more effectively to safeguard the adult, a referral should be made for a Safeguarding Adult Review (SAR).