7 Minute Briefing: Multi-Agency Audit Concerns Not Leading to an Enquiry

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What you can you do now

- Ensure you discuss the safeguarding concern with the adult or their representative and seek consent.
- Ensure you ask the adult and /or their representative about their desired outcomes and record them on the referral form.
- Ensure appropriate multi-agency information sharing happens at the concern stage, including getting back to the referrer for further information where appropriate.
- Ensure you are considering and where necessary applying the MCA, record this information on the form and in records.
- Ensure you understand your role and responsibility to raise safeguarding concerns in an appropriate and timely manner.
- Blue light notifications are followed up and that a chronology of significant events is used to inform the response.

Walsall Safeguarding Partnership

Right for Children, Families and Adults

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Background

An audit on Safeguarding Concerns that did not progress to a S.42(2) Enquiry took place (due to data suggesting this required more interrogation).

The partners who took part in the audit were from:

- Adult Social Care
- Black Country Healthcare Trust
- Walsall Healthcare Trust
- West Midlands Police
- West Midlands Ambulance Service
- GPs

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Next Steps for the Partnership

- Referring agencies should discuss concern with adult and seek consent, and record in the concern form.
- Review Concerns Referral Form.
- Attention to be given to the provision of Independent Advocacy as part of the wider MAA action plan and Performance Framework.
- Medication management and process for reporting errors to be reviewed.
- Information sharing and evidence of multi-agency working at the initial concern stage to inform threshold decision making.
- Training in Trauma Informed Practice for workers carrying our safeguarding enquiries.

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Aim of the audit

The Partners responded to the following questions:

- Was there effective application of making Safeguarding personal?
- Was the safeguarding concern discussed with the adult and/ or their representative?
- Did the Concern meet the statutory threshold in accordance with s42(1) Care Act 2014?
- Was the Concern referred and managed in a timely manner?
- Was feedback to referrer, person subject to concern and other relevant parties given the local authority given?
- Where appropriate alternatives offered e.g. s2 Prevention services, s4 IAG, s9 Assessment, s27 Review?
- On reflection, was the decision not to proceed to a s42(2) enquiry appropriate and proportionate?

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Key Findings

Blue light Notifications – there was no clear process in place for managing and reporting on police notifications and patterns of concerns and chronologies not consistently used to inform threshold decision, intervention.

Making Safeguarding Personal – voice of the adult not always evidenced, and more evidence of professional curiosity needed. Better understanding of 'trauma informed practice' where behaviour is language.

Information sharing – good evidence of information sharing not always evidenced, and missed opportunities to gather information at the concern stage, including from referrer and other relevant agencies to better inform decision making re s42(2)

Interface Exploitation and s42 Enquiries – Further guidance required on the pathway and interface for the exploitation panel and s42 enquiries.

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Key Findings

Inappropriate referral - in three of the cases there was either not enough information contained within the form, basic information missing, incomplete referrals received. Referrer not always clear on process, or what they are trying to achieve by making the referral, in particular case managers.

Safeguarding Concern Referral – in two cases, the referral was inappropriate for safeguarding and may be a training issue so that the threshold for s42 is better understood.

Decision Making – threshold for s42(2) – in two cases, the threshold for s42(2) enquiry was met but not followed through, in one case this related to concern about self-neglect, and another related to a person with mental health needs where the decision was made to end the s42 enquiry without evidence of assessing and managing the risk.

Mental Capacity Act – capacity and consent not always fully considered, or evidence recorded.

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Overview

The sample comprised of 6 adults which were audited by a number of agencies and an audit meeting took place on the 18 January 2024.

The return information was limited in parts, and it would have been helpful to have had other professionals attend the MAA meeting, e.g. GP, College Rep, Housing Officer.

One case required further action and may meet the threshold for a s44 Safeguarding Adult Review (SAR).

Police information was missing in two of the cases and needed to be followed up after the meeting.