Local Government Association

directors of adass adult social services

Decision-making: Section 42 Safeguarding Adults Enquiries

One day workshop
28th November 2018

Housekeeping

Fire Procedure

Breaks

Toilets

Mobile Phones / Devices

Smoking

Timekeeping and finishing time

Introduction to the day

Jane Lawson,
Adviser, CHIP, Local Government Association / ADASS.

Aims of the day

Making decisions about the circumstances in which safeguarding concerns become Section 42 Enquiries

The basis on which these decisions are made

What influences impacts on or drives those decisions

The consequences for people when we do / do not go down the S42 route (i.e. what difference does it make to outcomes for people?).

A focus on people who may need safeguarding support

- How far do these decisions about S42 impact on outcomes for people? What difference does the decision make?
- How far does the person, and their initial view on whether a concern constitutes abuse/neglect, influence the decision to go down S42 route?

The range of perspectives

- **Local Authorities** as decision makers on Section 42 Enquiries
- Insights from **data professionals**. How far are data and practice aligned?
- **Cross sector representation** How do these decisions impact across sectors? What is the impact of all organisations and their practice on decisions? How can LAs support clarity?
- **People representing a service user perspective**
- **SAB Chairs / managers** supporting effectiveness, development and assurance
- **Those with a regional / national role** supporting development.

What do we aim to produce from the workshops?

A shared understanding of core ingredients and principles that should form the basis for these decisions.

A briefing against which local practice and guidance can be revisited and developed.

Listening, constructive discussion, not judging …

- There is significant difference in how we approach this
- People have offered to set out their approach and what they have learned
- We don't have ‘right answers’ yet
- People must be able to talk freely about how they do things without judgement / criticism from anyone
- No one here is making judgements about whether people have been doing things “correctly”

PROCESS FOR THE DAY

Jane Hughes, Facilitator

Adult Safeguarding Consultant, Making Connections IOW Ltd.

Programme and presentation slides will be sent by email.

Care Act three years on….

Has the culture change in adult safeguarding happened in your area?

Yes

Have you embedded new ways of working in relation to adult safeguarding in your area?

Partially

Do you feel confident that s42 decision making in your area is compliant with the Care Act and statutory guidance?

Are adults at risk more able to lead their own safeguarding arrangements in your area?

No

HOW TO DEMONSTRATE LEGALLY LITERATE DECISION MAKING

Fiona Bateman,

SAB Chair and Solicitor

HOW TO DEMONSTRATE LEGALLY LITERATE DECISION MAKING

Fiona Bateman

Safeguarding and Legal Consultant and trainer

fionabateman@hotmail.com

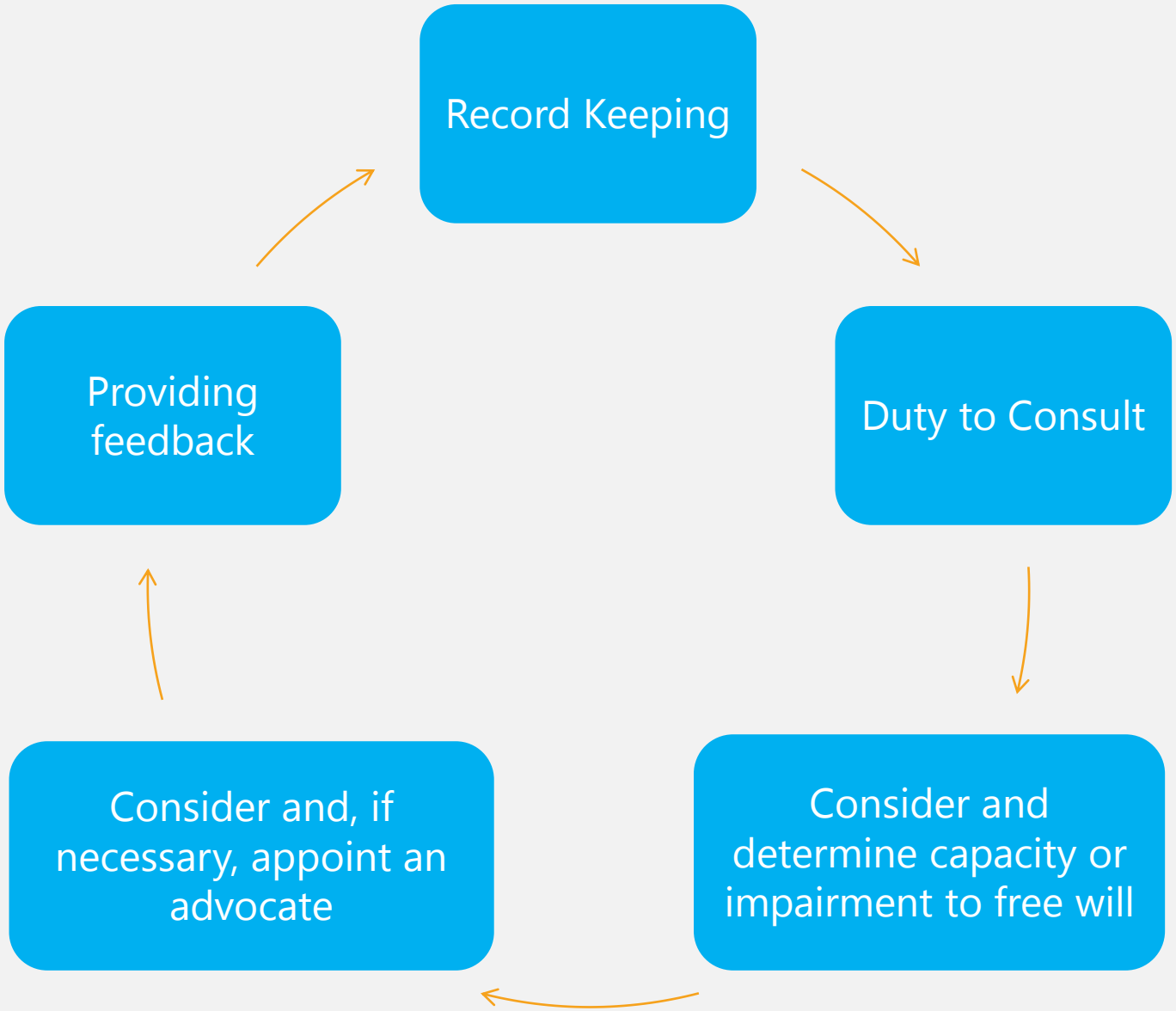
SAFEGUARDING : UNDERLYING PRINCIPLES

Each matter must be decided on the facts of that specific case, taking into account the duties in legislation, regulations and guidance.

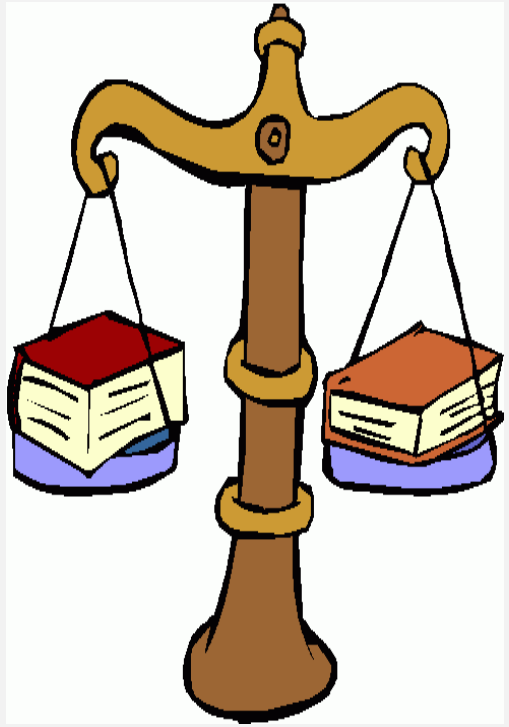
These are public law decisions so practitioners must also be confident they can demonstrate, in Court if necessary, they have:

- Upheld principles that decision making is lawful, reasonable and fair
- Protected against breaches of the adult/ PACH's human rights and advanced the principles of the Equality Act 2010
- All decisions respect autonomy, where there is reasonable cause to believe a person lacks capacity all decision are made with regards to the duties set out in the Mental Capacity Act 2005, practitioners also need to be mindful of external pressures than can impair free will
- Met obligations under the Data Protection Act 2018 and regulations.

PROCEDURAL SAFEGUARDS



ACCOUNTABILITY FOR SAFEGUARDING DECISIONS



All safeguarding decisions, actions or omissions are public law matters so anyone affected the decision, e.g. service user, carer or person alleged to have caused harm ['PACH'] could challenge either through:

- Complaint, in line with LA Social Services and NHS Complaints Regs 2009, with recourse to Local Government Ombudsman. LGO determinations are published!
- Judicial scrutiny, including within the High Court (Judicial Review) Court of Protection and Coronial proceedings.
- Safeguarding Adults Boards, including through quality assurance work and learning reviews conducted in line with s44 Care Act.

Safeguarding concerns may also raise wider legal duties related to negligence, contractual obligations, employment law.

S.42 DUTY

Reasonable cause to suspect

Adult at risk is experiencing abuse or neglect

As result of needs unable to protect themselves

make (or cause to be made) whatever enquiries necessary

to decide whether action is necessary and if so what and by whom

S.42 DUTY: 'REASONABLE CAUSE TO SUSPECT'

Guidance [pg7.5] and Making Safeguarding Personal principles encourage preliminary enquiries to involve the adult at risk or their representative. This will enable you to explore risk in context and may identify risks or concerns beyond that originally identified within the referral.

You will also need to consider:

- What you could be reasonably expected to know- requires proportionate review of case records, relevant enquiries and that information sharing policy and practice reflects partners' duty of care!
- All available evidence and proactively look for corroborating information, reasonable to use professional judgment to weigh up value placed on information.
- Whether there is any risk to the adult of disclosing concerns to the PACH. Remember public law requires that you give people an opportunity to put their case, so if you are not going to do so this needs very careful justification: *R(AB and CD) v Haringey London Borough Council* [2013]

Not always necessary in safeguarding situations to determine the truth of every allegation if there is sufficient evidence to justify lawful intervention: *London Borough of Ealing v KS & Ors* [2008]

Type

- •Abuse: Physical, discriminatory and organisational abuse
  - •Neglect, including acts of omission and self neglect, self- harm and suicide
- Exploitation: sexual, psychological, financial or material abuse, including MDS

indicators

- Apply observations, third party reports and any collaborating information **objectively**. Using practice tools (e.g. power and control wheel, clutter rating index) or eligibility thresholds for services (e.g. social care outcomes or CHC decision support tool descriptors) can reduce appearance of bias or subjectively
- Utilise research findings to demonstrate why suspicions are reasonable!

Pattern

- Does the concern affect children, or other adults at risk?
- Have their been repeat allegations or repeated failings, justifying concerns of organisational abuse ?

Level

- If proven, would this constitute criminal offence?
- Is there a relationship of trust, personal, commercial or contractual relationship between the adult and alleged perpetrator?

MSP

- What insight does the adult have into the level of risk, do they understand why practitioners have concerns linked to the duty of care owed to the adult? Is vulnerability linked to need for care and support?
- Is there any evidence of incapacity, coercion, undue influence or duress?
- What outcomes matter to the adult and will this reduce/ remove risk related to the duty of care?

'MUST MAKE (OR CAUSE TO BE MADE) WHATEVER ENQUIRIES IT THINKS NECESSARY'

'DECIDE WHAT ACTION AND BY WHOM'

Practitioners must consider whether they have legal authority to act and any plan must meet all relevant partners' duty of care either by reducing risk of harm or because further action would be an unnecessary or disproportionate interference of human rights.

Consider, if not s42 enquiry how will the identified risk be mitigated and how will that be communicated to:

- Adult at risk and support network
- PACH
- Safeguarding Adults Board?

Practitioner should also advise adults at risk or their representatives about how they can access support so that the adult at risk can secure civil law remedies when they have suffered harm or been exploited.

FURTHER READING

- 'Safeguarding Adults under the Care Act 2014', Jessica Kingsley Publishers, 2017
- https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice: MCA Code of Practice
- https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance: Care Act statutory guidance
- http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/#mental: Guidance on prosecuting crimes against adults at risk
- https://www.gov.uk/apply-forced-marriage-protection-order: guidance on forced marriage and duties to intervene to protect adult/ child at risk.
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf: Prevent Duty guidance and President's Guidance on Radicalisation: https://www.judiciary.gov.uk/wp-content/uploads/2015/10/pfd-guidance-radicalisation-cases.pdf

DEPARTMENT OF HEALTH AND SOCIAL CARE PERSPECTIVE

Jennica Smith, Policy Officer, Mental Capacity, Deprivation of Liberty Safeguards and Safeguarding. Andrew Ficinski, Policy Adviser and Rosemary Main, Statistician.

HEADLINE FROM THE 2017-18 PUBLICATION AND THE 2018 SAC SURVEY

Jim Butler,

Analytical Section Head, NHS Digital

Safeguarding Adults Collection (SAC)

A summary of the 2017-18 Publication and the 2018 SAC Survey

Information and technology
for better health and care

presented by Jim Butler,
Analytical Section Head

SAC 2017-18 – Key Findings

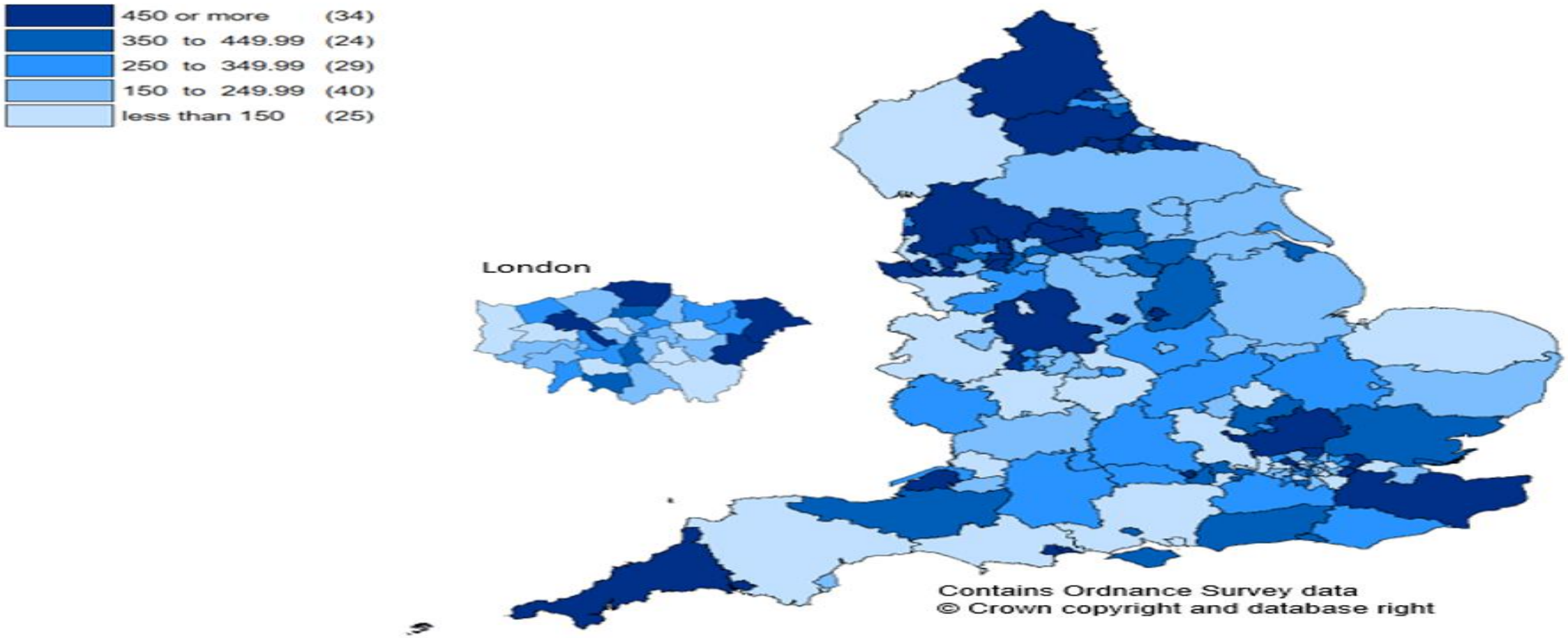
394,655 Safeguarding concerns raised in the year ▲ 8.2%

150,070 Safeguarding enquiries started in the year ▼ 0.7%

1 in every 43 adults aged 85+ subject of a S42 safeguarding enquiry

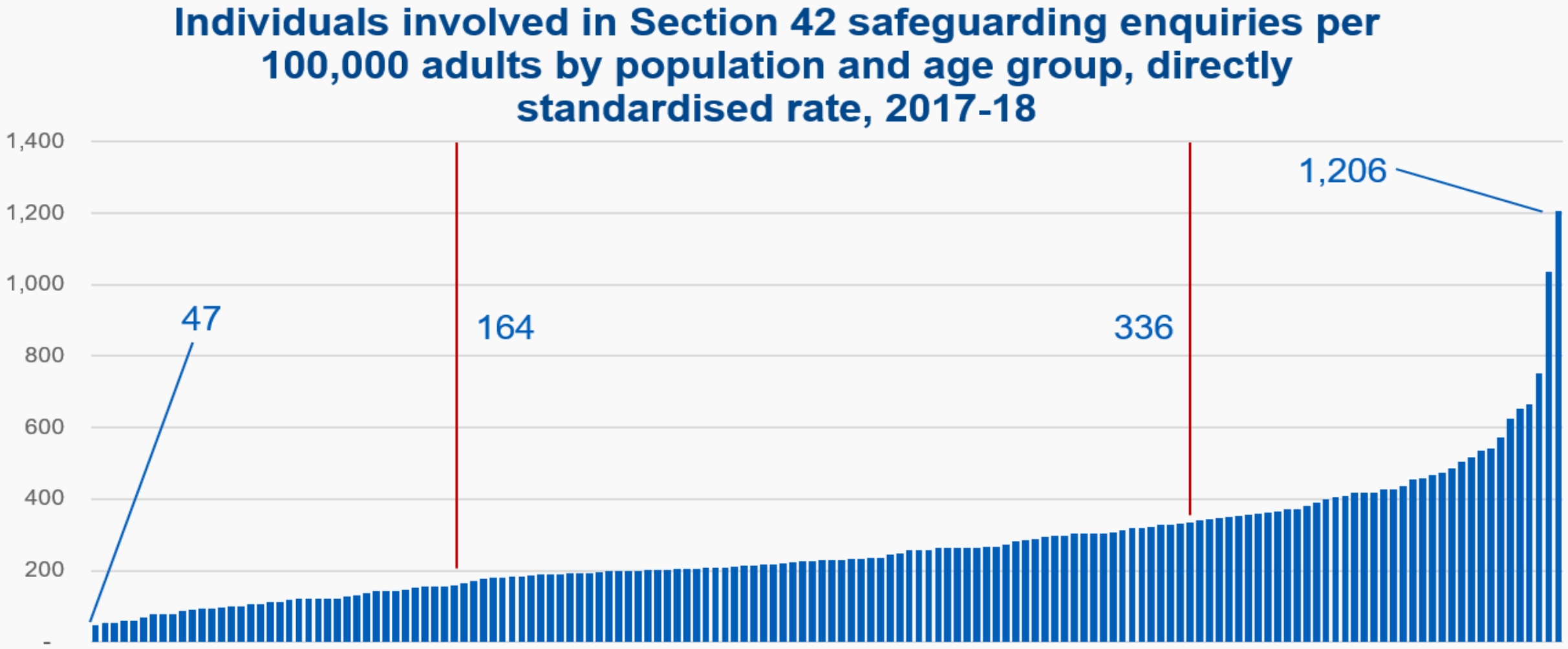
SAC 2017-18

Figure 1.2: The total number of safeguarding enquiries per 100,000 of the local authority population in 2017-18



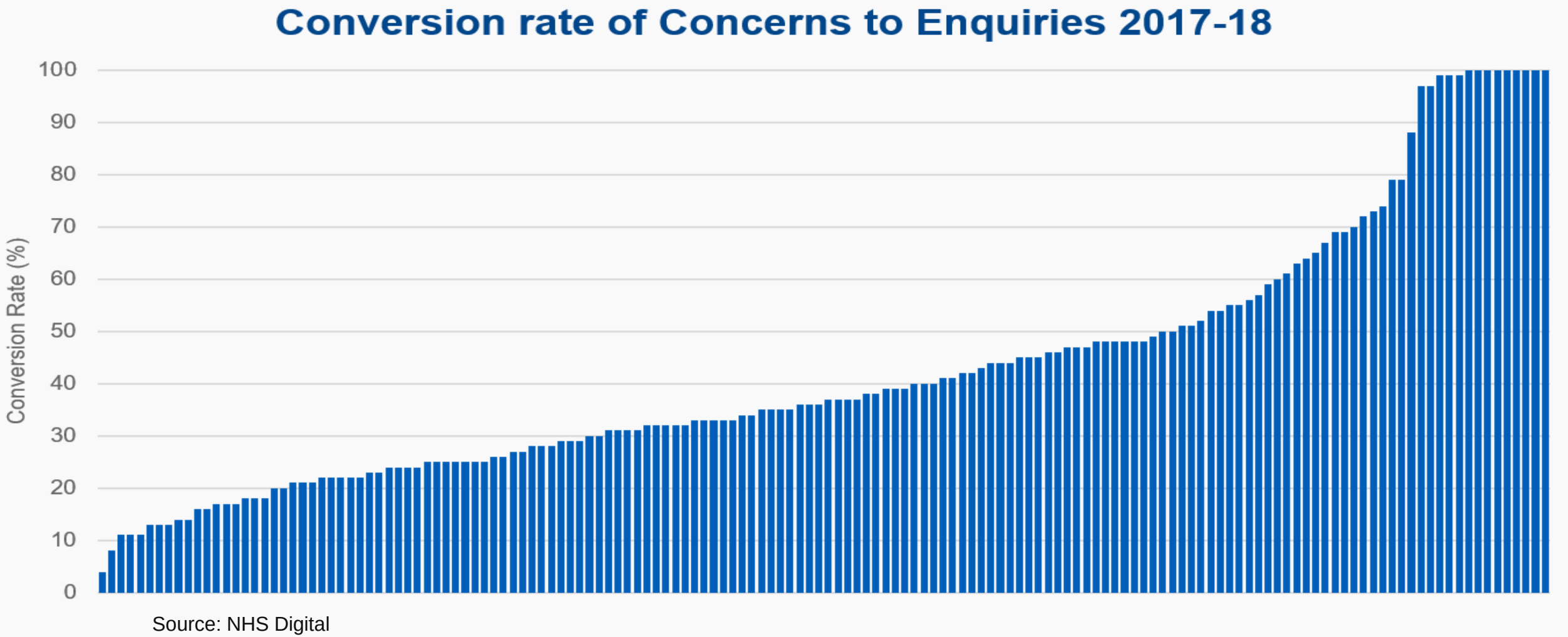
Source: NHS Digital

SAC 2017-18



Source: NHS Digital

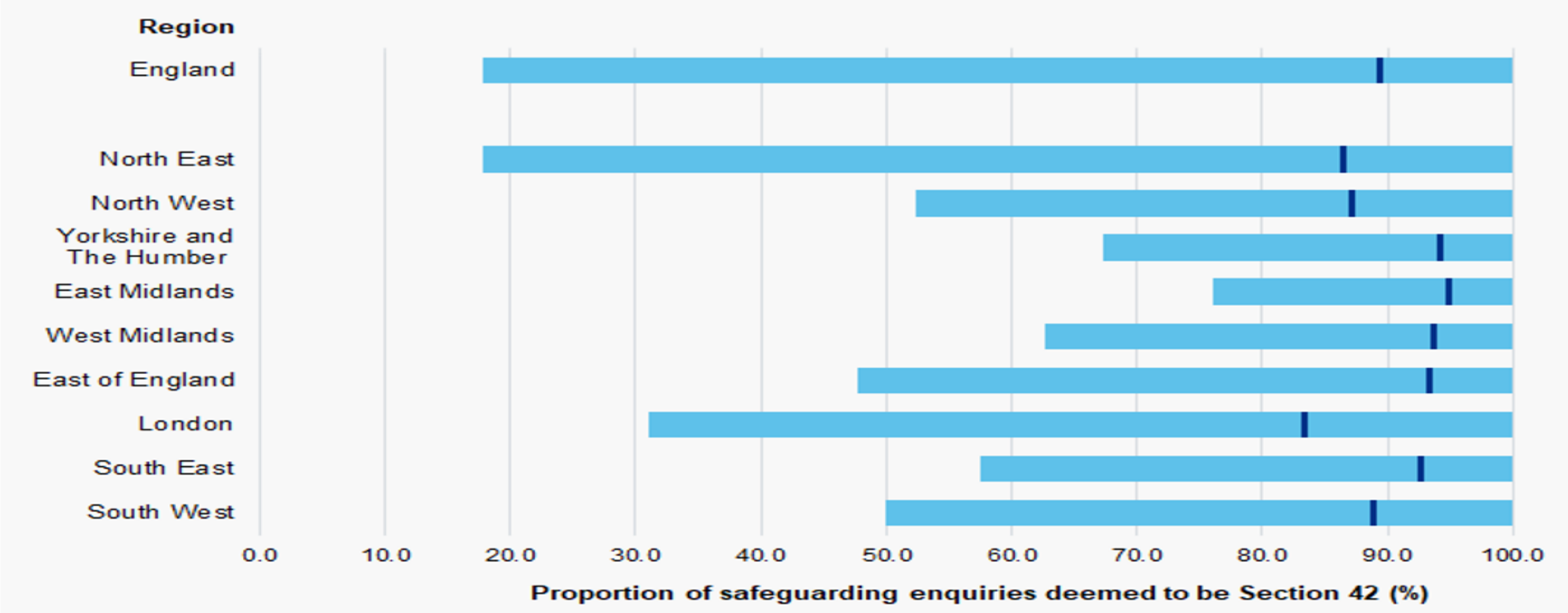
SAC 2017-18



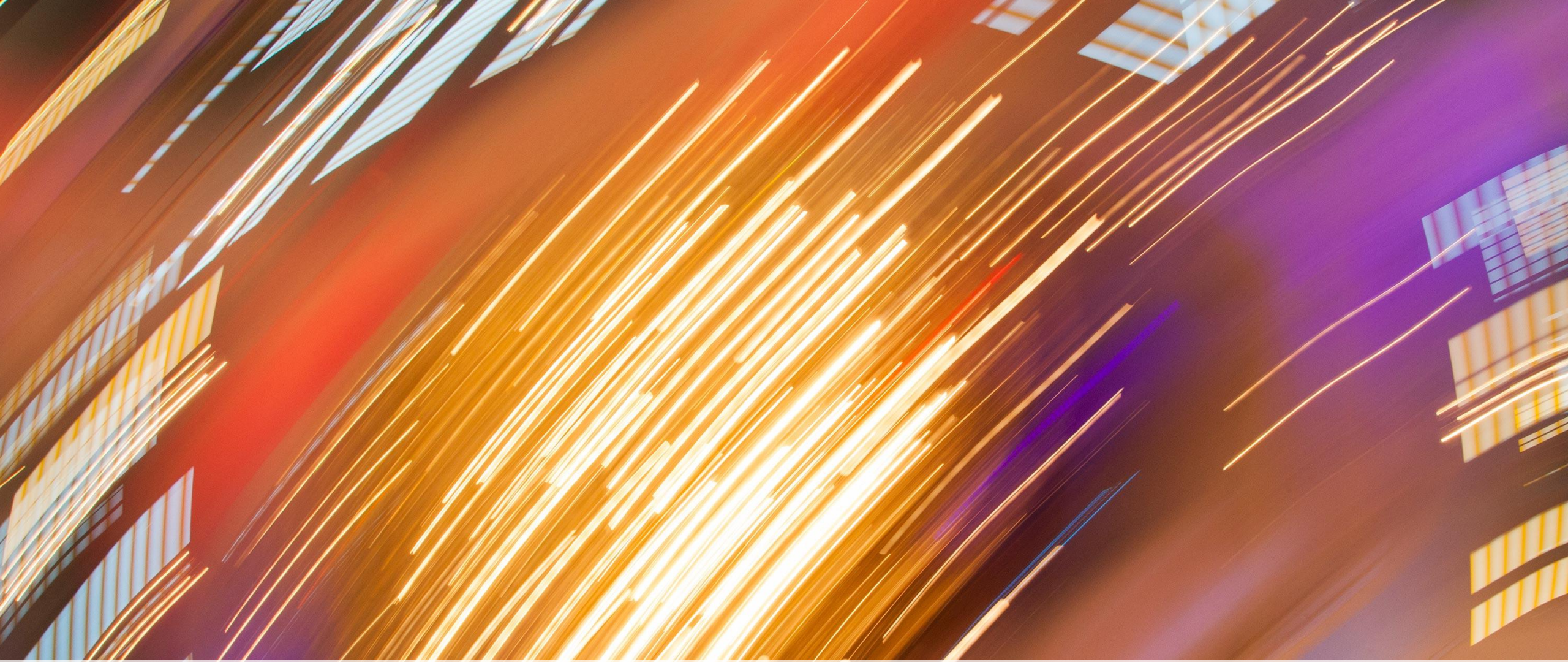
Source: NHS Digital

SAC 2017-18

Figure 1.3: The range of proportions of enquiries deemed to be Section 42 by region, 2017-18



Source: NHS Digital



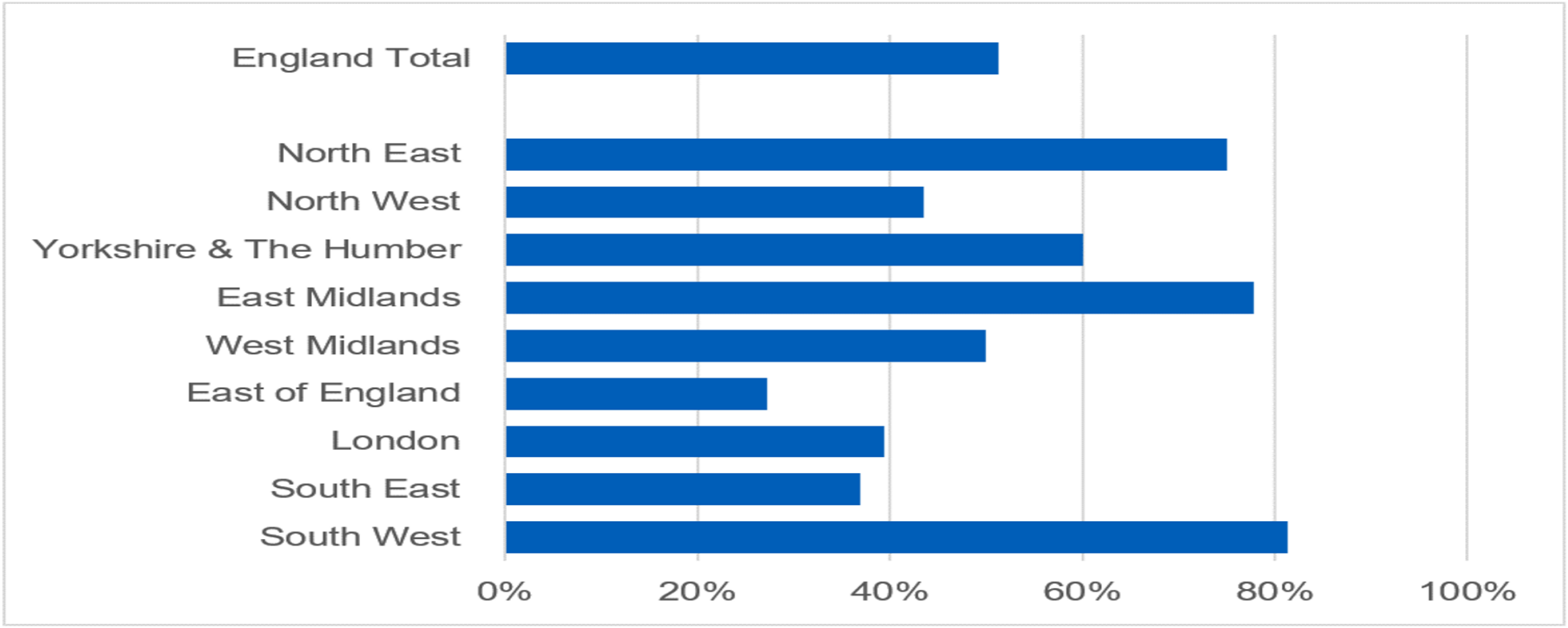
SAC Survey 2018

SAC Survey 2018

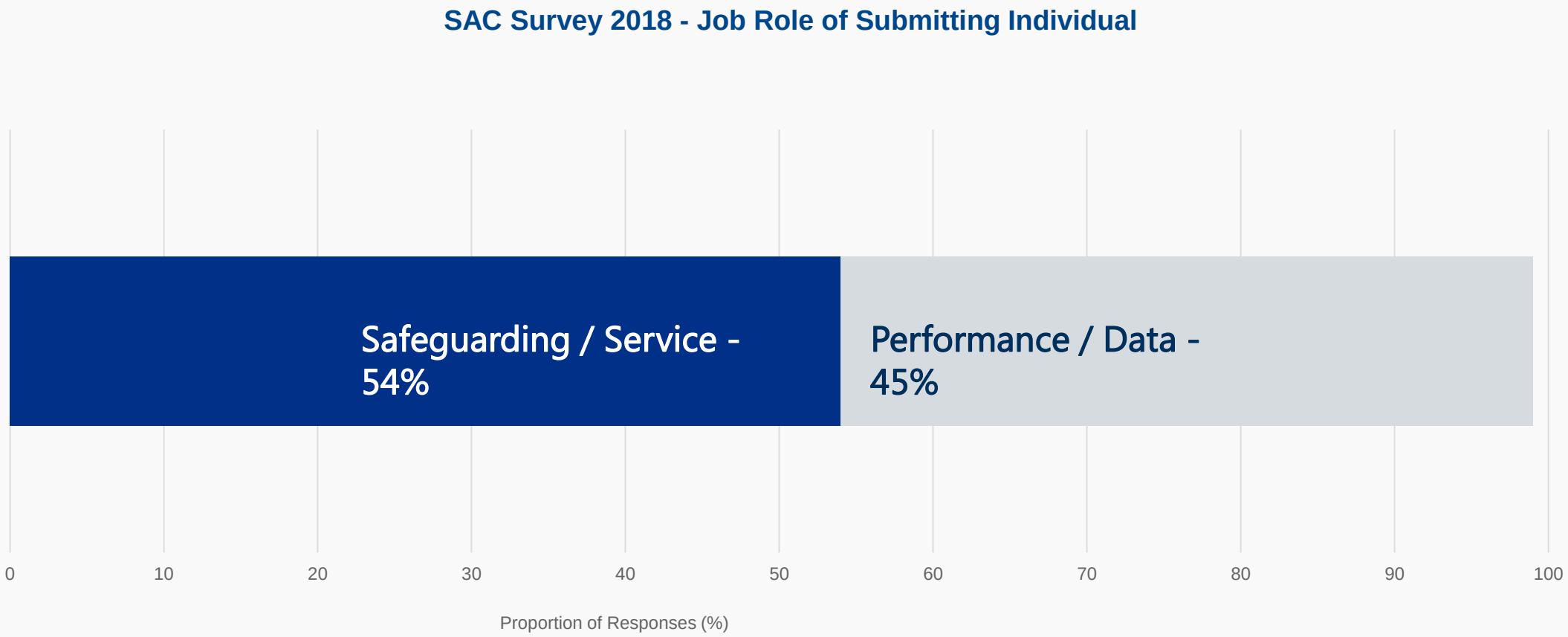
- A resource to aid interpretation of the SAC publication
- Qualitative focus
- Sector support – SAB Chairs, SAB Managers, LGA
- Voluntary, submitted online or via email
- 78 responses (51%).

SAC Survey 2018

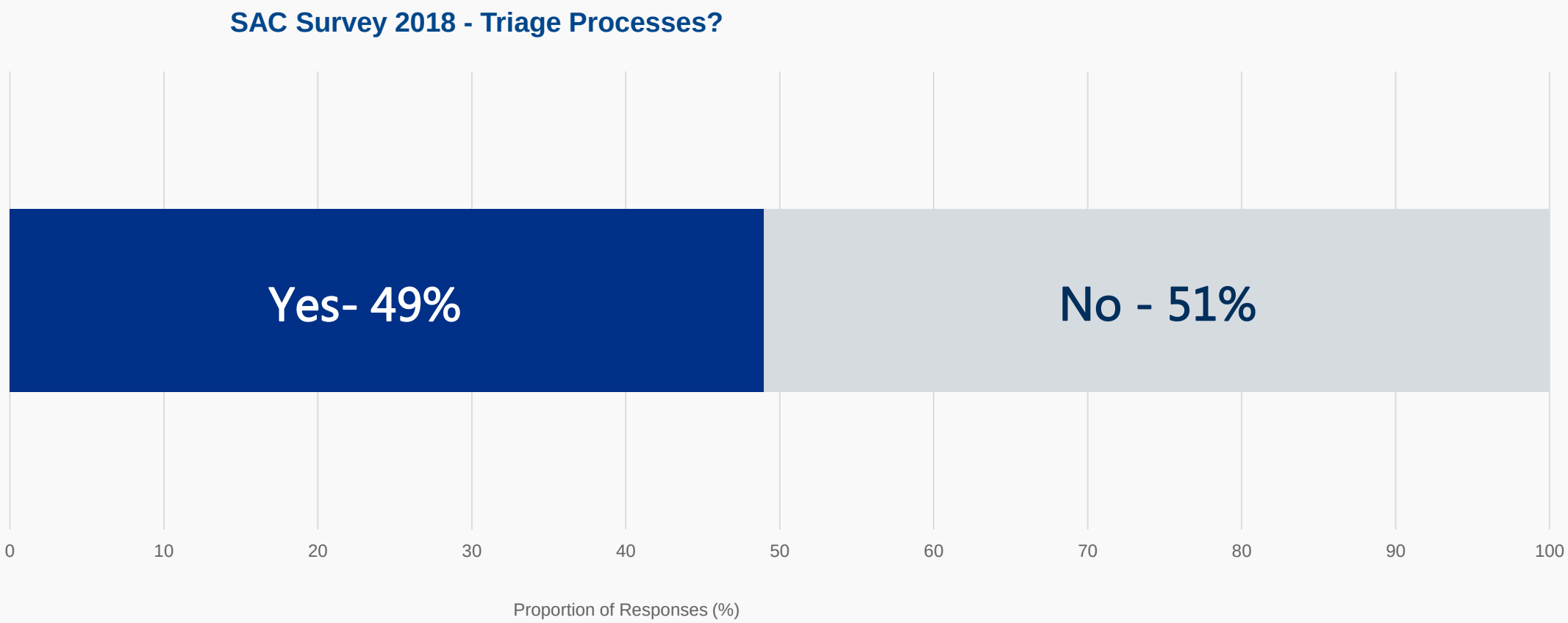
Figure 1. Response rate by Region.



SAC Survey 2018

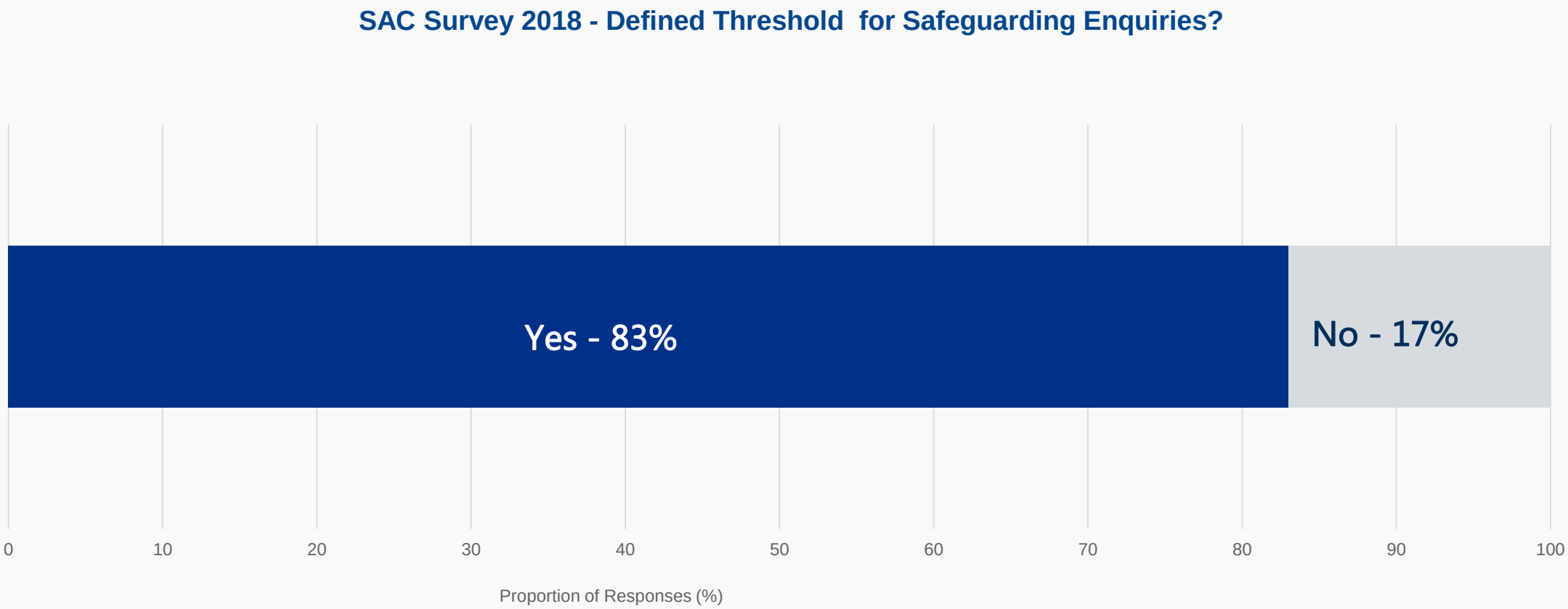


SAC Survey 2018

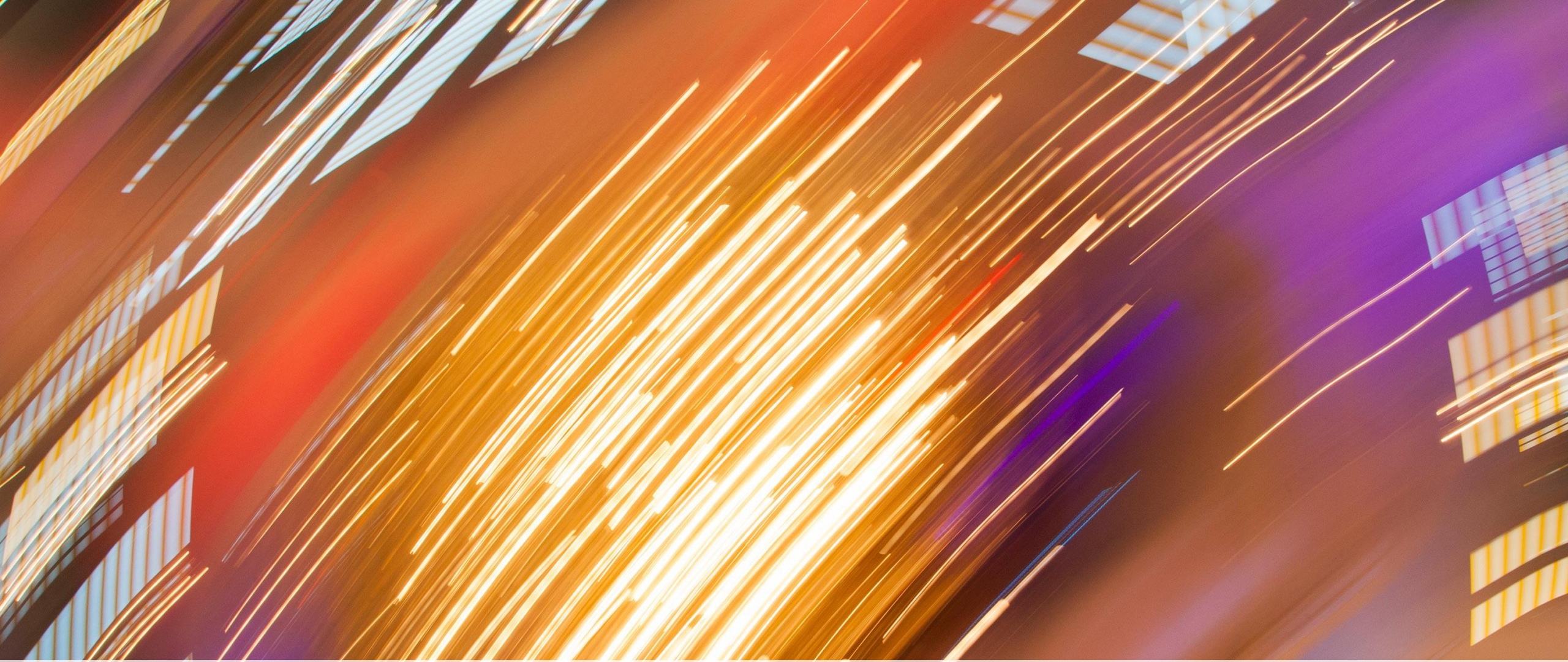


Are there processes in place in your local authority that result in some safeguarding concerns being addressed before they reach the safeguarding team and therefore are not reported in the SAC?

SAC Survey 2018



Do you have a defined process for the safeguarding team to determine the threshold at which a concern becomes an enquiry?



SAC – Power BI Interactive Report

SAC – Power BI Interactive Report

Map of key measures

Figure 1: Number of new safeguarding cases by selected measure per local authority in England, 2017-18

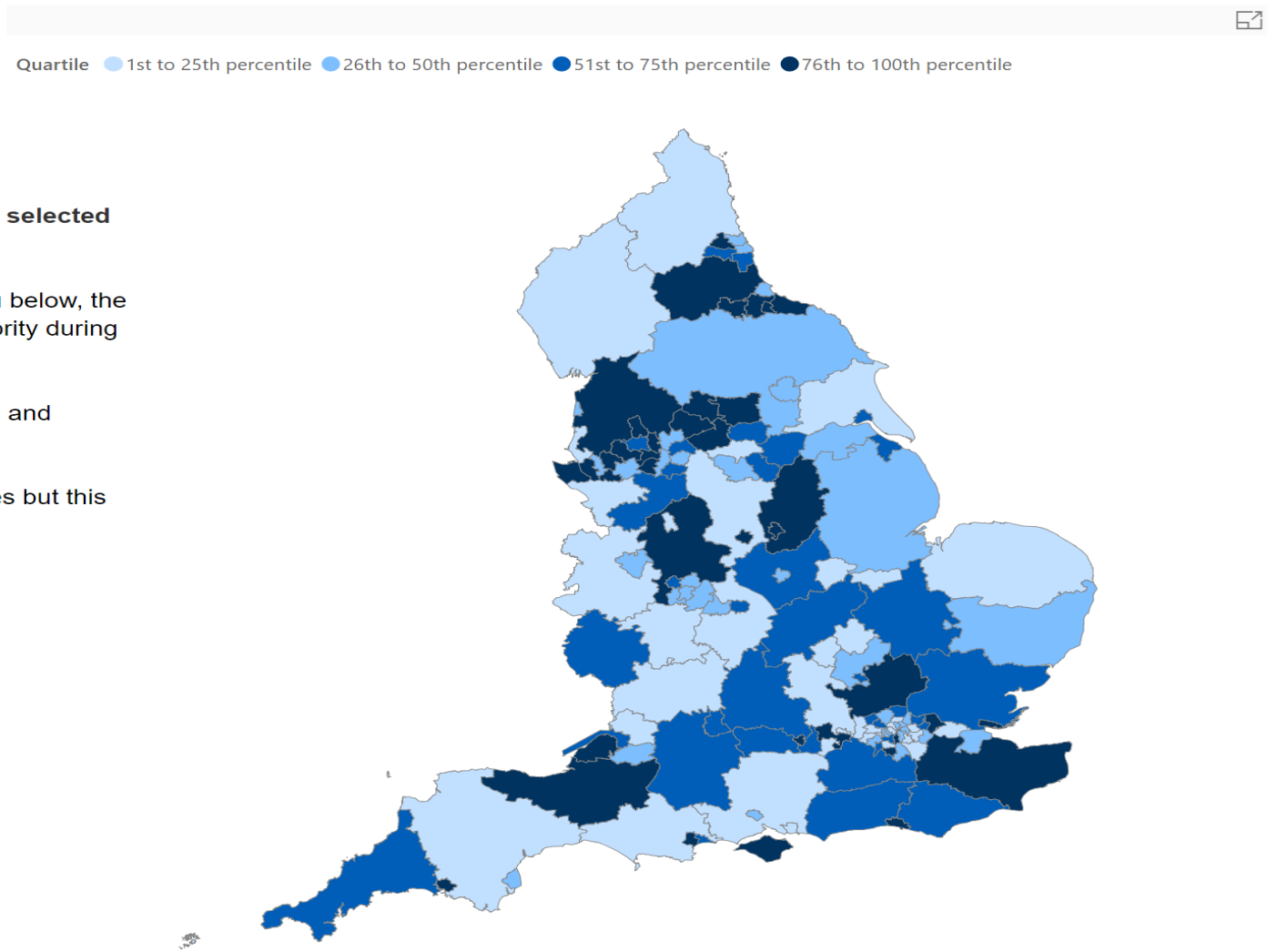
By selecting one of the measures listed in the menu below, the user can view the patterns of activity per local authority during 2017-18 for the selected measure.

Please hover over specific areas to view their name and associated values.

Please note darker shading represents higher values but this does not reflect good or bad performance.

Please select a measure

- ☐ 1. Concerns per 100,000 Adults
- ■ 2. Section 42 Enquiries per 100,000 Adults
- ☐ 3. Other Enquiries per 100,000 Adults



SAC - Power BI Interactive Report

NHS Digital

Section 42 enquiries

The analysis presented on this page relates to **Section 42 enquiries commenced during 2017-18**. Data relating to the local authority selected from the menu on the left side of the screen as well as that local authority's neighbours in respect to **CIPFA's nearest neighbours model** or **region** are displayed in Figure 3.

Figure 3: Number of Section 42 safeguarding enquiries commenced per local authority in England, 2017-18

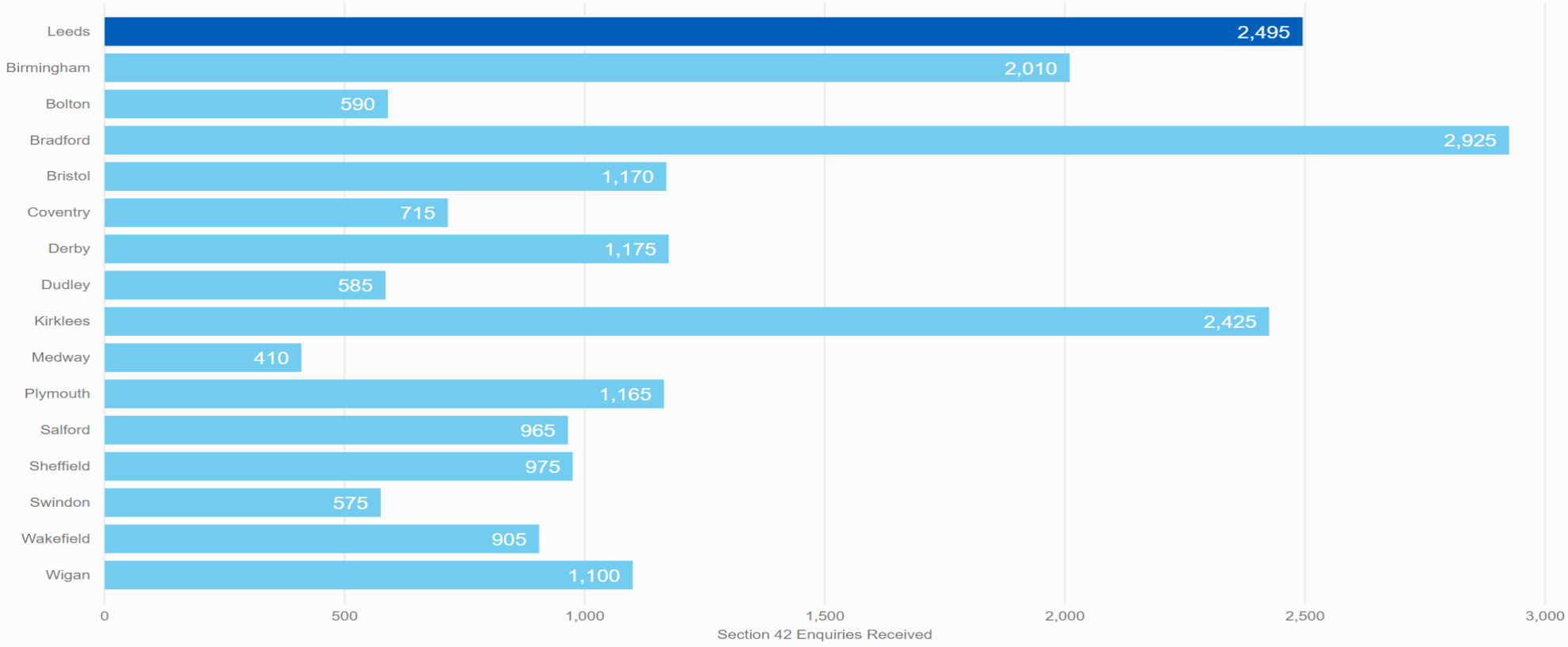
Please select a peer grouping

CIPFA Nearest ... | Region

Please select one local authority

Leeds

Leeds



Total number of Section 42 enquiries commenced during 2017-18 in England

131,860

Please contact us

enquiries@nhsdigital.nhs.uk

(FAO: Adult Social Care Statistics Team)

Adult social care statistics homepage: https://digital.nhs.uk/data-and-information/areas-of-interest/social-care

Power BI Hub: http://bit.ly/SocialCare_HUB

NHS Digital SAC Survey 2018: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/safeguarding-adults-collection-survey-of-local-definitions-2018

www.digital.nhs.uk

@nhsdigital

enquiries@nhsdigital.nhs.uk

0300 303 5678

Information and technology
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Local Government Association

Refreshments

You have a table number on your badge. Please move to this table after break.

Group discussions

Your table has a facilitator to guide you through the questions.

Principles

A principle is a general belief that you have about the way you should behave.
Morally correct behaviour and attitudes.
A fundamental source or basis of something.
A determining characteristic of something.
An adopted rule or method of application in action.

Ingredients

A constituent element of anything; component.
The ingredients of political success.
Component part or element of something.
An important part of anything.
A quality you need to achieve something.

SECTION 42'S AND THE YORKSHIRE AND HUMBER

Dave Roddis

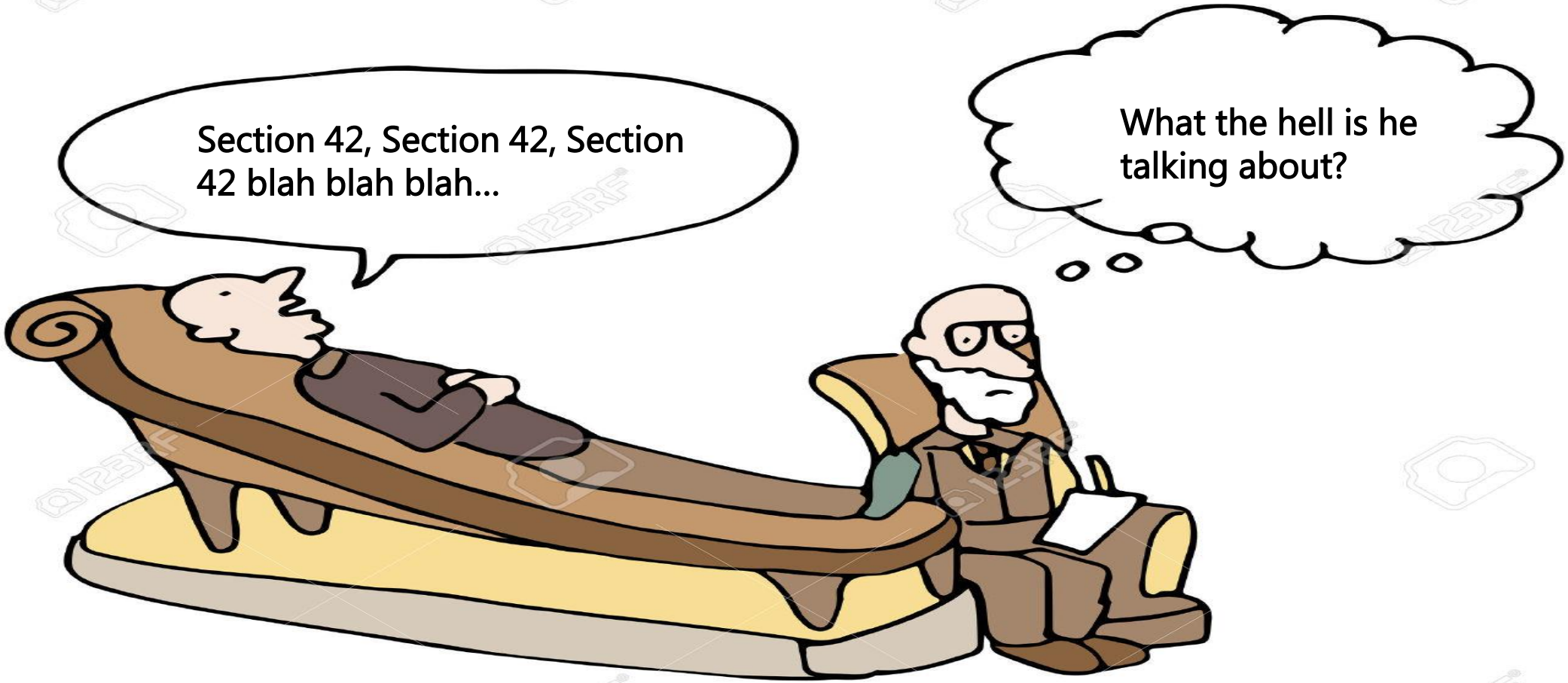
ADASS Yorkshire and Humber, Programme Director.

SECTION 42'S AND THE YORKSHIRE & HUMBER

Dave Roddis
ADASS Yorkshire & Humber, Programme Director

28th & 29th November
London

directors of adass
adult social services
Yorkshire & Humber

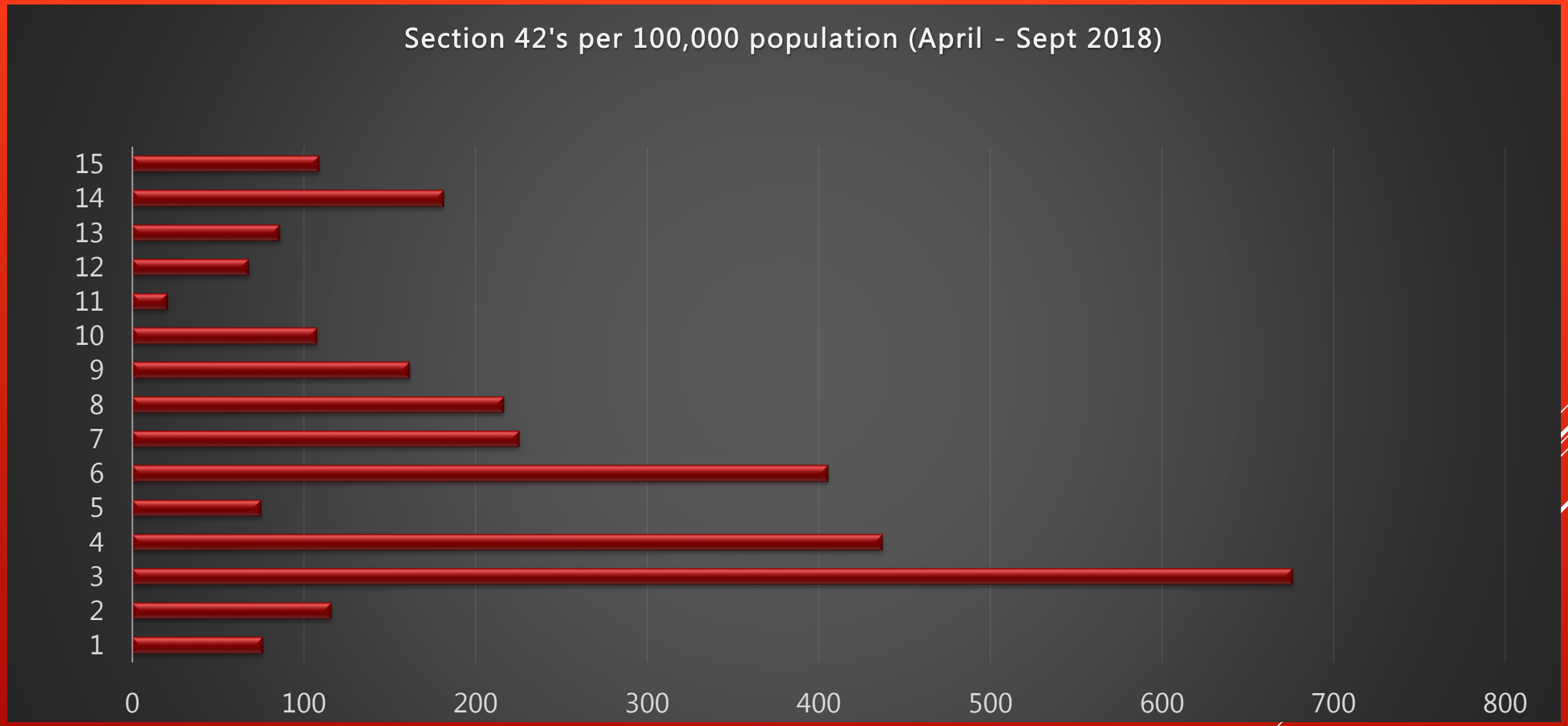

Section 42, Section 42, Section 42 blah blah blah…
What the hell is he talking about?

Y&H S42 JOURNEY

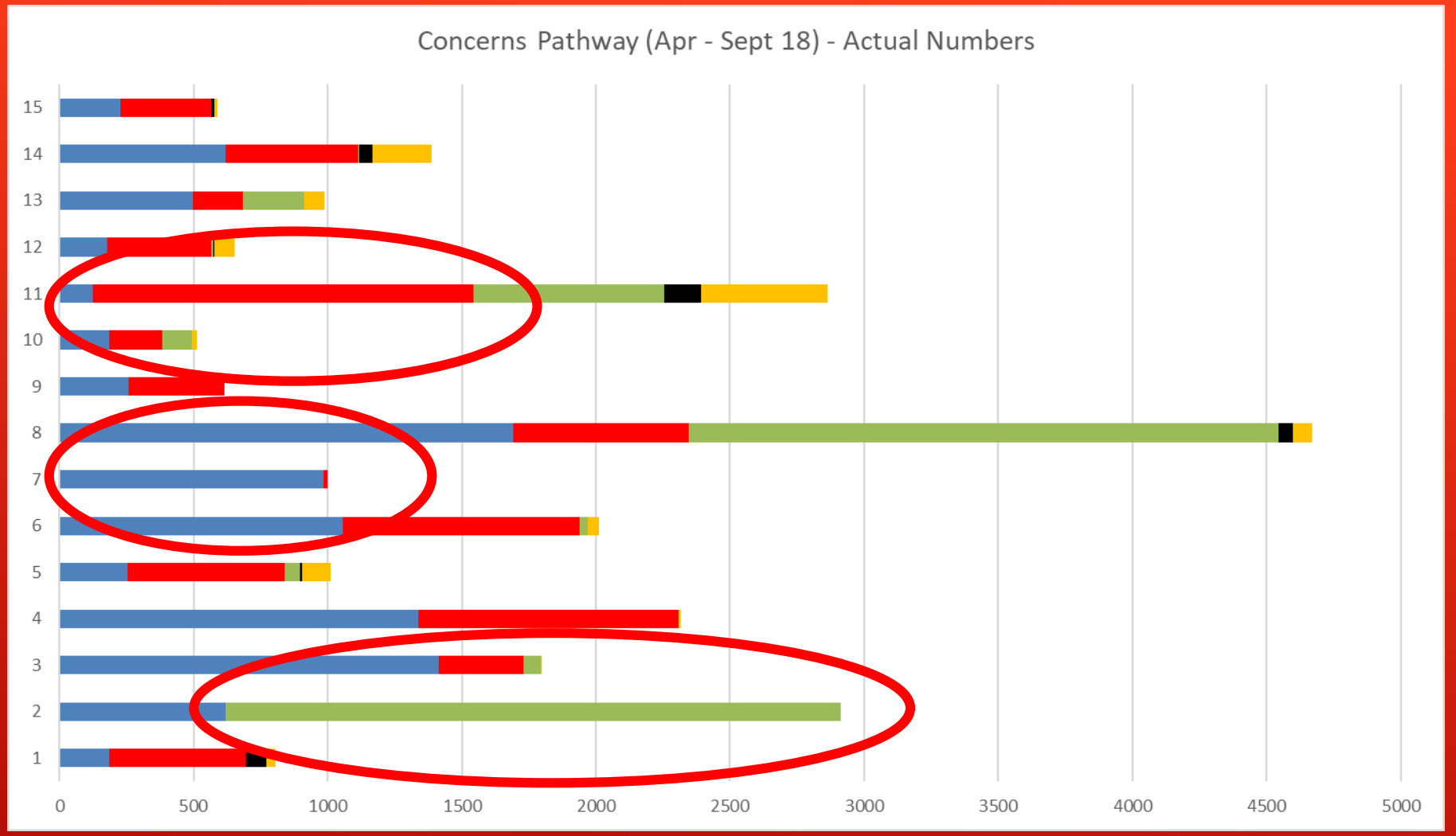
- MSP Stocktake – Performance Management needs strengthening
- Established benchmarking data as part of Dashboard
- Outliers – Section 42 – 16/17
- Development of the Regional Principles – Dr Adi Cooper Support
- IT Stocktake
- Outliers remain – 17/18
- Regional Safeguarding Decision Making Stocktake
- Regional Case Study Exercise/Workshop

- Differing points of access to report safeguarding concerns
- Who makes the decision to take into safeguarding also varies between authorities?
- There is inconsistency with the use of or recording of concerns which do not progress to formal enquiries.
- What do we mean by NFA
- Differing opinions on dealing with section 42 enquiries by telephone.
- **Recommendation**:

To conduct a "deep dive" exercise using actual case studies provided by authorities within the region to better understand decision making and identify areas of consistency/difference.



S42'S AND Y&H – DATA CURRENT POSITION



Section 42

NFA – No Further Action

Signposted

Other Enquiry

Awaiting Decision

S42'S AND Y&H – DATA CURRENT POSITION

S42'S AND Y&H – THE EXERCISE

- Developed through a regional task and finish group
- Supported by the ADASS Yorkshire & Humber Branch, the regional Safeguarding Co-ordination meeting and the regional Safeguarding Adult Board Managers network
- Sixteen real scenarios have been provided by four local authorities
- The aim of the exercise:
  - Work with the relevant safeguarding practitioners in their local area to assess each scenario
  - Determine the decision they would have made on each one
  - Explaining the rationale behind their decision

REGIONAL WORKSHOP

- Explore the collective answers, look at themes and to examine the rationale behind the decisions made.
- Use the learning to further enhance the regional principles for dealing with Section 42's that we currently have in place.
- Importantly, there is no right or wrong answer in this exercise, however……
  - We need a discussion about the rationale behind decisions - this will allow us to reach some regional consensus about what triggers a Section 42 enquiry.
  - Feed into national discussions taking place in London 28/29 November
  - Build a set of principles or the scaffold that support decision making
- Sector Led Improvement – opportunity to learn from each other and work as a collective regional group to improve practice and iron out any inconsistencies

KEY ISSUES IN DOING THIS EXERCISE?

- Local inconsistency due to interpretation of Section 42
- Issues around medication errors – how many would come into safeguarding from hospitals?
- Local debate over the 3 point test and how recording systems link to additional forms/tasks once it is selected that a concern meets criteria (are authorities undertaking initial enquiries/screening to prevent progressing to S42)
- What point concerns progress into enquiry.
- Questions still exist around second stage in 3 point test - challenges against MSP if screening out.
- Can be impacted by differing levels of expertise in safeguarding
- Positive/useful experience

THE EXERCISE HEADLINES

- All 15 Local Authorities have participated
- All indicated that they have had sessions where practitioners involved
- Some are implementing new practices/procedures as we speak or in the very near future
- Lots of positive comments received from participants
- Range of response (out of 16 – how many were classed as s42)
  - 15 – A
  - 14 – B,C,D
  - 13 – E
  - 12 – F,G
  - 10 - H
  - 9 – I, J
  - 8 – K
  - 7 – L
  - 6 – M
  - 5 – N
  - 4 - O

AREAS FOR EXPLORATION

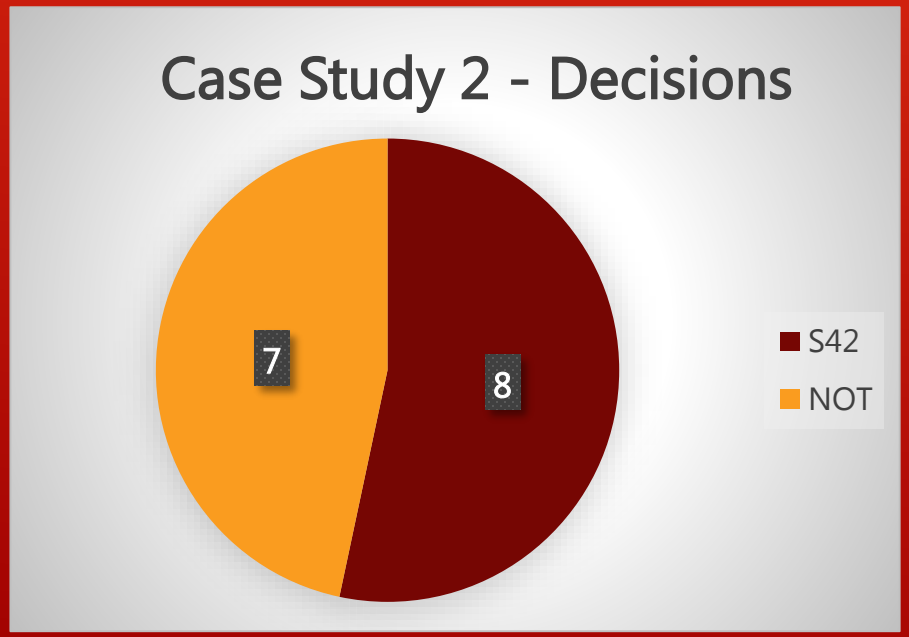
- Terminology – are we all talking about the same thing?
- Screening
- What does a Section 42 involve?
  - Minimal Response
  - Full Blown Investigation
  - Resolving at initial enquiry
  - S42 Telephone enquiries
- Further information needed – assumptions made
- Some local authorities seem to be using threshold documents to aid decision making
- Sub-regional procedures – do they improve consistency?
- Must remember that these are real stories involving real people.

- Chatham House Rules
- Safe house – are we happy to share your decisions with each other?

CASE STUDY 2 – MRS SMITH FALL

Case Details

- Unwitnessed Fall – Care Home
- Mrs Smith has dementia and requires a hoist
- Son – no further investigation needed



Rationale:

S42

- Neglect/Act of Ommission
- Staffing levels
- Other people could be at risk
- Unexplained fall

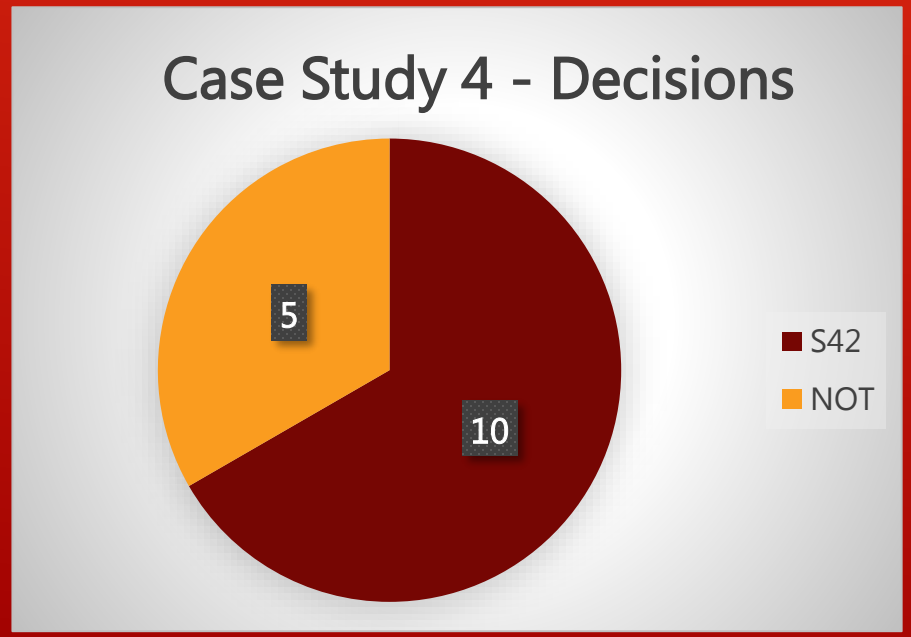
NOT

- Family don't want it progressing
- It was an accident
- Can't be prevented
- No evidence of neglect

CASE STUDY 4 – FRED AND BOB ALTERCATION

Case Details

- Unprovoked attack by Fred on Bob
- Fred (Vascular Dementia) Bob (Alzheimers)
- Witnessed by Fred's Son
- No signs of harm to Bob



Rationale:

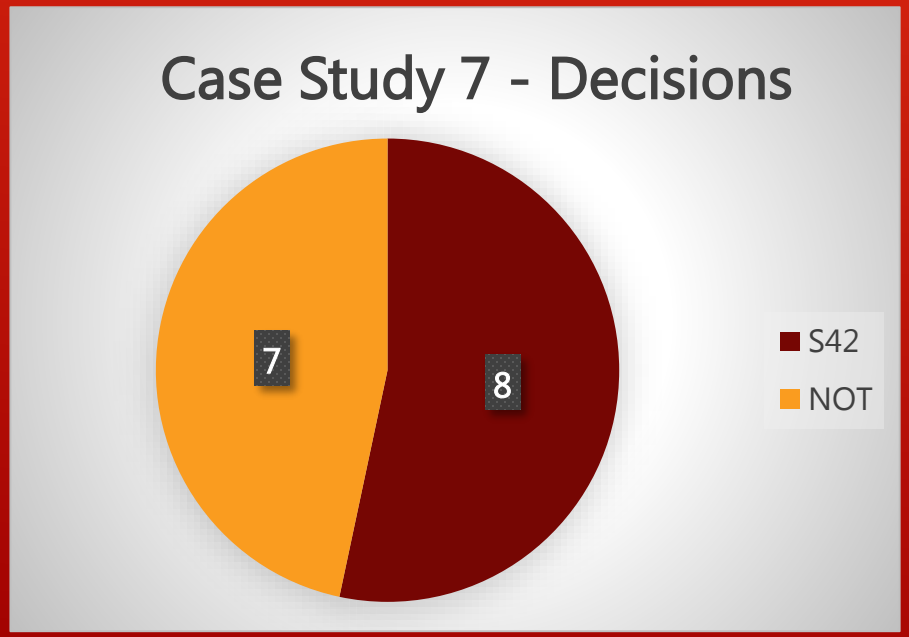
S42
- Fred assaulted Bob
- Physical abuse
- Both lack mental capacity
- Risk assessment needed

NOT
- No harm sustained
- Resident on resident
- Appropriate action taken to mitigate risk

CASE STUDY 7 – PETER PINCHED ARM

Case Details

- Peter – Severe Autism/LD
- Day Care 3 days a week
- Pinched on arm by another service user
- Bus stopped and separated



Rationale:

S42

- Physical abuse – caused harm
- Not able to protect himself
- Distressed
- Protect from further abuse

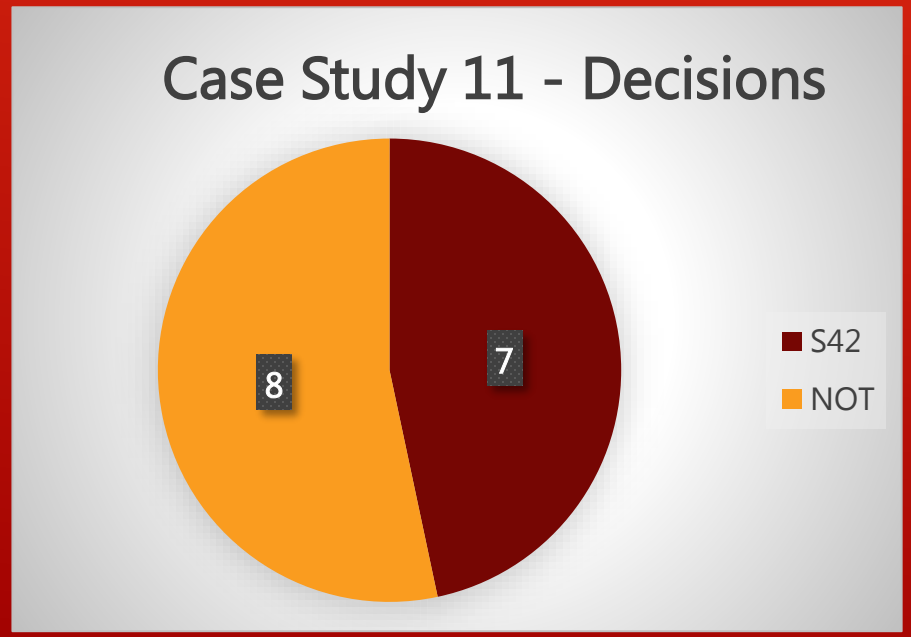
NOT

- Appropriate action taken
- Superficial injury only
- Risk management approach

CASE STUDY 11 – MEDICATION ERROR

Case Details

- Medication changed
- Old and new medication administered in error
- GP contacted – should be fine
- X did not feel any different



Rationale:

S42

- Person could not protect themselves from neglect
- Poor practice
- Others may be at risk

NOT

- One-off incident
- Appropriate action taken
- No harm
- No abuse/no neglect

OVERALL RESULTS

- CASE STUDY 1 (Health) – 12 / 3
- CASE STUDY 2 – (Fall) 08 / 7
- CASE STUDY 3 – (Fall) 1 / 14
- CASE STUDY 4 – (Altercation) 10 / 5
- CASE STUDY 5 – (Indecency) 0 / 15
- CASE STUDY 6 – (Sexual Assault) 14 / 0 / 1
- CASE STUDY 7 – (Physical Assault) 8 / 7
- CASE STUDY 8 – (Medicine) 15 / 0
- CASE STUDY 9 – (Fall) 10 / 5
- CASE STUDY 10 – (Medicine) 12 / 3
- CASE STUDY 11 – (Medicine) 7 / 8
- CASE STUDY 12 – (Scam) 10 / 4 / 1
- CASE STUDY 13 – (Neglect) 11 / 3 / 1
- CASE STUDY 14 – (Altercation) 11 / 4
- CASE STUDY 15 – (Gen. Care) 15 / 0
- CASE STUDY 16 – (Sexual Abuse) 8 / 4 / 3

CONCLUSIONS AND OBSERVATIONS

- People seem to be doing similar things on the ground however:-
- Two significant views:
  - If it meets the 3 point test then it's a Section 42!!!
  - All concerns are assessed/triaged and action takes place accordingly – this may result in not progressing to Section 42 even if it meets the 3 point test. Proportionate response
- Local guidance, local decision making tools and THRESHOLDS
- The three point test is not being applied consistently – its clear but needs more guidance – or we could count everything
- The system/process is maybe dictating what happens
- Data doesn't reflect the activity on the ground
- Section 42 = resources = work???
- Is Section 42 enquiry an indication of the extent of safeguarding/abuse that is taking place?
- Ban Thresholds!!!!

NEXT STEPS

- Take back any learning locally
- Report findings to the regional branch and safeguarding networks
- Revise and update the regional protocol
- Produce a summary of the outcomes of the exercise to provide additional guidance
- Share our exercise nationally
- Share our experience and feed into the discussions at the national workshop

Local Government Association

Group discussions

Your table has a facilitator to guide you through the questions.

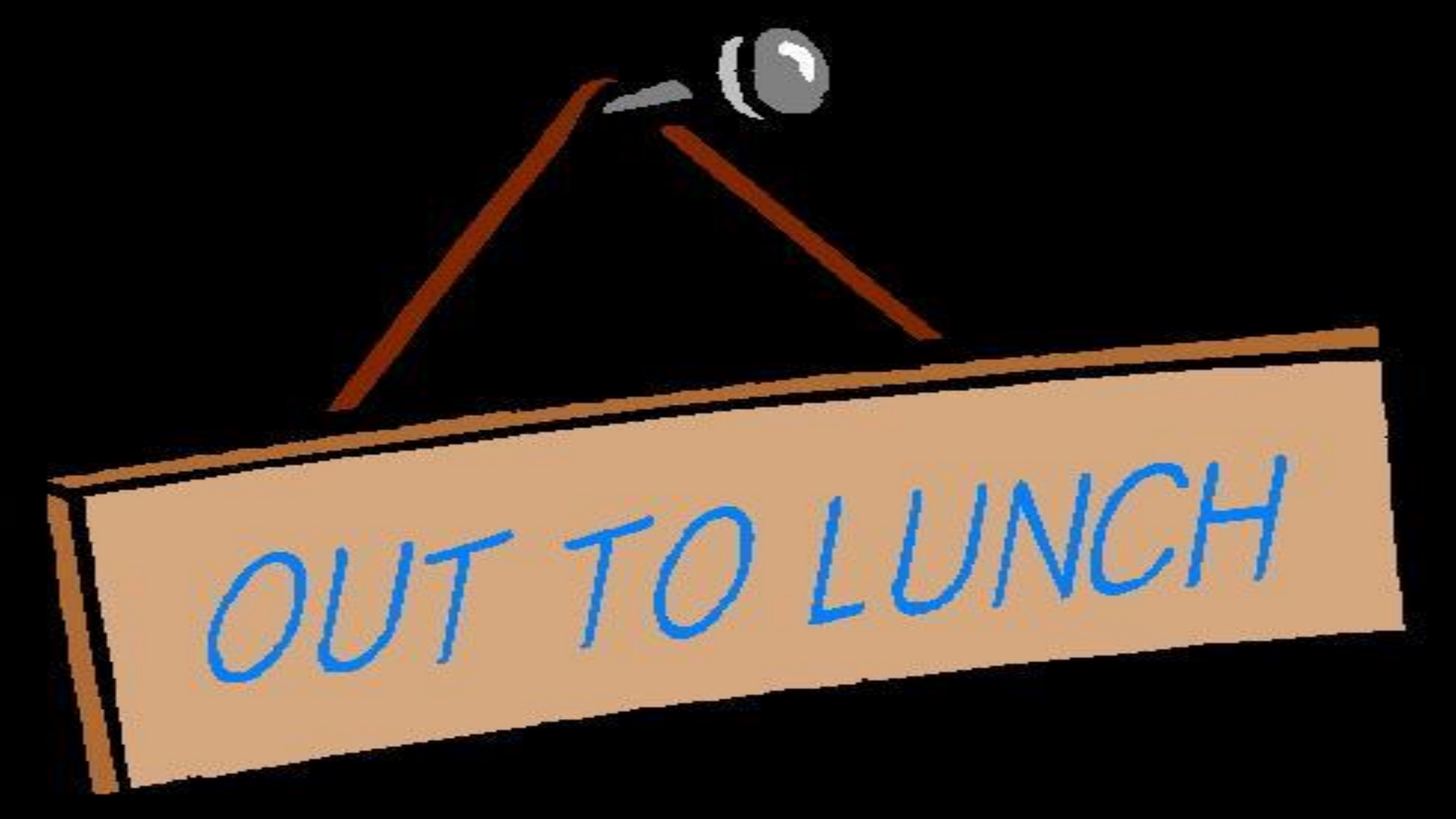
Principles

A principle is a general belief that you have about the way you should behave.
Morally correct behaviour and attitudes.
A fundamental source or basis of something.
A determining characteristic of something.
An adopted rule or method of application in action.

Ingredients

A constituent element of anything; component.
The ingredients of political success.
Component part or element of something.
An important part of anything.
A quality you need to achieve something.

You have a table number on your badge.
Please move to this table after lunch.
Thank you.


OUT TO LUNCH

Introduction to the afternoon session

Jane Lawson,
Adviser, CHIP, Local Government Association / ADASS.

REFLECTIONS ON HOW TWO APPROACHES TO SAFEGUARDING CAN IMPACT ON CONVERSION FROM CONCERNS TO S42 ENQUIRIES

Claire Bruin, Care & Health Improvement Adviser, East of England, Local Government Association.

Keith Dodd, Head of Adult Safeguarding and DoLS, Hertfordshire County Council.

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Reflections on how two approaches to safeguarding can impact on conversion from concerns to S42 enquiries

Claire Bruin, Care & Health Improvement Adviser, East of England, LGA

Keith Dodd, Head of Adult Safeguarding & DoLS, Hertfordshire County Council

Two different approaches

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- An Authority with a MASH, where media interest was triggered by the report by Action on Elder Abuse

- An Authority without a MASH where safeguarding concerns are managed through service led operational teams.

In the media spotlight

Patchwork of Practice - report by Action on Elder Abuse December 2017

Using the Safeguarding Adults Collection (SAC) 2016-17, concluded

- A postcode lottery
- 10 Councils 'converted' 100% of safeguarding concerns into S42 enquiries
- Some Councils, less then 10%
- Demonstrates differences in how an abuse concern is addressed
- BUT could also mean that older people & their families are being denied proper investigations
- Is it lack of resources, expertise or simply an unwillingness to investigate?

Local media attention

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- Local Authority with only 14% of abuse concerns being 'converted' into S42 enquiries
- Media questions about vulnerable people not being protected from abuse
- Easy to defend that this was not the case – all concerns looked into thoroughly
- MASH accepts all concerns with any suggestion of safeguarding issues – all logged as concerns, including concerns about the same person from different sources
- MASH then carries out triage
  - about 70% of concerns did not meet the 3 point test for safeguarding and were signposted elsewhere
  - Of the remaining 30%
  - About half were addressed without the need for a multi-agency meeting, often dealt with in the MASH
  - About half were passed to Locality Teams to lead on a multi-agency meeting & logged as a S42 enquiry.

Reflections

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- Does having a MASH increase the number of concerns logged and therefore reduce the conversion rate to S42 enquiries?
- Activity in a MASH to triage concerns that are definitely not safeguarding is not reflected in SAC – but may be reported locally
- How is the **activity** to address concerns where MASH has triaged and there is potential abuse/neglect being defined?
- S42 of the Care Act does not define what constitutes an enquiry, but requires the Local Authority to "……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……"
- Therefore, are **ALL the actions** taken by the MASH in connection with concerns that are triaged as potential safeguarding enacted under the duties of S42 of the Care Act?
- If so, this would have doubled the conversion rate from concerns to S42 enquiries in this case and would have reflected the actual number of enquiries made into potential abuse/neglect.

Issues post Care Act – LA with no MASH

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- Inconsistent decision making - Large number of decision makers across different localities and care groups

- Locally developed practices - Different approaches to dealing with concerns coming in leading varying response times and quality of response

- Offline safeguarding – Safeguarding enquiries taking place but not being recorded. This impacted on reporting and ability to audit and quality check safeguarding work.

Action taken

Redesigned our decision making pathway and recording system to improve consistency and accountability of decision making.

- How:
  - Clear guidance on recording of concerns for all entry points
  - Only trained managers able to decide on whether a concern becomes a S42 enquiry.
  - No thresholds for an S42 enquiry but eligibility based on the 3 questions

THE PERSON

Has needs for care and support (whether or not the local authority is meeting any of those needs)

and

Is experiencing, or is at risk of, abuse or neglect

and

As a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it

Safeguarding Concerns

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- Any referral received where the referrer is clear that they want to raise a safeguarding concern (whether it will meet the criteria or not).

- Any referral contain concerns around abuse or neglect whether or not the referrer has identified them.

- Do not need to raise just because information is sent in on a safeguarding form if what is being requested is something else e.g. a request for an OT assessment.

S42 and Other Safeguarding Enquiries

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S42 Enquiries

- All concerns that meet the 3 safeguarding questions
- A S42 enquiry can be as little as asking the adult at risk what they want to a full investigation. If closed at individual's request this will still constitute a S42 enquiry
- Individual outcomes are sought from the adult at risk and are recorded whether achievable or not.

Other Safeguarding Enquiries

- When not all 3 eligibility decisions are met but it is decided that a safeguarding enquiry is required.
- After eligibility decision follows the same process a S42 enquiry
- Does not cover other work such as a Care Act assessment or review.

Impact of changes

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- Before we made the changes in Herts our reported number of concerns put us as one of the lowest compared to regional and national comparators.

- Our conversion rate from Concern to S42 enquiry was around 48%

- Since the change the numbers of reported concerns have increased significantly and the conversion rate has also increased.

How do we Compare?

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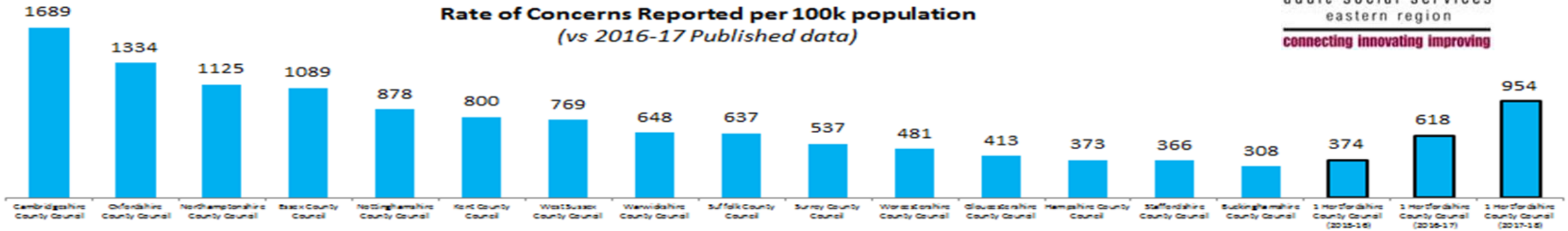
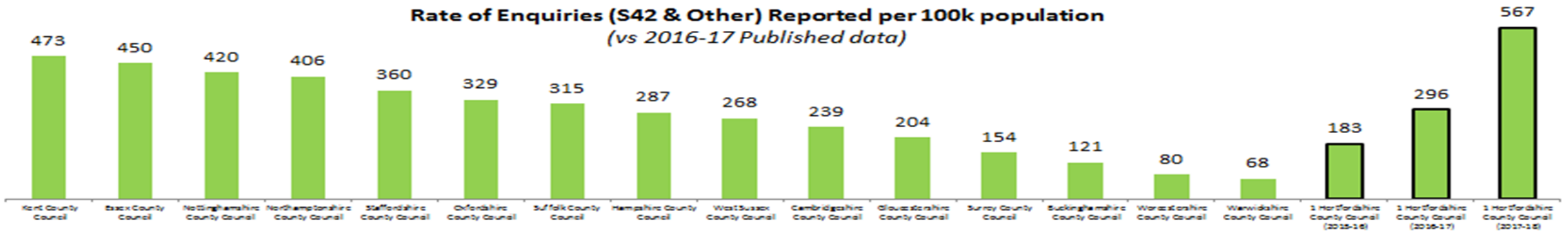
Rate of Concerns Reported per 100k population

(vs 2016-17 Published data)



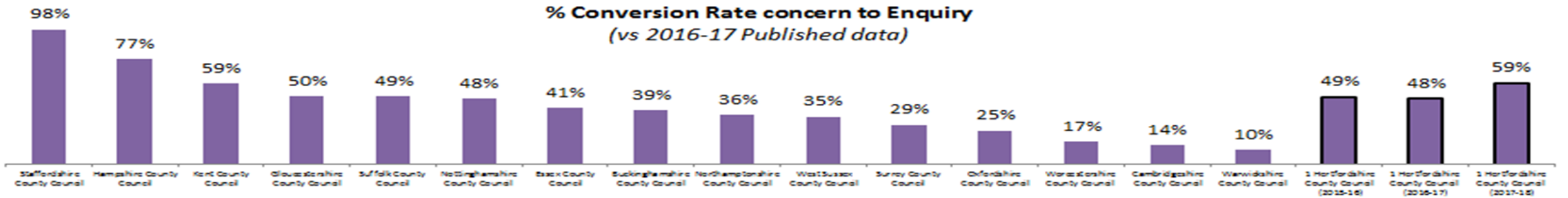
Rate of Enquiries (S42 & Other) Reported per 100k population

(vs 2016-17 Published data)



% Conversion Rate concern to Enquiry

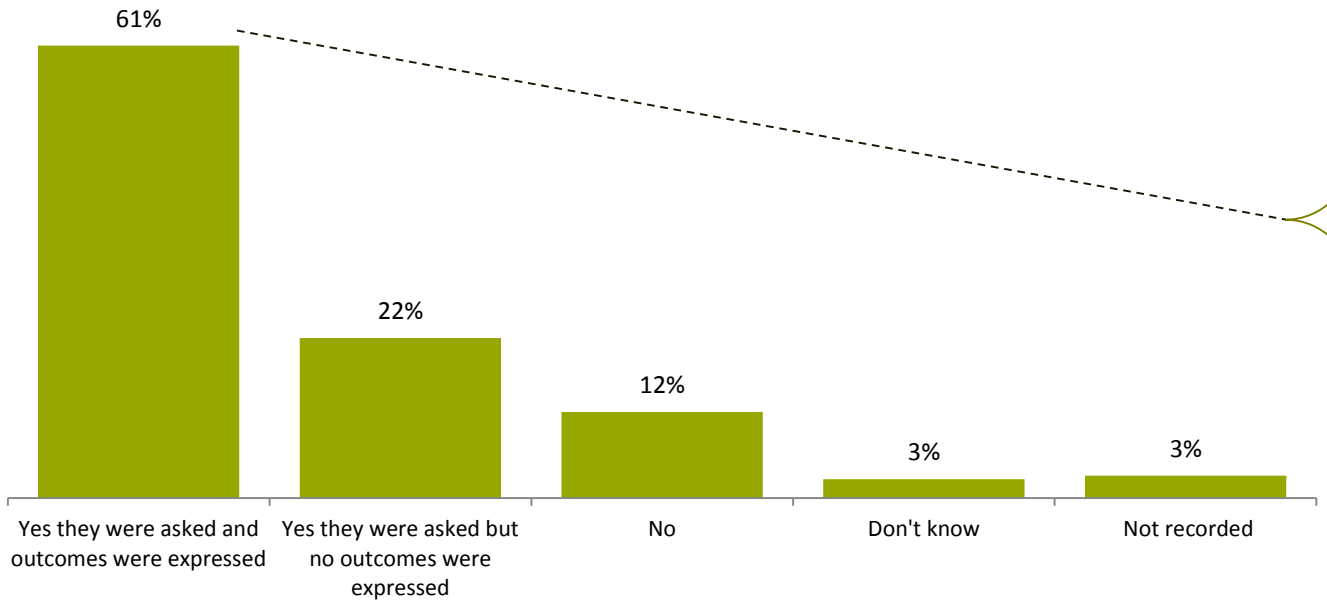
(vs 2016-17 Published data)

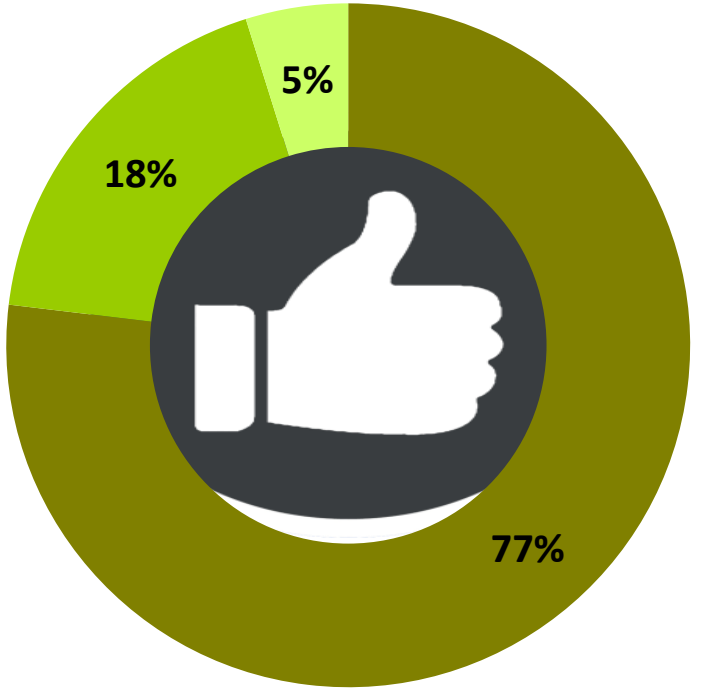


Making Safeguarding Personal

83% of clients involved in a safeguarding adults enquiry were asked what their desired outcomes were with **15%** either not asked or not recorded. **3%** answered that they "Don't know".

Of the clients who expressed their desired outcomes, **95%** had their outcomes achieved or partially achieved with only **5%** not achieved.





Key Issue

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What is an enquiry under the requirements of the Care Act?

S42 ENQUIRIES – IMPACT ON STATUTORY NOTIFICATIONS

Teresa Kippax,

National Advisor Safeguarding Children and Adults, Care Quality Commission. Directorate of Primary Medical Services and Integrated Care.

S42 enquiries – impact on statutory notifications

Teresa Kippax, National Advisor Safeguarding
28 & 29 November 2018

Current status

Safeguarding notifications

CQC receive on average 70000 per year

Majority from Adult Social Care providers

What happens with them?

CQC Improvements

Robustness of information

Guidance

New forms

Consistent messaging.

TO 'SECTION 42 OR NOT SECTION 42?'…THAT IS THE QUESTION

Malcolm Bainsfair

Head of Adult Safeguarding, MCA/DoLS and Principal Social Worker, Safeguarding Adults team, London Borough of Bexley.

To section 42 or Not section 42….that is the question…..

Malcolm Bainsfair
Head of Adult Safeguarding

LONDON BOROUGH OF BEXLEY

Decision Making in Response to a Safeguarding Concern

Principle decision…3 stage test and whether a safeguarding concern proceed as a formal Section 42 Enquiry…… or whether the concern can be more proportionally addressed by other means.

Local position……..2017/18.

Total number of safeguarding concerns received	1133
Number of concerns which became Section 42 Enquiries	352
Percentage of concerns which became Section 42 Enquiries	31.1%
Number of non statutory enquiries	801

Decision making

When determining a decision, consideration of a number of factors <u>includes</u>:

- Was harm caused, how serious was the harm or abuse / risk of harm or abuse - the consequence / impact
- How often has the risk of abuse or harm occurred - history /context
- How many adults at risk were exposed or could have been exposed to the harm or abuse - vital interest or potential organisational abuse
- What is the likelihood of the abuse or harm reoccurring? – frequency
- Wishes/decisions of the adult.
- **If in doubt consult with Safeguarding Adults Team…..**

Decision not to proceed with a section 42 enquiry

- Does the situation involve abuse, neglect or exploitation?
- Does the adult have identified care and support needs
- Does the adult have the mental capacity to make an informed choice about their own safety, there is no public interest or vital interest considerations and they choose to live in a situation in which there is risk or potential risk.

If a decision is made to proceed with non statutory enquiries:

- The referrer is informed of the decision.
- Triage Manager determines the nature of non statutory enquiry/response
- The Triage Manager designates the most appropriate person to feed back to the adult.
- Note: A decision not to proceed does not preclude information sharing where appropriate.
- Safeguarding Adult Team and where appropriate QA Team notified of non statutory response……**opportunity to scrutinise and challenge**…

Examples of lower level concerns

- Staff error on one occasion causing little or no harm, e.g. skin friction mark due to ill-fitting hoist sling
- Moving and handling procedures not followed on one occasion not resulting in harm
- Adult does not receive prescribed medication (missed/wrong dose) on one occasion - no harm occurs
- Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but little or no distress caused.
- Missed home care visit on one occasion - no harm occurs
- Care plan does not address assessed needs / or is not followed on one occasion and no harm occurs
- One off incident of low staffing due to unforeseen circumstances
- Isolated incident involving adult on adult not resulting in harm or distress
- Person has fallen and sustained an injury. Risk assessment in place and was followed.
-

Non Statutory safeguarding enquiries

Non statutory responses may include:

- Pass to QA – for specific targeted interventions or as part of wider service surveillance
- Care Act Assessment
- Carers Assessment
- Referral to other agency (GP, Police, Other LA, Acute Health, MH, Domestic Abuse Services etc.)
- Formal Complaint
- Advice & Information
- Other (Please Specify).

What we need to know.

What do we know

- Outcomes of section 42 enquiries.

What do we not know

- **outcomes of non statutory enquiries.**

What are we seeking to do

- Build greater data analysis of non section 42 and develop better supported decision making.

Ensure safety net arrangements

- Concern can be reconsidered as a section 42 at any point.

WHEN DOES A SAFEGUARDING CONCERN BECOME A SAFEGUARDING ENQUIRY ?

Nicky Beaton

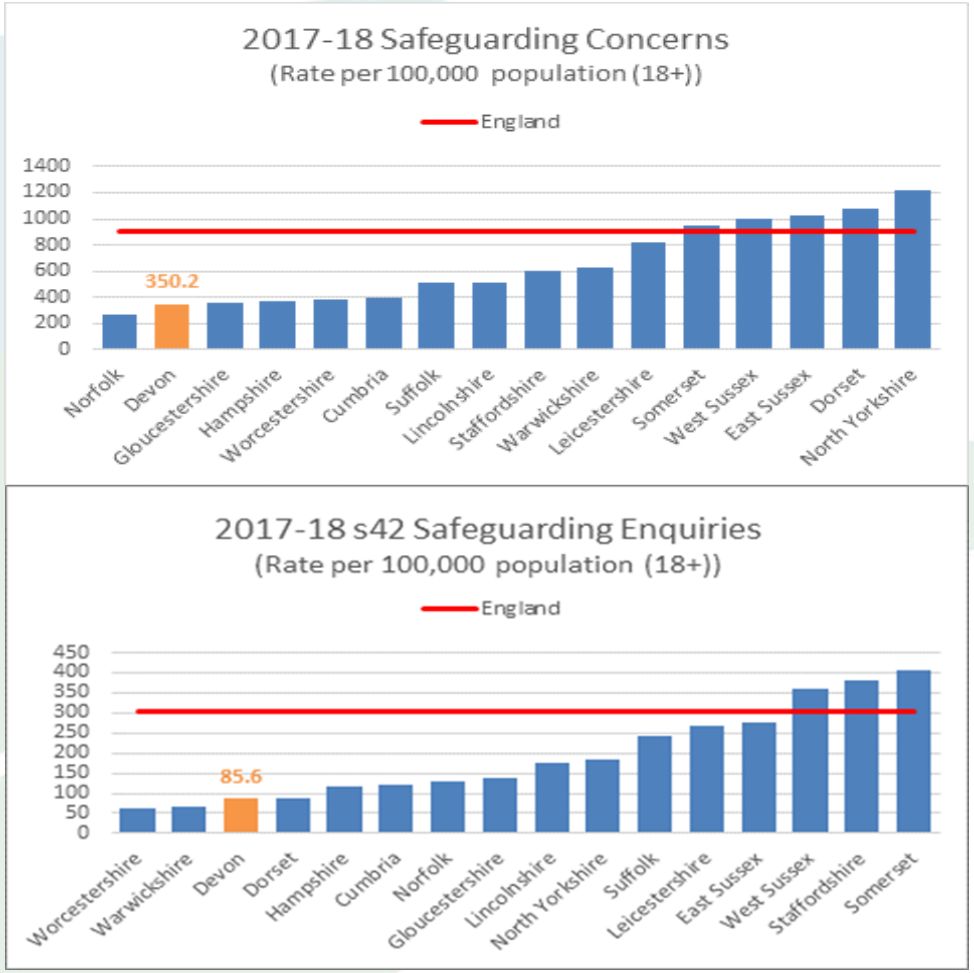
Safeguarding Adult Practice Lead for Devon County Council.

When does a Safeguarding Concern become a Safeguarding Enquiry?

A presentation by Nicky Beaton – Safeguarding Adult Practice Lead for Devon County Council

Why is this of interest to Devon County Council?

- In our National Return for 2017-18, Devon experienced a lower rate of concerns relative to our population then any of our comparator authorities.
- Similarly, our rate of enquiries (concerns that meet the threshold for further investigation) was also low relative to our population.
- Devon was curious about why this might be.



What did Devon do?

- Devon County Council decided to invite the LGA to undertake a Peer Challenge with a focus on Safeguarding activity, processes and practice.

- In addition, Devon County Council has been undertaking a number of internal audits to bring about a better understanding of our Safeguarding Adult work.

- Part of this thinking was to consider why we might be benchmarking low in terms of our concern to enquiry rate when compared to our comparator authorities.

What has the audit work / thinking revealed?

- As Safeguarding Adult Practice lead for Devon County Council, I was concerned by that data in the National return. My experience and intelligence from practice monitoring the activity of our Safeguarding adult hubs indicated that we were making the correct decisions as to whether a safeguarding concern would progress to a Safeguarding enquiry or not.
- My attendance at SW ADASS adult safeguarding network (South West Association of Directors of Adult Social Services) afforded the opportunity to speak to other Local Authority colleagues about this. Through these discussions I identified a subtle difference in our approach which may account for the low figures within the National Return.
- To demonstrate this, I have provided the following case example:

Safeguarding concern received

- Allegation of acts of omission and neglect by a care home provider, reported by the registered manager of the care home.
- Client has care and support needs, diagnosis of dementia and did not receive her medication over two days.
- Registered manager reported the safeguarding concern to their local authority safeguarding adult hub. A concern was raised and triaged by a Social Care Assessor.

Triage of the safeguarding concern revealed the following:

Registered manager reports

- Client had not received her medication for 2 x days.
- Once identified, staff contacted out of hours GP for advice and guidance. Informed to restart medication, and to increase monitoring and observations.
- Following morning, registered manager, contacted client's G.P, reports and checks that no further action is needed.
- Registered manager contacts client's representative – daughter to report what had happened.
- Registered manager takes the identified staff member off medication rounds. Places this person on re-training. Confirmed once completed staff member would be buddied up on medication rounds to ensure competency.
- Registered manager informs that they have made some system changes after identifying some pressure on medication rounds at weekends.

Social care assessor checks

- Contacts the client's representative (daughter) to ensure she had no further concerns and to establish what she would like to happen next.
- Contacts the client's G.P. to check on the information received from the registered manager.
- Contacts the registered manager again to confirm on dates of training for the staff member and gather further detail regarding system change within the home.
- Checks our internal provider record for the care home for any patterns or trends in relation to medication errors for this home.

Outcome

- Social Care assessor after information gathering is satisfied that safeguarding duties apply in this case: the client has care and support needs, has experienced abuse, namely acts of omission and neglect and could not protect herself from the experience of abuse due to her dementia.
- However, the social care assessor recommendation is to close the safeguarding concern with no further action from Safeguarding. His information gathering had established that the provider responded appropriately to the concern. Put in place immediate protection planning, updated risk assessments, provided further staff training and assessed the need for a dedicated room designed specifically for medical / medicines treatment. In addition, contact with the client's representative did not raise any further concerns and they indicated they were happy for the concern to be closed. Contact with the health professionals involved did not raise any further questions. Finally, checks of our internal provider record for the home did not identify any emerging trends in relation to this concern.

Why is this case important?

- It identifies the subtle difference.
- Our safeguarding adult hubs work safeguarding concerns by undertaking information gathering, triangulating that information whilst throughout applying the principles of MSP (making safeguarding personal)
- In concluding safeguarding concern forms on our system, they will tick the box which indicates if the concern has reached the threshold for when safeguarding duties apply.
- However, in their decision making they will also apply the Safeguarding principle of proportionality: the least intrusive response appropriate to the risk presented.
- Therefore, despite having reach the threshold for when safeguarding duties apply, the principle of proportionality may indicate that there would be nothing further to be achieved by progressing the concern into an enquiry and allocating this out to the Health and Social Care team for further investigation.
- Therefore they will recommend closure at the concern stage.

Why does this subtle difference matter?

- It could be argued that the triage work undertaken on Safeguarding concerns i.e. information gathering and the triangulation of this information could actually be considered as being safeguarding enquiry work.
- If so, this therefore, could give a narrative as to why Devon might be benchmarking low within the National Return relating to the number of safeguarding concerns that are converted to safeguarding enquiries.
- As practice lead, I would propose that the safeguarding adult hubs are highly skilled in information gathering, applying MSP and speaking with all relevant people involved in order to make an appropriate and proportionate decision to close concerns. We will always acknowledge when safeguarding duties apply but the recommendation and decision to close will also evidence the principle of proportionality, the least intrusive response appropriate to the risk presented.
- Additionally, within Devon, we assure and monitor our decision making by completing monthly practice quality reviews.

Thank you for listening – Any Questions?

Contact: Nicky Beaton - Safeguarding Adult Practice Lead

Devon County Council

Nicky.beaton@devon.gov.uk

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Refreshments

Group discussions

Your table has a facilitator to guide you through the questions.

Moving forward and LGA workplans for 2019

Jane Lawson,
Adviser, CHIP, Local Government Association / ADASS.