Staffordshire & Stoke-on-Trent Adult Safeguarding Partnership

AS2 MULTI-AGENCY PLANNING DISCUSSION DOCUMENT

ID No:	Key Worker:
NHS No:	Primary Support Reason:
First Name(s):	Surname:
Title:	Preferred Language:
Date of Birth:	Age:
Gender:	Marital Status:
Ethnicity:	Religion:
Current Address (including Post Code):	Current Telephone No:
Permanent address (including Post Code):	Preferred contact address (including Post Code):
Accommodation Type:	
Main Telephone No:	Mobile No:
Email Address:	Preferred contact method (e.g. tel. no, email):
Employment Status:	Lives with:

Adult with Care and Support Needs

Client preferred name	
Team	
Organisation completing this form	**Delete those not applicable SSSFT, NSCHT, IF, SSOTP and SCC**

All information in this document is considered by the MASH/District as PROPORTIONATE, NECESSARY and JUSTIFIED to share with partners in the interests of protecting Adults with Care and Support Needs.

The information on this form has already been assessed by the agency holding the information as relevant to share. For the purposes of this document, relevant information is defined as information that has a bearing on the case.

Further Requested Information

This form should be completed for Adult Safeguarding cases.

The following information is being requested to facilitate a risk assessment of an individual or an address to protect the health and safety of Adults with care and support needs. Only relevant information is being requested.

Date Concern raised

D	D		M	M		Y	Y	Y	Y

Incident log ref	
Date concern received by MASH/District	

Details of Adult with Care and Support Needs

Details of the concern/s (what are we worried about?)

What is current location of the Adult?

What are the views & desired outcomes of the Adult (if known)?

Access to the Adult

Is there already an advocate or representative involved?
Yes/No (delete as applicable)
If yes, provide details

Does the Adult have substantial difficulty in understanding or participating in the enquiry process?

Yes/No (Delete as applicable)
If yes, explain why

Does the Adult have any issues relating to mental capacity?

Yes/No (Delete as applicable)
If yes, explain what

Does the Adult have any communication issues (e.g. need for interpreters or intermediaries)?

Yes/No (Delete as applicable)
If yes, provide detail of issues

Details of 1st Person Alleged to be Responsible for Causing Harm

Details of 1st Source of Risk			
Surname		Forename/s	
Title		Client ID Number	
Known Alias		Ethnicity	
Gender		Religion	
DOB/Age			
Full Address inc Postcode		Telephone Number	

What is current location of the Source of Risk?

Does the Source of Risk have any communication issues (e.g. need for interpreters or intermediaries)?

Yes/No (Delete as applicable)
If yes, provide detail of issues

Details of 2nd Person Alleged to be Responsible for Causing Harm

Details of 2nd Source of Risk			
Surname		Forename/s	
Title		ID Number	
Known Alias		Ethnicity	
Gender		Religion	
DOB/Age			
Full Address inc Postcode		Telephone Number	

What is current location of the Source of Risk?

Does the Source of Risk have any communication issues (e.g. need for interpreters or intermediaries)?

Yes/No (Delete as applicable)
If yes, provide detail of issues

Agencies Involved in Completion of MAPDD

Please select all relevant Agencies involved by marking with an X

Police		Adult Social Care	
Other Local Authority		Housing Provider	
Other Provider Agency		Care Quality Commission	
Residential Home		Nursing Home	

Domiciliary Care Agency		General Practitioner	
NHS Commissioner		NHS Provider	
Acute Hospital NHS Trust		Mental Health Community Service	
Mental Health Hospital		Other (please specify)	

Other (please specify)

People Involved in Planning Discussion

Name	Organisation (if applicable)	Role and contact details

Current Agency Information - What is known about the Adult with Care and Support Needs?

Police (include document source)

Adult Social Care (please state name of organisation and include document source)

Employer (please state name of organisation and include document source)

Regulator (please state name of organisation and include document source)

Commissioners (please state name of organisation and include document source)

NHS Bodies (please state name of organisation and include document source)

Others (please state name of organisation and include document source)

Current Agency Information - What is known about the Potential Source of Risk?

Police (include document source)

Adult Social Care (please state name of organisation and include document source)

Employer (please state name of organisation and include document source)

Regulator (please state name of organisation and include document source)

Commissioners (please state name of organisation and include document source)

NHS Bodies (please state name of organisation and include document source)

Others (please state name of organisation and include document source)

Details of Concerns Post Information Gathering

Summary of Concerns

	Yes/No	Details
Are there other adults at risk of abuse?		
Are there other children at risk of abuse?		
Are there any young carers involved?		

Criminal Offences (to be determined in discussion with Police officers)

What offences may have been committed? (Please name them specifically including MCA offences)

If an offence has been committed but will not be investigated by the Police, please state why not

Risk of Harm Information (comment on the following)

Impact of the alleged abuse	
Duration and frequency of alleged abuse	
Apparent premeditation, threat or coercion	

Threat to development and/or independence, well-being and choice	
History of abuse	

People responsible for information gathering

Name of person responsible	Organisation	Contact Details

Risk of Harm Assessment & Decision

Indicate your decision on the level of harm that has already occurred (and provide your reasoning below)

none, low, medium, high (delete as appropriate)

Detail your reasoning for your decision on the level of harm that has occurred

Indicate your decision of your assessment of the potential future risk of harm (and provide your reasoning below)

(delete as appropriate) None, 1 = Low, 2 = Low, 3 = Low, 4 = Medium, 5 = Medium, 6 = Medium, 7 = Medium, 8 = High, 9 = High, 10 = High

Detail your reasoning for your decision on the potential risk of future harm

Section 42 Enquiry Decision

Is the Section 42 enquiry to proceed?

(Delete as appropriate)

Yes – Proceed with Section 42 enquiry
No

If no, please record why not below

If 'Yes' please complete the Section 42 Enquiry Plan, section.

If 'No' please obtain managers comments below.

Info - If the Section 42 enquiry is not to proceed, send to team manager for authorisation.

Manager Comments – Only enter if the Section 42 Enquiry is not to proceed

Manager to complete Section - AS2 Authorised By

Section 42 Enquiry Plan

	Yes/No	**Details**
Is the local authority undertaking the section 42 enquiry?		If Yes enter which Team/Organisation i.e. ASET or IF
Is the local authority causing the section 42 enquiry to be undertaken by another organisation?		If Yes complete section - Organisation undertaking section 42 enquiry (if not local authority)

Organisation undertaking section 42 enquiry (if not local authority)

Name of Organisation	

Contact Telephone number	
Contact email address	
Accountable person's name	
Accountable person's role	

Potential Contributing Agencies to Section 42 Enquiry

Indicate how many organisations you feel should take part in section 42 enquiry	(Delete as applicable) • Single agency enquiry • Joint agency enquiry • Multi agency enquiry

Info – if joint or multi chosen above - check all that apply by marking with an X

Police		Adult Social Care	
Other Local Authority		Housing Provider	
Other Provider Agency		Care Quality Commission	
Residential Home		Nursing Home	
Domiciliary Care Agency		General Practitioner	
NHS Commissioner		NHS Provider	
Acute Hospital NHS Trust		Mental Health Community Service	
Mental Health Hospital		Other (please specify)	

Other (please specify)

Initial Section 42 Enquiry Plan

Name of professional coordinating section 42 enquiry plan	Organisation	Contact Details

Safeguarding Officer (only if local authority)

Name	Organisation	Team

Initial Enquiry Plan

What Safety Outcomes are desired for the adult with care and support needs?	

Interview of the adult with care and support needs

Action	Safeguarding or enquiry officer responsible	Completion date
(Delete as applicable) Video interview, statement, other (give details)		

Other (give details)

Action	Safeguarding or enquiry officer responsible	Completion date
Interview of person/s alleged to be responsible for harm (potential source of risk)		
Interview of witnesses		
Medical examination (if required)		
Other evidence required - please state below		
Health and safety investigation (HSE/Local Authority)		
Other actions - please state below		

Other (give details)

Action	Safeguarding or enquiry officer responsible	Completion date
Feedback to adult with care and support needs		
Feedback to person raising concern		
Feedback to relatives/informal carers?		
Inform Professional Body?		
Inform DBS – disclosure and barring service?		
Referral to MAPPA		
Inform CQC – Care Quality Commission		
Inform Advocate		
Other - please state below		

Other (give details)

Initial Protection and Support Plan for the Adult with care and support needs

Action	Person Responsible	Completion date

Additional Support to Adult with care and support needs

Action	Person Responsible	Completion date
Assessment for adult with care and support needs		
Mental Capacity assessment		
Mental Health Act assessment		
Referral to advocate (is required if adult with social care needs has substantial difficulty in understanding enquiry process)		
Other (please state)		

Other (give details)

Action and/or Support to person alleged to be responsible for harm (potential source of risk)

Action	Person Responsible	Completion date
Assessment for person alleged to be responsible for harm (potential source of risk)		
Mental Capacity assessment		
Mental Health Act assessment		
Carers assessment		
Referral to advocate		
Other (please state)		

Other (give details)

Meetings Required

If other, please state

Name of person arranging meeting

Date copies of MAPDD sent to participants	

AS2 Completed By

Form Completed By			
Name		Role	
Team		Telephone	
Organisation			

AS2 Authorised By

Decision Making Manager			
Name		Role	
Team		Telephone	
Organisation			

Note: When attaching this word document to CareDirector through attachments, select the following:
Document Type – Case Management
Document Sub Type – Adult Protection