Safeguarding Adults Review

In respect of ‘Frankie’

Multi-agency safeguarding investigation of suspected non-accidental injuries

August 2023

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1. Introduction

1.1. Swindon Safeguarding Partnership ('SSP') have commissioned this discretionary Safeguarding Adult Review ('SAR') to explore how well partners respond to concerns regarding suspected non-accidental injury and with regards to the completion by a third party of a safeguarding 'caused enquiry' under s42(2) Care Act 2014. The review is centred on the experiences of a gentleman, who for the purposes of anonymity we are calling 'Frankie'. Frankie was, at the time of the incident in 2022 a 77-year-old white British man with advanced dementia, a chronic right shoulder dislocation[1] and was immobile. He required nursing care and was dependent on others for all activities of daily living.

1.2. Prior to his diagnosis and eventual admission into a care home, Frankie was married for over 40 years. He loved classical music and was a keen pianist. He also loved Chinese food and getting dressed up for a day of horse racing with his wife. After his retirement, he was an active member of his local Lions club and volunteered at his local Citizen Advice Bureau, utilising his financial knowledge and skills to support local residents. His wife sadly died in 2021, prior to her death she had been Frankie's main carer and he moved into residential care shortly thereafter. In conversations with the reviewer, the manager of his first care home placement (Care Home A) spoke of a quiet, reserved man. It had, understandably, given the later stages of his dementia, taken time for staff to get to know his preferences, but the manager rightly took pride in her staff's efforts to support Frankie so that he was able to engage with other residents and with activities in the home.

1.3. On the 19.06.22 he was taken from Care Home A to the Emergency Department at the Great Western Hospital in Swindon via ambulance with swelling and bruising to his upper arm and back. Following examination, he was treated for a right midshaft spiral humerus fracture. Due to the nature of the injury, Frankie's presentation and delay in seeking medical assistance, clinical staff questioned if this should be investigated as a non-accidental injury and referred the matter to the local authority for a safeguarding investigation, under s42 Care Act 2014. In line with local and national policy, the Local Authority requested Care Home A complete, as part of the safeguarding enquiry, their own investigation into the possible causes of the injury.[2] This was undertaken by the care home manager. Despite interviewing all staff working during the timeframe and observing CCTV of communal areas, that investigation was unable to explain how the injury occurred. Frankie was discharged on 18.08.22 to a new care home placement (Care Home B) following a best interest decision by professionals involved in his care.

1.4. Prior to his hospital discharge, the matter was escalated in line with SSP's policy, because of disagreement between hospital and adult social care safeguarding leads as to whether it would be safe to discharge Frankie back to Care Home A whilst the investigation was ongoing. The SSP's Practice Review Group reviewed the case on the 01.11.22. The group recognised that whilst the pain Frankie would have experienced was significant, it would not constitute serious abuse or neglect[3] and therefore proposed a discretionary review to explore multi-agency responses to suspected non-accidental injuries in adults.

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1 He had previously been admitted and treated for dislocated right shoulder on the 09.06.11, 13.01.22 (also required treatment for healing fracture of acromion), 19/06/2022 (Displaced proximal humeral fracture and shoulder dislocation).

2 In line with powers under s42(2) Care Act 2014. The request for a third party to lead on undertaking s42 safeguarding enquiry functions is known within local processes as a 'caused enquiry'.

3 This is defined within 14.163 Care and Support Guidance to include circumstances where '*the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect*.'

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. This review is not intended to duplicate employment duties, re-investigate causes of harm or apportion blame. This review will examine the effectiveness of safeguarding procedures (both multi-agency and individual organisations) to inform and improve local interagency practice. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to respond collectively to address the concerns raised during the s42 enquiry.

Themes

2.2. The review covers the period of the s42 enquiry, namely from 18.06.22 - 18.08.22. Relevant information known to the reviewer outside this timeframe is included for analytical purposes only. The SSP has prioritised the following themes for elucidation through this review:

- Was the s42 safeguarding enquiry undertaken in line with local policy and best practice; is there any learning or good practice that should be highlighted?
- Where concerns are raised about professional care settings, is there evidence within the local authority's triage and safeguarding enquiry of early involvement with commissioners or regulators?
- Where there are concerns regarding non-accidental injury, are health and police colleagues involved in those enquiries in a timely way?
- Is the local safeguarding policy clear on procedures for responding to concerns regarding non-accidental injury in adults with care and support needs; what support will partners and care providers require to implement forensic assessments of injuries where significant or serious abuse is suspected?
- Is the quality of 'caused enquiries' robust?
- Are local safeguarding escalation processes to resolve inter-agency dispute working well?

Methodology

2.3. The SSP commissioned an independent reviewer to conduct this SAR using the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time method. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

Involvement of Frankie, his family and professionals in this review

2.4. Frankie was unable to engage in this review due to his advanced dementia. Frankie received professional support from an independent advocate (commissioned by SSP) who attended panel meetings and the learning events to represent his voice at those meetings and within this report.

2.5. His only surviving relative explained he also felt unable to take an active role in the review process because of his own health needs, but did speak with an independent advocate. The reviewer wishes to express her sincere thanks to his relative for providing important information about Frankie. He also confirmed that it would have mattered to Frankie to have understood how his injuries were sustained.

2.6. The review also benefitted from support of a panel of representative from SSP partner agencies for their oversight and support in coordinating the provision of information, namely relevant case files, investigation reports and local policies. The following agencies supported this review:

- SSP Business Support Unit
- Swindon Borough Council's Adult Social Care (commissioning and safeguarding teams)

- Wiltshire Police
- B&NES, Swindon & Wiltshire Integrated Care Board [ICB]
- Great Western NHS foundation hospital [GWH]
- Care Home A

2.7. In addition, multi-agency learning events took place, both with front-line practitioners who worked with Frankie and the leaders who oversaw the services involved in supporting them. The manager and deputy manager of Care Home A also contributed. We are grateful to all who generously and openly supported this review.

3. National and Local Legal and Policy Context

3.1. Throughout national and local adult safeguarding policies the primary focus is to support the identification and notification to the local authority of possible abuse or neglect of 'adults at risk'[4] and to ensure any subsequent investigation is conducted effectively. To support good safeguarding referral practice, Swindon Borough Council has on-line guidance[5] which includes descriptors to enable decision making by family, unpaid carers and any professional working across all agencies about whether to refer a safeguarding concern to the council. This guidance specifies circumstances where lower-level concerns should prompt practitioners from SSP partner agencies to consult with their own internal designated safeguarding leads. It also provides descriptors of high risk that require a safeguarding concern to be submitted to the council for a s42 safeguarding enquiry to be completed. The guidance and local safeguarding policy aligns to best practice regarding decision making criteria.[6] It highlights the responsibility to report and undertake safeguarding enquiries (even against the expressed capacitated wishes of the adult at risk) if there is a duty of care or wider public interests, for example organisational abuse, or risks identified to other adults at risk or children. This obligation is in recognition of the legal duties under the Human Rights Act 1998 to intervene to protect life if the risk is real and imminent and to protect against inhuman and degrading treatment. These duties are not expunged if an adult, even with capacity, refuses support.[7]

3.2. Local data suggest that since 2016 there is a much wider understanding of the duty to report safeguarding adult concerns. In the 2021-22 NHS PowerBI report,[8] the Council reported receiving 2035 (equivalent to 1182/100k) safeguarding concerns from members of the public, staff and partners, up from 700/100k in 2016-17. Of those 40% converted to either a s42 enquiry (n805) or to 'other safeguarding enquiries' (n15). Currently safeguarding concerns come to the attention of the local authority via two different routes, namely:

- members of the public, providers and most partner agencies (including SWAS and hospitals) submit the on-line referral form. In order to be able to do so, the person completing this must register with the council's website, however there is also an offer to professionals to seek further advice from the Council's Safeguarding adults team via their email or direct telephone number.

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[4] An 'adult at risk' if defined at s42(1) of the Care Act 2014 as 'an adult with care and support need, at risk or experiencing abuse and neglect and who, because of their care and support needs, is unable to protect themselves.

[5] The safeguarding policy and procedures (available at: https://safeguardingpartnership.swindon.gov.uk/downloads/file/976/adult_safeguarding_policy_and_procedures) a flow chart, 'threshold guidance' (available at: and 'Know your role' document available at: https://safeguardingpartnership.swindon.gov.uk/info/14/policies_and_publications and the interactive threshold e-guidance is available at: https://www.swindon.gov.uk/xfp/form/795

[6] In accordance with LGA's briefing (https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf)

[7] Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74 (10 December 2008) (bailii.org) and *Rabone and another v Pennine Care NHS Foundation Trust* [2012] https://www.supremecourt.uk./cases/docs/uksc-2010-0140-judgement.pdf

[8] As reported by NHS Digital power BI available at: https://app.powerbi.com/view?r=eyJrIjoiZmQ4MzJlYWEtMTc4Mi00ZTM4LTk2YTMtY2E5NDFkNTIzOGI2IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9. This is comparable to the national reported rise of 45% from of 839/100k in 2016-17 to 1218/100k in 2021-22.

- Frontline police officers complete a Police Protection Notice ['PPN'] and submit this for consideration to their internal safeguarding leads who will triage and, if appropriate, refer these on to the Council's safeguarding hub.

3.3. Local policy clarifies that, following receipt of a safeguarding concern, responsibility rests with Swindon Borough Council's Adult Safeguarding Team ['SAT'] to '*carry out proportionate information gathering to ascertain whether or not there is reasonable cause to suspect the criteria for a s42 enquiry is met.*' If they are not met, the SAT can consider if an 'other safeguarding enquiry is required' or conclude that no further action is required. In this scenario the SAT are required to record how any residual issue and risks will be addressed or harm prevented, e.g. through early intervention or preventative support, alternative offers such as a carer assessment or other investigative or multi-agency risk management processes. Local policy stipulates it is the Council (as lead agency) that is responsible for '*recording and evidencing decisions as to whether or not to proceed with the duty to make enquiries under s42*.'[9]

3.4. If the criteria are met, then a s42(2) investigation must be undertaken. During the review timeframe, SSP were setting up a Safeguarding Hub. At the time of this incident, it was (and remains) not yet fully functioning as a multi-agency safeguarding hub ['MASH'], but staff from the police and social care were able to provide initial information sharing and advice on safeguarding concerns arising from Police Protection Notices or those referred via adult social care's initial contact team (who triage safeguarding concerns). There are now also daily meetings between police, social care and health professionals to discuss new referrals.

3.5. Once it is determined the s42 criteria is met, the enquiry is allocated to an enquiry manager. These are 'experienced *social workers who are capable of managing high risk enquiries within reasonable timescales, of communicating with a range of partners and chairing complex meetings and making complex Safeguarding decisions… they must ensure that the person is involved in all stages of the safeguarding process… The Enquiry Manager is responsible for establishing who is best placed to complete enquiry actions and reports (including 'caused enquiries'*)'.[10] Under the local policy, the enquiry manager can call on support from an enquiry officer but the policy is also clear that all 'relevant partners'[11] are expected to cooperate with the local authority in the exercise of their safeguarding function to prevent abuse and neglect, recognise, report and respond appropriately when abuse or neglect occurs.

3.6. There is an expectation within both national and local policy that partners will lead on enquiries where they have relevant expertise or additional responsibilities to conduct the investigation (referred to as 'caused enquiries'). SSP's safeguarding adults policy provides further guidance on multi-agency involvement (p17), parallel investigations and who is best placed to lead (p29) and more detailed guidance for professionals, providers, commissioners, and regulators on the expectations for those undertaking the role of 'Caused Enquirer' (p38-41). Whilst the policy actively encourages the Enquiry Manager to request others undertake enquiries, it remains clear that it is for the Enquiry Manager to coordinate any enquiry and retain responsibility for the quality of any safeguarding intervention and this is reflected within the pro-forma reports that are expected to be completed throughout the local processes (Appendix 7). The relevant procedures and timescales for completion of key tasks are also set out within the local policy (p34).

[9] Page 8 SSP's adult safeguarding policy and procedure, dated June 2021
[10] Op cit, page 13
[11] defined by s6(7) Care Act 2014 and including police, NHS bodies, the DWP, prisons and probation services.

Interface with providers duties to provide safe care

3.7. SSP's safeguarding adults policy explains (p39) that the Council and ICB contract and quality monitoring staff are best placed to undertake enquiries relating to concerns about quality of care within care provider settings or organisational abuse. Providers reporting incidents are expected, in line with regulatory and contractual obligations, to submit concerns to the generic email address in the Council's Contracts team at Contracts@swindon.gov.uk. The Contracts team keeps a log of these cases to evidence the requests and actions completed.

Interface with police duties to investigate is a crime is suspected

3.8. The local safeguarding policy (at p28) alerts the need to involve police early whenever criminal activity is suspected. In particular, it reminds readers that section 20-25 Criminal Justice and Courts Act 2015 introduced specific offences[12] of ill-treatment or willful neglect by a care worker or care provider. Ill-treatment is defined[13] as:

- deliberate conduct on the part of the offender which could properly be described as ill-treatment irrespective of whether it damaged or threatened to damage the health of the victim; and
- a guilty mind involving either an appreciation by the offender at the time that he was inexcusably ill-treating a patient or that he was reckless as to whether he was inexcusably acting in that way.

3.9. Wilful neglect requires the offender to have behaved deliberately so for example by consciously withholding necessary medication or where they could not care either way if that medication is provided so in other words where they are reckless. What is not required is actual harm caused to the patient by either the treatment or the neglect.[14]

3.10. The SSP's local policy requires all Wiltshire Police officers to remain alert to the heightened risks of exploitation and more severe adverse impacts experienced by adults with care and support needs who are victims of crime as part of their everyday duties. Any request by an enquiry manager for police involvement will be triaged by the police decision maker (working within the safeguarding hub) but in the main police are expected to respond as follows:

- Welfare concerns: police officers responding will alert relevant support services via PPNs which are sent to the Council. Requests by relevant partners for assistance with 'welfare checks' will be actioned where there is information that identifies the police powers of entry[15] are required.
- Adults at risk who are victims or witness to a crime or anti-social behaviour: police from community policing teams will work with partner agencies utilising risk assessment processes (MAPPA, MARAC, Community MARAC etc.)
- Adult at risk experiencing or at risk of abuse from a connected person or person in a position of trust: Currently the local policy states that whenever there are concerns involving someone in a 'position of trust (i.e. undertaking a professional role or acting under deputyship or power of attorney) the Safeguarding Adults Investigation Team ('SAIT') must support the enquiry. However, resourcing issues has meant that the police have recently had to disband this unit so now whenever there is reasonable cause to suspect a crime, the case will be allocated to the most appropriate investigation unit, either CID or the volume crime unit. This decision is made at sergeant level.

[12] These offences sit alongside similar offences under s127 Mental Health Act 1983 and s44 Mental Capacity Act 2005

[13] *R v Newington* (91 Cr.App.R. 247, CA.)

[14] *R v Turbill and Broadway* [2014] 1 Cr.App.R. 7, further details of the definitions and how they apply to these offences can be found at: https://www.cps.gov.uk/legal-guidance/ill-treatment-or-wilful-neglect-offences-sections-20-25-criminal-justice-and-courts

[15] Police have free standing powers of entry to arrest someone for an indictable offence (s17(1)(b) Police and Criminal Evidence Act [PACE] or there is a risk to life and limb (s17(1)(e) PACE, but this power limited as must demonstrate reasonable concern of serious bodily injury: *Baker v CPS* [2009] Police common law powers to enter to deal with a breach of the peace only applies in emergencies and when harm is actually done or likely to be done to a person/property in their presence: *Blench v DPP* [2004]

4. Chronology and analysis of agencies' actions

4.1. At some time between 3.41pm on the 17.06.22 and 8.18am on the 18.06.22 Frankie suffered an injury to his arm and ribs.[16] There were no incidents of note (e.g. falls or manual handling incidents) reported within his care records by staff, but at 7.37am on the 18.08.22 staff recorded he had a swollen and bruised arm which had '*been like it all night*'. By 8.35am a senior carer at Care Home A recorded his '*ribs are also bruised*'.[17] It is understood that advice was sort from 111, who advised to call his GP. A request was made for his GP to provide advice; this was subsequently provided by the Out of Hours GP who advised (at 9.37pm) that Frankie should be taken to hospital for an x-ray. Care staff reported they continued to provide personal care to Frankie throughout the day, that he ate as usual and didn't appear to be in any obvious pain. Care staff called 999 for a hospital conveyance at 10.09pm and that he was subsequently taken a 4.45am on the 19.06.22. Ambulance staff noted on their case notes that he had padded cot sides on his bed, required a turntable to mobilise but was otherwise immobile. Crew members also took (albeit poor quality pictures) of his injuries. Later that day the crew raised a 'Quality of Care' safeguarding referral and submitted this to Swindon's Adult Social Care, CQC and his GP in line with expectations under their own and the local multi-agency safeguarding policies. This was good, pro-active safeguarding practice.

4.2. On his arrival to the Emergency Department of Great Western Hospital [GWH ED] Frankie was unable to explain how the injury had occurred. He was examined and found to have '*a humeral fracture and potential rib fractures requiring trauma and orthopaedic input… He was handed over as a bed bound patient without any witnessed falls/accidents and the bruising and fractures are not able to be explained – [Frankie] is not sure of why or how the bruising and fractures have happened - When asking for consent from [Frankie] and explaining that it was being done to ensure he is safe and looked after, [he] was keen for this to be done, answering very clearly.*'[18] Frankie's injuries was recorded on a body map, but no further photos were taken. The ED's safeguarding lead ['SL'] requested expert medical opinion on the likely causation of the injuries. Frankie was subsequently admitted to GWH for treatment and on the 20.06.22 the ED DSL raised a safeguarding concern to the local authority, noting within this Frankie was likely to be referred by ward staff to the discharge planning hub on or around the 23.06.22. Again, this was good safeguarding practice, in line with the hospital's and local multi-agency safeguarding practice.

4.3. The local authority officer who reviewed the referral on the 20.06.22 made a note as part of the triage to request an allocated enquiry officer '*contact care home to gather further information around the concern, cause and timeline in relation to seeking medical attention*'.[19] The officer screening the concern rated the urgency of response as green (low level) as Frankie's immediate needs were addressed by health staff within the hospital. Neither this concern or the concern submitted on the 19.06.22 by SWAS was opened as an active s42 enquiry. Adult social care staff involved in this review accepted there was sufficient information within the referrals to conclude the circumstances met the criteria for an enquiry. This decision was therefore in breach of the local policy, but was not picked up or corrected subsequently by senior managers undertaking their supervision role. At this time, the multi-agency safeguarding processes required any concerns that met the s42 criteria[20] could be referred for discussion at a daily safeguarding hub but were expected to be swiftly allocated to a locality team for an enquiry manager to commence investigations. However, it appears that either pressures on the locality teams at the time or the misunderstanding that this concern was still at the 'information gathering' stage of any enquiry caused a delay to the allocation of an enquiry manager so a

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[16] This timeframe was determined during the subsequent investigation by Care Home A, who viewed CCTV footage of communal areas.
[17] Taken from the timeline prepared by Care Home A and South Western Ambulance's IMR prepared for the purposes of this review.
[18] Taken from the safeguarding triage notes, prepared for the purpose of a subsequent 'Best interest' meeting and shared with this review.
[19] Taken from the ASC screening record submitted for this review.
[20] This threshold is met whenever, an adult with care and support needs, is at risk of or had experienced abuse or neglect and, because of those care needs, is unable to protect himself. [section 42(1) Care Act 2014]

safeguarding adult planning meeting (required by p35 of local procedure) was not called. There was also insufficient consideration given to how to secure Frankie's voice in the enquiry. Given his cognitive impairment and the lack of a suitable person to assist him, an enquiry manager was expected under the local policy (in line with obligations under the Mental Capacity Act 2005 and s68 Care Act 2014) to appoint an independent advocate for Frankie. These two failings were significant in contributing to the delay in securing multi-agency agreement on the various tasks that were needed to be undertaken by different partners to progress the enquiry. It also prevented relevant partners from establishing agreement as to Frankie's safeguarding outcomes and a person-centred risk assessment in breach of SSP's policy (p30).

4.4. A further review of the case on the 24.06.22 by the triage enquiry manager recognised that the response was now outside of the expected timescales under local safeguarding policy but noted this was due to '*priority work taking place on triage,… I have advised this is completed by end of next week'.*

4.5. Following contact from GWH's DSL and ward staff on the 29.06.22, a further review of the case prompted the triage enquiry manager to contact the person they believed had been allocated the case to undertake the safeguarding enquiry. At this point they realised that individual no longer worked for the local authority and that the required follow up actions set out in their notes of the 24.06.22 had not been completed. Thereafter, they contacted the manager of Care Home A to ascertain what steps had been undertaken to investigate the cause of the injuries. Case records suggest that consideration was not given by the triage enquiry manager to triangulate information with CQC or the Council's quality assurance team. This is relevant because at that time Care Home A had been assessed by CQC as requiring improvement for leadership. In conversations with the reviewer, Care Home A's manager explained that CQC's findings related to previous management and that they had been employed to address CQC's concerns. The care home manager explained, at the last site visit CQC conducted, the inspector had complimented the manager for the significant improvements but wished to see those improvements embedded before amending the rating. They had now been waiting for a re-inspection by CQC for over 2 years. There is no evidence on the case records that this information was sought by the Council's enquiry manager as part of their determination that the 'caused enquiry' undertaken in Frankie's case would be completed by an individual with relevant skills and training. In conversation with the reviewer, the care home manager confirmed she had received training to complete enquiries and had extensive experience of doing so.

4.6. The quality of the investigation by the Care Home A was of a high standard. It was objective, thorough and took into account all relevant considerations. At that time, the care home manager confirmed she had reviewed Frankie's care records, taken formal statements from 6 staff members who were on shift between the 17-18.06.22 and watched all available CCTV footage for any signs of distress or anxiety within the staff team or from Frankie. One member of staff had, following legal advice, been suspended from practice on the 08.07.22 pending the completion of the investigation. Contemporaneous case records report (and the Care Home manager confirmed in conversation with the reviewer) she was equally concerned to ascertain how the injuries may have occurred. The care home manager gave the enquiry manager details of Frankie's health and medical history which were relevant to the enquiry, but did not receive information known to the enquiry manager that the hospital had sought a medical opinion regarding whether this was a non-accidental injury. Following that conversation, the triage enquiry manager formed the view that there was no evidence of deliberate abuse and advised the hospital's DSL it would therefore be safe for Frankie to be discharged from hospital to Care Home A. It does not appear from case records that the information provided by the care home manager about Frankie's care needs were passed to staff caring for Frankie at the hospital. Unfortunately, the enquiry manager did not take the opportunity to rectify the earlier failing to hold a planning meeting and bring together all relevant organisations so that information pertinent to the enquiry could be shared. This was again in breach of the local policy and represented another missed opportunity to ensure robust safeguarding practice.

4.7. By the 30.06.22 Frankie had moved to Swindon Immediate Care Centre ('SICC'). This is a 'step-down' facility within the hospital, but run much like a community hospital for those who require rehabilitation support rather than acute medical care. The SICC staff completed a capacity assessment and consequently their DSL requested an independent mental capacity advocate ('IMCA') involvement and more assurance that Care Home A were able to manage his additional care needs following the fracture. The triage enquiry manager replied stating it was not '*proportionate to delay discharge, while we await for the full internal investigation*.' Later that day, the DSL queried if the enquiry manager had received '*the opinion of the medical team as to how this fracture may have occurred. It maybe you have obtained this already…This type of fracture is quite complex and usually associated with falls, sports injury, where bones are twisted with great force. It may be there is another explanation from the medical team, but I feel we need their opinion if it has not been gained, to try and piece together what may have happened. If you have not obtained a medical opinion, I am happy to contact the team that reviewed him at the hospital. Additionally, I am concerned about the level of bruising with the injury and the fact that the doctors who came to visit on the 22/6/22 reported there were finger marks to be seen on his back. This gentleman is not on any anti-coagulants preinjury as far as I can see I have attached an initial report based on the clinical notes, but we can get a further opinion*.' Following a discussion with another triaging enquiry manager on the 31.06.22, the original triaging enquiry manager reported they had agreed the level of investigation completed was a proportionate response and, it appears from the case records, the matter was considered concluded.

4.8. On the 02.07.22 GWH's orthopaedic consultant provided a medical opinion to the hospital's DSL which was passed to the enquiry manager stating, Frankie '*has a spiral fracture of his humerus. These injuries occur due to a twisting mechanism. This could have occurred if he caught his arm and then turned in bed. Or if an external twisting force was applied by someone else. The thing that concerns me is that when this fracture occurred it would have been very painful which would have caused a change in behaviour even if the patient was not able to verbalize his pain. This would have occurred prior to the swelling and bruising developing. Staff did act by calling 111 when they noticed the bruising, and I do not know the patient well so it is difficult for me to say how obvious it would have been that he was in pain. Not all spiral fractures are caused by non-accidental injury, but they can be, as they require the application of a twisting force. Not all fractures are recognized immediately, but this fracture would have been very painful and if it was not picked up initially I would like to know that the patient was being provided with adequate care*.'[21] It does not appear from this note that the consultant was provided with all information available to the enquiry manager regarding Frankie's frailty, mobility and care plan. Again, the involvement of this consultant or hospital partners in a multi-agency safeguarding strategy meeting or discussion would have enabled a more robust, shared view on whether the injury resulted from an accident or was more likely than not to have been deliberate abuse or neglect.

4.9. On the 06.07.22 the enquiry manager spoke again to the care home manager who confirmed '*the night staff reported and monitored as per usual, he slept all night not showing any pain or discomfort, handed this over to day staff. Day staff supported with personal care, and saw/assessed the swelling and then saw the bruise on his upper waist. 111 was called, waited for call back, then waited for GP to come the next day, then ambulance was called. He was still getting dressed and being supported with personal care at this time… There are paddings on his bed rails; however there is scope for him to be able to put his hand down the sides and twist…. There is an unsubstantiated theory that he could have come out of his stand aid too quickly and gone back and put his elbow on the arm of the chair to then have caused the spiral injury to his upper arm bone, this is also consistent with the bruise on this upper waist, as this is where the belt is situated*.' The enquiry manager concluded '*the staff have been transparent;*

[21] Taken from GWH's IMR prepared for the purpose of this review.

and in my view Care home manager has also been transparent about the unexplained injury.'[22] Following this discussion the enquiry manager again reiterated their view that there was no further risk to Frankie of returning to Care Home A, but it does not appear from email communications that the information that was known to the enquiry officer (i.e. the nature of scope of the investigation undertaken by Care Home A) was shared with the DSL for SICC. Instead, the enquiry manager asserted that the issue was now one for the hospital to consider as it was a matter of a safe discharge and that, if they had ongoing concerns, they should involve an IMCA and hold a best interest meeting. The enquiry manager requested they and the care home manager should be invited to any subsequent best interest meeting. Again, the enquiry manager did not take the lead by arranging this as part of the safeguarding enquiry. Later that day, SICC held a pre-best interest meeting and agreed to submit a request for an IMCA to be appointed.

4.10. It is understood that, perhaps due to the decision to collect further information within the triage team rather than allocating this to a locality enquiry manager or to the Council's contracts and quality assurance team, Frankie's injuries were only first discussed at the safeguarding hub's daily meeting on the 07.07.22. At that time police agreed to record it within their NICHE case records as a suspicious incident, but the hub police officer (in consultation with their supervising Sergeant) concurred that there was insufficient information or evidence that would justify a reasonable suspicion that a crime had been committed.[23]

4.11. On the 11.07.22 GWH's DSL emailed the enquiry manager, cc'd to ICB Nurse/Trusted Advisor and ward manager, providing copies of photos of Frankie's injury. The IMCA requested a further referral to enable them to provide support for both the change of accommodation issue and safeguarding enquiry, providing assurance that the same person would carry out both remits but required this for contract monitoring processes. Following this, the enquiry manager stated they had not yet concluded this met the criteria under s42(1) because it had not yet been proved the injuries were non-accidental. This was a misunderstanding of the criteria under s42(1) as the duty to conduct an enquiry would have arisen in this case if there was reasonable cause for concern that the injuries resulted from poor quality care (neglect) as well as if this had been purposeful non-accidental injury (abuse). In discussion with the reviewer all practitioners and managers were satisfied that, given Frankie's inability to protect himself, there should have been no question that the threshold for an enquiry under s42(1) had been met at the point of the first referral from SWAS (19.06.22) or the hospital's referral (20.06.22).

4.12. GWH's DSL responded on the 11.07.22 re-iterating concerns regarding defensible decision making within the safeguarding procedure as '*the decision was made to send him back to the care home, whilst the investigation had not been completed, additionally there was no medical opinion sought as to how this injury could have occurred before making the decision to send the gentleman back to the care home. We still do not know why there was finger marks on his back when the doctor came to see him. He did not lie in his bed on his own and sustain this injury, at the least this is likely to have occurred as a result of poor manual handling practices by staff as the gentleman is immobile independently. He cannot speak for himself regarding this injury and he has no family to advocate on his behalf. We have a duty of care to speak on behalf of this gentleman, this is through the [best interest] process, so he needs an advocate. Also, there is not consensus on this decision to send him back to the care home. Surely we need assurances from the service around their manual handling practices. We need assurance that with his increased needs with an injury which may never heal, that staff are competent to manage him safely.*' Whilst those issues may have been sufficiently addressed for the enquiry manager during his conversations with Care Home A's manager, there is no evidence that a summary of

[22] Taken from the ASC screening note made available to this review.

[23] Given the nature of the injury (a fractured arm) it is accepted that had this been intentionally inflicted this would amount to Grievous bodily harm, equally police would need to consider wilful neglect or ill-treatment offences under s44 Mental Capacity Act 2005 or s20-25 Criminal Justice and Courts Act 2015

those discussions were passed to the hospital. Instead, it appears that the enquiry manager considered their decision making in isolation, not giving sufficient regard to the ongoing duty of care shared between the relevant partners to protect Frankie from future harm or protect against an unsafe hospital discharge.

4.13. On the 12.07.22 Care Home Manager interviewed the remaining care assistant and agency staff who had been working during the timeframe when the injury occurred. Neither staff were able to recall any incidents that could have caused the injury. The investigation was inconclusive, though accepting the injury had occurred during the night shift of the 17.06.22 and the Care Home Manager's final report requested the police complete further investigation. Her report stated that both carers on that night shift had '*separately confirmed he appeared in discomfort/pain when they were supporting him with personal care, but hadn't taken action until the morning when they noticed considerable swelling/bruising.*' The Care Home Manager included a request within the report that Frankie be allowed to return to the home as *'over time he has started to interact with the other gentleman on the floor and joins them for lunch and activities, I would also like to know if Frankie has been spoken to as he has lucid moments and I wonder if he is able to assist with this enquiry and also have a part to play in choosing if he may like to return.'* The same day the hospital's DSL escalated their concerns to the Council's SAT manager to advise of the case following discussion with the ICS Safeguarding lead and considered escalating the case formally to the SSP. They were advised by Council's assistant team manager '*the safeguarding referral is going to be closed. I understand that whilst there have been concerns raised regarding the significant injuries [Frankie] sustained; there is no evidence any abuse has taken place. I also understand that [Care Home A] have been transparent, co-operative, and supportive during the investigation with safeguarding to ensure any concerns have been investigated fully and have plans in place to maximise [Frankie's] safety. As a result, SBC safeguarding believe it is appropriate for [Frankie] to return ... I don't believe a [best interest] decision is needed for discharge planning or accommodation needs to be undertaken, as the decision to live there was made prior to admission; and there is no substantiated reason or framework for Frankie to not return at this time, so the previous decision to live there still remains valid. I am happy to attend a professionals meeting if still felt needed and though X is off after tomorrow, I have spoken with her manager and a representative from SBC Safeguarding can attend in her absence. Please let me know how you wish to proceed.*' Again, it does not appear that the information available to the Council's SAT regarding the safety planning put in place by Care Home A was shared with the hospital. Frankie had advanced dementia and, following his injury, it was proportionate to review and possibly revise his care and support plan (a legal duty under s27 Care Act). As such there is a duty to consult with the adult or, if they lack capacity to consent to any changes, make decisions in the person's best interest (s4 Mental Capacity Act 2005).

4.14. On the 14.07.22 a professionals meeting between the Council's adult social care and hospital staff was scheduled for the 19.07.22. The police records noted on this day police staff from within the safeguarding hub inputted a Niche record relating to the injury, but confirming they would take no further police action following review by the SAIT's Detective Sergeant as there was insufficient evidence to prove non-accidental injury or confirm a criminal offence had taken place. The enquiry manager also spoke with the manager who confirmed she had alerted CQC to the injuries on the 16.06.22 and that CQC had asked her to notify them of the outcome of the internal investigation and safeguarding enquiry. She later updated CQC that the police had concluded no further action was required. She also agreed that, on Frankie's return, her staff would:

- Body map regularly: she will put in place alerts on the care noting system for carers to body map after every transfer
- Hourly wellbeing checks: with the alert for carers to make reference to his position and where and what he is sitting/laying in.
- Full body hoist sling moving forward, double handed care and no stand aid usage

- Pain chart every medication round.

4.15. The triage enquiry manager therefore concluded that it was not necessary to initiate a safeguarding enquiry and there was '*nothing further that can be investigated. Criteria has not been met to progress either. I have sent this outcome to leadership for ratification*'[24] It does not appear from the case notes, that information available to the enquiry manager was shared with the hospital DSL to inform decisions regarding safe hospital discharge.

4.16. On the 19.07.22 the professionals meeting was held (though noted that Frankie's advocate had sent apologies). It was agreed to arrange for his advocate and SaLT to see him on the ward and for SICC to establish his views or wishes. The matter was also further discussed with the Interim Head of Service that day, where a decision was reached to progress to an enquiry. The safeguarding enquiry was completed by an Assistant Team Manager on the Adult Safeguarding Team.

4.17. The following day, a meeting between the Council's safeguarding team, contracts team and Care Home A (again advocate sent apologies) confirmed the care home was still needing to interview an agency worker who had worked with Frankie on the day of the incident. Thereafter, the enquiry manager spoke with the CQC Inspector, who confirmed that CQC were aware of the concern and that they were still awaiting the internal investigation report from Care Home A. Frankie's advocate also met with him and noted he appeared unable to communicate with her regarding the concern and how he was feeling. The Advocate agreed to visit Frankie again.

4.18. On the 21.07.22 Frankie's advocate sent an email stating he had expressed a wish not to return to Care Home A and that he stated this several times. The advocate advised it was their view that it would not be in Frankie's best interests to return to Care Home A given the severity of injuries sustained. The advocate requested a new placement be identified. The enquiry manager spoke with Care Home A's manager and sent a copy of the advocate's report to the Community Response Hub to begin the process of discharge planning. In discussion with the reviewer, the care home manager expressed her disappointment in not having been invited to assist with any review and revision of his care needs or being contacted to find out how best to communicate with Frankie, what they knew of his preferences and how best to meet his needs in a person-centred way. She felt Frankie's case provided clear lessons regarding communication between all those involved in safeguarding and best interest decision making.

4.19. The following week (29.07.22) a speech and language therapist ('SaLT') confirmed to the Council's SAT they had '*tried and failed to ascertain [Frankie]'s thoughts around returning to Care Home A and his wishes for discharge*.' On the 03.08.22 a joint visit (with IMCA and SAT) confirmed Frankie lacked capacity. GWH's Head of Clinical Operations also wrote to the GWH Social Work Manager with concerns regarding Frankie's prolonged stay in hospital and risks to his wellbeing of deconditioning. A social worker from the hospital discharge planning team confirmed to GWH Head of Clinical Operations they had met Frankie '*on 2 occasions, one with SaLT supporting. I was unable to ascertain his views regarding returning to the care home. I have been in contact with Safeguarding and X is visiting today at 4pm with the IMCA and will wait feedback from this visit.*' Following this visit a best interest decision was made, with input from the Council's SAT assistant manager as to where Frankie should reside. Care Home A were notified on the 15.08.22 that the Council were now likely to close the safeguarding enquiry. In response, the Care Home A manager raised concerns for Frankie given the time he had spent in hospital and asked for an explanation as to why it had been decided to move his placement. This was not forthcoming. He was subsequently moved to Care Home B on the 18.08.22.

[24] Taken from ASC screening form, which notes oversight by assistant team managers on the 15.07.22 and 19.07.22. it was noted that the feedback to the referrer should be verbal.

4.20. The formal safeguarding enquiry was subsequently closed on the 01.11.22 and sometime that month the Council's contracts team completed a manual handling desktop review of Care Home A staff.

5. System Findings and Recommendations

Was the s42 safeguarding enquiry undertaken in line with local policy and best practice, is there any learning or good practice that should be highlighted?

5.1. Within this case there was good practice identified, including:

- Ambulance crew members and ED staff who all reported their safeguarding concerns that Frankie may have suffered ill-treatment/ abuse or neglect.
- Ambulance crew made a note of relevant information for any subsequent enquiry into whether this was an accident, abuse or neglect. Reporting that Frankie had padded sides to his bed and the additional aids needed by him to mobilise.
- In line with local policy, ED staff reported this also to their DSL within the hospital who followed up the referral.
- The DSL arranged for advice from an appropriate clinician re nature of the injury and likely cause.
- A body map and photos of the injuries were taken, though GWH return noted concerns were raised about the quality of the pictures.
- The care home manager notified CQC and commenced their enquiry in a timely way. The care home manager sought and acted on legal advice to suspend the paid staff member on the 08.07.22 and provided updates, including their conclusions of their investigation, to the enquiry manager and CQC.

5.2. SICC staff gave careful consideration of their duties to ensure safe hospital discharge and protect against Frankie's future harm, their onward enquiries complied with expectations under the Mental Capacity Act 2005, NHS Act and Care Act.

5.3. There were also some examples of non-compliance with local policy which directly impacted on the professional conflict which later arose. They also adversely impacted on timeliness and successful outcome of the enquiry.

- The photographs of Frankie's injuries were of a poor quality, which could have impacted on the orthopaedic consultant's ability to form a definitive conclusion on the nature (accidental or otherwise) of the injuries and on the reliability of this evidence within subsequent investigations, civil or criminal proceedings. In discussions with the reviewer, hospital ED staff recognised they need equipment within ED to secure quality images and body maps.
- Police were not notified at the earliest opportunity so were unable to provide guidance to prevent contamination of any evidence.
- There was limited information available to ED staff on his admission. A more comprehensive overview of Frankie's frailty, his mobility and communication issues and how these were managed within Care Home A prior to the incident would have assisted ED staff and the orthopaedic consultant provide more definitive advice on the nature of any caused enquiry, i.e. was this likely to have been an accident, abuse or neglect.
- The concern was not triaged correctly or allocated as a s42 enquiry to a locality team or the Council's quality assurance team. As a result there was poor coordination across the different agencies involved in the enquiry. Neither the enquiry manager (or their supervising managers) held a safeguarding planning meeting and, whilst the key people to be involved were subsequently identified, they did not have an opportunity to agree key tasks or come to a shared understanding of what had happened, what outcomes would matter to Frankie or how to avoid future harm to him. This caused significant delay in progressing the enquiry

and determining how best to protect him from future harm. It also resulted in unnecessary professional conflict between the hospital staff, Council SAT and Care Home A's manager.

- Expert medical opinion, available to the enquiry manager regarding the injury, was not made available to Care Home A's manager conducting the 'caused enquiry'. It also remains unclear how the medical opinion informed future protection plans for Frankie or the police decision not to formally investigate.
- There was delay in appointing an advocate to support Frankie during the safeguarding enquiry and future protection planning/ care plan review. Within discussion with the reviewer, staff spoke of improvement plans in place with advocacy services to improve timeliness of support to adults at risk. They explained there were quarterly reports on the impact of those plans, but that high levels of vacancies within the Council's contract and commissioning teams were having an effect on how quickly this could be achieved.
- It is not clear if any action was taken by Care Home A's manager or SAT to ascertain if the agency who supplied the other care worker were also notified of the investigation and the outcome.

5.4. It is understood that, at the time of this incident, there were considerable pressures in allocating cases to enquiry managers within locality teams. This would undoubtedly have placed additional pressures for the triage enquiry manager in having to hold cases for longer than was envisaged when local policies were devised. It may be prudent to make allowances and contingent business plans for periods when the triage experience high volume or disruptions in being able to allocate work across other Council teams. As noted in section 3, there is local guidance available within the safeguarding policies to support effective responses which does allude to roles and responsibilities of relevant agencies. However, the presumption that only qualified social workers can perform the function of an enquiry manager may not be sustainable in the long-term, given the significant increase in safeguarding work over recent years and pressures felt in social care presently.

5.5. Since this time, the Council have invested in a new case recording system (Liquid Logic) and are currently working to introduce a MASH with co-located staff from across police, social care and health. It is expected that this will be operational in late 2023. Once operational, the MASH will take on the role of triage and overseeing complex safeguarding enquiries, including those where multiple organisations may be conducting separate strands of a 'caused enquiry'.

5.6. SSP have recently set up a 'caused enquiry' task and finish group to ascertain how SSP can support professionals from across the wider professional partner agencies and provider services network to carry out an enquiry in line with Care Act obligations and it is likely that that group will work to embed the learning from this review.

5.7. Professionals involved in the review also spoke of work underway to strengthen the interface between safeguarding enquiries and obligations to quality assure safe care in provider services. The Council has introduced a quality assurance team within their contracts and commissioning team. This is overseen by the Head of Safety and Assurance. The Council has also appointed a lead to develop a new quality assurance framework to ensure that commissioned care providers of Swindon are well led. For services commissioned through Swindon Borough Council, the framework will be designed to ensure people who use services can expect person centred care that is safe, effective, caring and responsive and that the voice of the person is at firmly at the centre of decision making. Professionals involved in the review also spoke of a strong commitment from a body of private care providers who were working closely with the Council to ensure policy and practice was fit for purpose and affirmed that providers were really invested in raising the bar for everyone.

5.8. Whilst the care home manager was able to confirm they received external training on the competencies needed to complete safeguarding ‘caused enquiries’, staff from other sectors did not have access to this. All practitioners involved in the review felt training that reflected local policy and procedures would undoubtedly improve practice and enable a more consistent approach going forward.

5.9. Whilst not within the scope of this review, practitioners and senior managers took the opportunity to voice concerns that the current requirement to complete an online form (and the requirement to register to do so) may put off partners from raising concerns. Hospital staff spoke of difficulties international nurses had in operating the referral pathways and queried whether the lack of anonymity could also put off members of the public. They explained presently the format requires that this is completed directly onto text boxes and that the webpage times out very quickly. In practice this makes it extremely time consuming to complete an on-line referral with all available information. This unintentionally incentivises poor information sharing at the initial point of contact, which can only hamper good quality triage. They asked that, when the Adult MASH is developed, the on-line referral form mirrors practice used by the Children and Family MASH which has a downloadable form. Senior managers also asked if the new pathways could provide an automatic acknowledgment so that relevant partners and member of the public know their concerns have been received and are aware of how they follow up if they believe they should be involved (according to local policy) with a planning meeting or if they do not receive notification within the timescales set out in the policy.

System findings:

Decision making in this case within the Council’s SAT was not consistent with the local or national safeguarding policy objectives. Insufficient regard was given to Frankie’s need for an advocate and to ensure a coordinated approach to the enquiry. A distinction was made between the ‘caused enquiry’ regarding possible non-accidental injury and other possible explanations which would equally have required a safeguarding enquiry (namely neglect). The enquiry manager, their supervising officer and other professionals involved in the investigation appeared unclear on the interface between the s42 processes and obligations to ensure safe care is provided within commissioned provider care settings. There was also an artificial separation in this case between the initial concerns and a subsequent need to explore whether it would be safe for the hospital team to discharge Frankie to Care Home A when this could and should have formed part of his protection plan.

Recommendation 1: Swindon Borough Council provide assurance to SSP, perhaps by way of an audit of cases closed at the triage stage, to ascertain if decision making does correctly identify if the 3 criteria under s42(1) are met and that they also consider duties under the Human Rights Act 1998 and wider public interest. This would provide a further opportunity to evaluate the impact on the increased capacity within the MASH (including the benefits of co-locating police and health colleagues) and the effective use by SSP partner agencies of the decision support tool.

Recommendation 2: SSP should raise awareness of the on-line decision tool across provider and partner agencies so there is a consistent understanding of when a concern will meet the criteria for an enquiry and how that will be conducted.

Recommendation 3: SSP’s caused enquiry task and finish group should identify mechanisms or measures which could be reported via Liquid logic data capture to demonstrate improvements in triage and enquiry manager’s practice, most notably to demonstrate:

- key information is recorded to support timely decision making on whether an advocate is required
- triage staff record information from partners or the Council’s Quality Assurance team to ascertain if providers have the relevant expertise and training to complete ‘caused enquiries’

- the safeguarding adults person centred risk assessment (appendix 6) and 'Caused Enquiry form' (appendix 8) have been completed and received senior management oversight.
- Whether a safeguarding planning meeting has taken place within the indicative timescales detailed within the policy.

Where concerns are raised about professional care settings, is there evidence within the local authority's triage and safeguarding enquiry of early involvement with commissioners or regulators?

5.10. The SSP's local policy currently aligns with national policy in its approach to request third party providers undertake enquiries, where the abuse or neglect was alleged to have occurred within their registered setting. DHSC's Care and support guidance advises '*the nature and timing of the intervention and who is best placed to lead will be, in part, determined by the circumstances… It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service.*'[25]

5.11. SSP's local procedure explains the local authority can ask other organisations to '*take on the role of a caused enquirer. As a Caused Enquirer, the organisation / agency completes specific enquiries based on agreed Terms of Reference and then reports back to the allocated Enquiry Manager, who will review as needed. The Enquiry Manager will determine if further actions and enquiries are necessary under the enquiry procedures on receipt of the report. The specific tasks will be determined either at the triage stage by the Enquiry Manager in the Safeguarding Team's screening hub or at the point of the Safeguarding Adults Planning Meeting through discussions with the relevant agency*'. This confirms that '*Health and social care providers and other employers will be the appropriate body to undertake enquiries relating to internal care concerns and staff misconduct and poor practice issues in line with their Human Resource policy and allegation management processes.*[26] Appendix 7 of the policy includes a copy of the Caused Enquiry form that must be completed by the Adult Safeguarding Team, the Nominated Enquirer and subsequently signed off by those involved in the review. Whilst this expectation was not met by the enquiry manger in this case, it is also important to acknowledge the failings were not corrected when more senior managers within the SAT became involved.

5.12. Whilst in Frankie's experience the involvement of commissioners was delayed (such that they reviewed the case only after the period subject to this review), there was evidence that the care home manager notified CQC in a timely manner. It was not evident on the case records that the enquiry manager had sought to make direct contact with CQC despite prompts within local guidance to do so. However, during conversations with the reviewer police officers working within the safeguarding hub confirmed where there are allegations of possible neglect or abuse within commissioned provider settings, the Council's quality assurance team (responsible for monitoring care contract obligations are met by private care providers) are heavily involved in the daily safeguarding hub discussion, sharing information if there are any issues regarding the quality of care issues of any particular provider. Those discussions are minuted and recorded on the enquiry report, and they are also uploaded to the adult at risk's case files. Police do not routinely receive a copy of those minutes. They also confirmed that there is an expectation that the care provider will notify CQC and that this is usually done.

5.13. Senior commissioning managers also explained that they do expect to be notified if a concern was triaged and the care provider had a CQC rating of 'requires improvement' particularly in the category of well led. They explained upon such notification they would review their records and provide information to an enquiry manager very quickly. If necessary, they can conduct a visit to the care setting within 24 hours. They acknowledge that, during this review period, there were

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[25] Care and Support Guidance pg14.42-75

[26] See p38 of the policy, Part 3 procedures and appendix 7 of the multi agencies policy and procedures

several care home providers who were experiencing Covid outbreaks so this may have impacted on their ability to visit, but they could support an enquiry by conducting desktop reviews, for example of manual handling compliance training, as they had in this case by November 2022. Senior managers also expressed hope that the additional focus within the new CQC assurance framework on people's experiences should further enhance a person-centred approach when concerns are raised within provider settings.

5.14. Commissioners also confirmed they hold workshops to support care homes where the CQC rating for 'well led' requires improvement and that they work closely with those homes on specific improvement plans so that positive change can happen at pace. They reported they usually get good engagement from providers.

5.15. In Frankie's case the SICC staff should be commended for taking into consideration whether the home could safely meet his additional need when determining his hospital discharge plan. However, it appears there were no mechanisms for hospital-based staff to, independently from the enquiry manager, obtain the necessary assurance. The enquiry manager did not appear cognisant of their pivotal role to support onward safety planning.

5.16. Managers acknowledged the current system (ellipse) is very fragmented and expressed hope that the new case recording system (liquid logic) will assist triage and enquiry managers to navigate all relevant information on a person's case file more easily. This should also enable faster identification of relevant teams/ partner agencies to involve in decision making. They were also hopeful that the new MASH will improve practice as health, social care and police records will be much more accessible at the enquiry planning stage.

5.17. In addition to the changes proposed by Swindon Borough Council, practitioners involved in this review felt Frankie's experiences offered opportunities to improve the local policy framework further, perhaps through the development of a standard operations practice that would seek to clarify what support would be available for those undertaking 'caused enquiry' that reflects the new CQC framework and risk-based approach to their inspection obligations to ensure that there is clear coordination on evidence gathering so that quality of care and safeguarding issues inform the overall ratings.

5.18. SSP may wish to give consideration as to whether, once the MASH is fully functioning, professionals from disciplines other than social care could take a lead role as an enquiry manager. In addition, the decision support tool may benefit by adding clarity to enable any partner agency to take a lead or convene a safeguarding enquiry or protection planning meeting.

System findings:

Whilst there was some practice that was not consistent with the local policy, practitioners and senior managers were able to offer assurance that they understood the purpose for early engagement with commissioners and regulators. Although those involved in the review spoke of the value in connecting safeguarding enquiries with quality-of-care responsibilities, there was a lack of clarity within the Council's SAT that this would form part of the s42 enquiry. Whilst it was not a feature in this case, if left unaddressed within the policy this could result in too little consideration being given to indicators of organisational abuse or the interface with other risk management processes, such as the new CQC assessment process or provider concerns framework.

Recommendation 4: The Council and SSP, perhaps through their 'caused enquiry' task and finish group, should agree protocols for ensuring s42 enquiry data is available to inform commissioners and regulators undertaking their functions. Mechanisms (qualitative and quantitative data) should be agreed and reported to SSP so that practice is improved, and this can be demonstrated within any future CQC inspection.

Where there are concerns regarding non-accidental injury, are health and police colleagues involved in those enquiries in a timely way?

5.19. The National Analysis of SARs (published in 2020) identified several common areas for practice development necessary to achieve the safeguarding policy objectives of the Care Act. One such concern is that too often adults at risk involved in SARs were signposted to other agencies, with no follow up and insufficient checks to ensure those agencies could meet the needs/ risks identified. The initial triage concluded Frankie was at low risk, as his needs would be met at ED. This view was formed without consultation with the hospital's DSL or, it seems, taking into account the concerns voiced earlier by the Ambulance crew. The police were only notified of a possible non-accidental injury (which, if proven, would amount to grievous bodily harm) three weeks after the incident.

5.20. The ED DSL explained to this review that neither she or the ED Matron made a request for a police investigation when Frankie was first admitted as they did not have sufficient information regarding his mobility and were awaiting this medical evidence before determining if police should be notified.

5.21. In consultation with the reviewer, police colleagues explained that the threshold to commence a police investigation on 'reasonable suspicion' is not high. Usually, an investigation will start if officers, having considered the information available to them, feel on a scale of approximately 2 or 3 out of 10 that an offence may have been committed. Consideration of relevant information for Frankie's case would have been if this injury was likely to have been caused unavoidable due to his own frailty (accident), by deliberate intent (abuse) or due to unacceptable poor care (neglect). To weigh up those possible causes, it was crucial that police officers understood his level of mobility, the fragility of his bones etc. They explained that ultimately this is a professional judgement call but that there is a presumption that a police investigation would commence whenever there was an allegation of sexual assault or if a physical assault had been witnessed or if medical view suggested this was a deliberate non-accidental injury or wilful neglect.

5.22. Police colleagues noted that if injuries of this nature were identified on non-mobile infants these would be 'red flags' and usually result in very clear responses by hospital staff, police and social care. Hospital staff explained that, whilst there should be no difference in responses when injuries of this nature are reported to non-mobile adults who (due to cognitive impairments) are unable to protect themselves, they felt it was important to highlight that it should not be assumed that hospitals can provide a 'safe place' for an adult whilst an enquiry is undertaken. This would need to be determined on a case-by-case basis, preferably as part of an early safeguarding planning meeting and several factors will need to be taken into consideration, including:

- The adult's capacity to determine where they wish to reside or whether to accept further medical treatment. If an adult has capacity or it is not in the adult's best interest to remain in hospital, hospital staff will have no legal powers to compel an adult accept admission onto a ward or prevent them leaving the hospital until after the safeguarding enquiry is completed.

- The ongoing risk of further injury must be carefully weighed against the risks for an adult of an unplanned move to alternative placement or to remaining in hospital where the risk of cross contamination or significant de-conditioning is a factor.

5.23. Any new policy should not therefore assume an automatic hospital admission for adults where non accidental injury which may require forensic examination, as is the policy for under 18s.

5.24. The police were also keen to explain that any new policy must be clear that it is for the police to collect forensic evidence as this is what would be required under PACE. It is therefore essential that, where there is reasonable cause to suspect non-accidental injury, ill-treatment or wilful neglect, police must be involved much earlier than occurred in Frankie's case in the decision making regarding the form an enquiry should take.

Is the local safeguarding policy clear on procedures for responding to concerns regarding non-accidental injury in adults with care and support needs, what support will partners and care providers require to implement forensic assessments of injuries where significant or serious abuse is suspected?

5.25. In discussions with the reviewer practitioners and senior managers accepted verbal handovers of information from care home staff to ambulance, to ED staff and thereafter ward staff and safeguarding leads can exacerbate delay and opportunities for miscommunication. Whilst the new electronic patient records enable more timely and consistent information sharing between primary and secondary health providers, there are opportunities to adopt good practice used elsewhere to improve continuity of care and enable timely risk assessment whenever an adult at risk with cognitive or communication difficulties requires unplanned attendance at hospital or other health settings. Staff spoke about developing the social document 'This is me' used in many provider care settings to include key information regarding the person's level of mobility, frailty and specific care, dietary or communication needs[27] so that this information travels with the adult, particularly if it is not possible for care home staff to accompany a patient for non-planned admissions. This would enable hospital based staff providing care and undertaking safeguarding functions to be better informed.

5.26. In discussions with the reviewer, the care home manager explained her organisation does ensure their staff are trained and vetted, that she and her deputy manager knew the expectations to report the incident and followed these, notifying CQC, the Council via a safeguarding concern, the owner and thereafter conducting their investigation. The care home manager confirmed she had found the contact with the safeguarding team during this incident reassuring, but felt 'out of the loop' regarding Frankie's care whilst he was in hospital and still did not understand the rationale for their exclusion from ongoing protection planning. She highlighted that she had important information about how to communicate with Frankie and that this information should have been sought to improve his continuity of care, even if he ultimately did not wish to return to her home.

5.27. She was strongly of the view that guidance should be improved to support a more joined up approach to investigating possible non-accidental injuries. She had been left with the impression that professionals from social care or health had presumed she would not explore this with candour and that such a presumption was baseless, highlighting it was in her interests (and the interests of her staff and residents) to thoroughly explore likely causes and identify what had happened to prevent future harm to Frankie or any other resident. Unfortunately, she reported her experience in this case was not an isolated incident. She explained, due to the nature of her work and the needs of her residents she does notify the Council's safeguarding team whenever an incident occurs. She spoke of a recent example where they had raised a sexual safety issue between two residents but had not received an acknowledgment to that referral. After some time chasing, she explained they were left to feel this was often a 'tick box' rather than a genuine opportunity to better understand across the different organisations how an adult at risk could be safeguarded from future harm.

System Findings:

Currently there is limited guidance available (either locally or nationally) to support effective implementation of the wider safeguarding responsibilities for professionals (including within health and criminal justice roles, providers, commissioners and regulators), to move from an existing model which required staff to 'recognise and report' concerns, to one that encompassed the different roles and responsibilities which require coordination of tasks when concerns are raised about a suspected non-accidental injury (abuse).

[27] This would mirror the health passports used to support effective health care to adults with learning disabilities commonly used throughout the UK.

Recommendation 5: SSP should work with the police, ambulance, ICB and hospital safeguarding leads to agree clear guidance for emergency responders on what information police and specialist forensic examiners will need to assess if an injury is non-accidental. Particular importance should be given to ensuring that whenever an adult at risk who has communication difficulties (including due to cognitive decline) attends hospital unplanned that they travel with sufficient information (within comprehensive 'this is me' document) to assist clinicians to understand their level of frailty, what special measures are in place within the adult's care plan to reduce risk of injury, their level of cognition and any mobility issues, i.e. if they are able to assist with transfers or are wholly non mobile. The 'This is me' document should also include contact details for key persons of relevance to the person (family support, care manager etc.) so that information can be quickly obtained in the ED setting.

Recommendation 6: SSP may also wish to develop a pro-forma to support forensic examinations of an adult victim of suspect assault or non-accidental injury.[28]

Is the quality of 'caused enquiries' robust?

5.28. The quality of the 'caused enquiry' undertaken by the manager of Care Home A was robust. As detailed above, better communication between the care home, hospital staff and enquiry manager would very likely have resulted in a more holistic understanding of the likely cause of the injury at an earlier opportunity. The care home manager, in conversation with the reviewer, was able to verify her level of training and previous experience in undertaking such enquiries. However, practitioners from across different disciplines explained that, whilst they were likely to have received training on investigations in respect of their usual work, most were unaware of specific training available to assist them to gain confidence to undertake 'caused enquires' relating to safeguarding adults. Managers accepted it would usually be the responsibility for each partner organisation to ensure staff were competent to undertake duties outlined within the SSP policy, but felt it may prove more cost effective for the SSP to explore multi-agency training opportunities for third party organisations undertaking the 'caused enquirer' role, as this would also ensure any programme was delivered to a standard that SSP expect, taking into account local processes and lessons from local reviews.

5.29. Practitioners wished to highlight that Frankie's experiences presents an opportunity to have open, honest conversations with all stakeholders to support effective, safe care. They spoke of the benefits felt across the whole system following pro-active work done during the Covid lockdowns to support providers and acute hospital staff respond to care home residents and prevent harm.

5.30. Commissioners involved in this review recognised that, for some homes (particularly those with a large number or residents or who cater for higher needs), managers may be conducting a high volume of 'caused enquiries' at any one time and that, given their other responsibilities, a system approach needs to take into account the information those managers will need (for example when a care home should involve police and the level of their involvement, how to obtain expert opinion on the likely nature of the injury etc.) to conduct their enquiries efficiently and effectively. All involved in this case spoke of the need for early planning or strategy meetings, a clear timeline for actions and routes to feedback to all parties conducting different aspects of a 'caused enquiry'. This would enable all those involved to monitor drift and prevent overloading the Council's frontline social work teams. They highlighted the opportunities to build peer support between providers so that owners and senior managers could draw on expertise across the sector to ensure enquiries were robust and objective.

5.31. There are also opportunities to make use of existing forums to reiterate safeguarding principles of accountability, but also of proportionality, prevention and protection. Providers also spoke of

[28] By way of an example, SSP may wish to review the work of the faculty of forensic and legal medicine. https://fflm.ac.uk/wp-content/uploads/2022/05/FFLM-Pro-forma-Forensic-Examination-Adult-Victim-of-Suspected-Assault-Non-Accidental-Injury.pdf

the value for managers and care staff of engaging with the Council's provider meetings. They recommended better use of that forum to seek to resolve the current communication issues between the Council's safeguarding hub (soon to be MASH), the Quality assurance team and provider services. In particular, this forum could provide cross sector learning from Frankie's experiences and support the implementation of recommendations arising from this review, including any new guidance on expectations for investigations into non-accidental injuries. Managers suggested monitoring who attends the provider forum could act as an indicator of a 'well led' providers. They spoke of how locally they see how valuable peer support across the sector has become during and since Covid. Providers are reportedly working together by naturally forming peer group support groups. The Council's quality assurance team also hosts monthly meetings to provide context and learning from safeguarding concerns data, notifications, site visits from the social work review team. They hope to also use intelligence re unplanned hospital admissions, GPs and other health professionals who visit residents to further enhance the individual risk assessment for each home. That individual risk assessment for each provider would then enable the MASH/ triage or enquiry manager to confirm if someone has sufficient competency to undertake 'caused enquiries'.

System finding:

The local policy provides clear guidance and robust procedures, but further work is required to embed standardised practice to ensure those undertaking and overseeing 'caused enquiries' receive relevant information to complete the task. SSP's caused enquiry task and finish group may wish to explore whether the caused enquirer has received feedback following completion of their investigation.

Recommendation 7: The Council to advise SSP if a mechanism within the Liquid Logic for reporting at system level if feedback has been provided to the third party on the quality of their enquiry. This will assist the quality assurance team or SSP to quickly identify where there is training need.

Recommendation 8: SSP should utilise the provider forum to regularly update and disseminate key learning from audit and case review activity to this sector. It would provide a cost effective (particularly now these can be held virtually) platform to upskill the sector and set clear expectations. It should also be used to hear from the sector key issues or any changes in the nature of safeguarding concerns they are experiencing.

Recommendation 9: The local policy should include a presumption that third parties can be expected to undertake caused enquiries, but that the presumption is rebuttable if there is insufficient evidence they have the required expertise or training to complete this to an adequate standard.

Recommendation 10: SSP's caused enquiry task and finish group explore the training needs of third parties undertaking caused enquiries and provide an options paper to the Partnership to consider how best to disseminate local policy expectations and achieve consistency of practice.

How effective were the interventions by the assistant manager and ICB in resolving the disagreement in a timely way? What support is available now, or might be needed, to ensure staff recognise the importance of critical challenge and maintain a culture of open, continuous learning re safeguarding practice.

5.32. There is evidence within Frankie's case records of respectful, critical challenge between professionals that was person centred. There is also evidence of escalation to more senior managers within SBC's safeguarding team and the ICB lead. However, there were clear tensions between the views of the Council's SAT, the provider and staff within the hospital and advocate regarding Frankie's ongoing protection planning.

5.33. Practitioners and senior managers involved in this review felt that the use of the SSP's escalation policy was effective in this case as it assisted in progressing substantive actions

within the enquiry. However, they commented too on the importance of relational practice and how intonation within written communications do not always convey the complexities of issues.

5.34. It is less clear whether, when seeking to avoid or resolve professional conflict, the enquiry manager responsible for oversight of the strands of investigation and Frankie's protection plan had a full understanding of the nature of tasks or relevant roles and responsibilities. There is also little evidence that practitioners involved in the case referred to SSP's safeguarding adults local policy for direction. In discussions with the reviewer, staff from the hospital (and specifically SICC) spoke of their expertise in assessing complex health needs and the regard they had when planning discharges for the need to ensure continuity of care and prevent against future harm or, as far as it is possible, an escalation in the person's health needs. They felt, had they known the steps the care home manager had taken to ascertain how the injury had occurred and what plans were in place to prevent a re-occurrence, they would have been able to come to an informed view far sooner.

5.35. Whilst outside the scope of this review, his advocate raised concerns to practitioners and senior managers that Frankie was given very little real choice regarding alternative options. This was largely due to availability within the market. She was, however, reassured that all those present during discussions understood that it is crucial for new placements to understand how the person's needs may have changed, know important information (his interests, preferences). She endorsed the proposal to develop 'this is me' documents to travel between placements and hospitals but also reiterated the need to ensure that important procedural follow up assessments or reviews are completed where there has been an unplanned transfer of care to ensure the adult has settled well and their needs are being safety met in a person-centred manner.

System finding:

There was evidence within this case that the escalation process worked well and all those involved in the review felt confident that this was an effective way to overcome barriers to joint working. However, at present there isn't a formal report received by SSP on the number of times the escalation process is used, in what circumstances and what outcomes this achieves. Understanding this might assist the SSP to evaluate the efficacy of local policies or specific training needs.

Recommendation 11: SSP agree a mechanism to receive reports from partner agencies on the frequency of use of the escalation process and outcomes.

6. Glossary

GWH ED	Emergency Department of Great Western Hospital
ICS	Integrated Care System
IMCA	Independent Mental Capacity Advocate
NICE	National Institute for Health and Care Excellence
MASH	Multi-Agency Adult Safeguarding Hub
PPN	Police Protection Notice
SAIT	Safeguarding Adults Investigation Team, Wiltshire police
SAR	Safeguarding Adult Review
SAT	Safeguarding Adults Team, Swindon Council
SICC	Swindon Immediate Care Centre
SL	Safeguarding Lead
SSP	Swindon Safeguarding Partnership
SWAS	South Western Ambulance Service