Swindon Safeguarding Partnership

Safeguarding Circle

Executive Summary

Safeguarding Adults Review: Frankie

Caused enquiry into possible non-accidental injury

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] A thorough investigation 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

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'.

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.

The scope, methodology and themes under 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.

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?

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

[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*.'

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. 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.

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?

3.1. 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. The crew also 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.

3.2. 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.

3.3. 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.

3.4. 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. 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.

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.

3.5. 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'.

3.6. 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.

3.7. 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.

3.8. 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.

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 managers 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?

3.9. 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.*'[4]

3.10. SSP's local procedure explains the local authority can ask other organisations to '*take on the role of a caused enquirer' and* 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.*[5] 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. This expectation was not met by the enquiry manger in this case, nor were failings corrected when more senior managers within the SAT became involved.

3.11. 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. 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 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. They also confirmed that there is an expectation that the care provider will notify CQC and that this is usually done.

3.12. 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. Thereafter they review their records and provide information to an enquiry manager very quickly. They can conduct a visit to the care setting within 24 hours. During this review period, there were 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.

3.13. 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.

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

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

3.14. 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. Managers expressed hope that the new case recording system (liquid logic) will 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.

3.15. 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, 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.

3.16. 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?

3.17. 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 reference to 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.

3.18. In consultation with the reviewer, police colleagues explained that the threshold to commence a police investigation on 'reasonable suspicion' is not high. 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.

3.19. 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.

3.20. 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.

3.21. 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?

3.22. 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. 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[6] 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.

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

3.23. The care home manager confirmed she 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. She was strongly of the view that guidance should be improved to support a more joined up approach to investigating possible non-accidental injuries.

System Findings:

Currently there is limited guidance available (either locally or nationally) to support effective implementation of the wider safeguarding responsibilities for professionals to move to an approach that encompassed the different roles and responsibilities which require coordination of tasks when concerns are raised about a suspected non-accidental injury (abuse).

Recommendation 5: SSP should work with the police, ambulance, ICB and hospital designated 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.[7]

Is the quality of 'caused enquiries' robust?

3.24. The quality of the 'caused enquiry' undertaken by the manager of Care Home A was robust. 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 verified 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. 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.

3.25. Practitioners wished to highlight that Frankie's experiences presents an opportunity to have open, honest conversations with all stakeholders to support effective, safe care. In 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 so a system approach

[7] 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

needs to consider the information[8] those managers will need. All 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 prevent drift and 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.

3.26. Providers also spoke of the value of the Council's provider meetings and 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.

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.

3.27. 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. 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

[8] 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.

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.

3.28. Frankie's advocate also 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.