EAST RIDING OF YORKSHIRE COUNCIL

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RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

FOLLOWING THE INQUEST TOUCHING THE DEATH OF JANET BROWN TOWNEND

PROVIDED BY HANNAH FEENEY – HEAD OF SERVICE, SAFEGUARDING AND QUALITY ASSURANCE, ADULT SOCIAL CARE AND HEALTH, EAST RIDING OF YORKSHIRE COUNCIL

Matters of concern	Response
There was a referral to Adults Safeguarding from both Yorkshire Ambulance Service and Hull Royal Infirmary regarding concerns as to the care Ms Townend had received. As a result of the referrals there was a review that was deemed necessary. However, the quality of that review was lacking.	It is usual practice that the local authority may receive multiple safeguarding concerns about the same person and in relation to the same circumstances. It is good practice that both Yorkshire Ambulance Service and Hull University Teaching Hospital Trust recognised the potential signs of abuse and neglect and acted in line with local East Riding Safeguarding Adults Board Multi-agency Safeguarding Procedures. Both safeguarding concerns received were triaged by East Riding Adult Social Care and Health Safeguarding Adults Team and progressed under section 42 of The Care Act 2014 on the grounds that there was reasonable cause to suspect that Janet Brown Townend: (a) had needs for care and support (b) was experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs was unable to protect herself against the abuse or neglect or the risk of it The safeguarding adults enquiry process seeks to understand the likelihood of whether abuse or neglect occurred and takes appropriate action based on the findings. A response as to the quality of the section 42 work undertaken will be provided below.
The Safeguarding Adult Review that took place did not probe the responses received appropriately from the care company and the Community Nurses in any way.	The Safeguarding Adult Review referred to here is a Section 42 enquiry that was undertaken by a qualified and registered social worker from East Riding Adult Social Care and Health.

[redacted]
Interim Executive Director of Adult Social Care and Health (DASS)

In evidence it was heard that the procedure adopted did not record how the responses had been obtained. The family's input was not recorded. The process happened hastily and the review not to the appropriate standards that would have been of any benefit. In evidence it was heard that there was a lack of professional curiosity and the full review process not followed or documented properly.	When a safeguarding adult concern is received by the local authority and is related to potential neglect by the professionals caring for the person, the social worker would make enquiries with the services subject to the allegations made as happened in this case. A social worker undertaking a S42 enquiry may seek the information they require through a range of different methods and in a way that they believe is proportionate to key lines of enquiry. This can range from gathering information by email or over the telephone to attending a service or a property to speak to a person directly or view records. They must also strike the balance between responding in a timely way and taking enough time to review all the information available to them. As the professional accountable for the enquiry and any recommendations or actions required in response to their analysis of the information received, the social worker will use the method they believe gives them what they need to complete the enquiry. It is good practice that a social worker will make their methodology clear in the S42 report and that they will present their rationale for the approach they take and how this has assisted them to achieve the outcome they reach. The local authority accepts that this did not fully happen in this case. The record of the enquiry also lacked analysis of the information that was received from both services approached for information and it was not fully triangulated with other information gathered from both Janet Brown Townend herself and members of her family within the record of the section 42 enquiry. It is difficult to say whether the outcome of the enquiry would have been different had these issues been addressed, however, it is acknowledged that the recorded evidence for decision making and subsequent actions in this case could have been improved. The practice issues identified in this enquiry have been addressed with the individual practitioner and lessons learned disseminated within the team. The adult safeguarding service has also been under a programme of transformation and continuous improvement since early 2023 that has resulted in changes that support good practice in this area. At the time of this enquiry taking place, ERYC ASCH had undertaken a full review and remodel of the safeguarding adults

	service with the aim of ensuring that the processes, paperwork and practice achieves the best possible outcomes for all people subject to intervention under section 42 of the care act 2014. In November 2023 (after this enquiry took place), as part of the implementation of a new service and practice model for safeguarding adults, the service launched a new set of forms to record safeguarding adult concerns and section 42 enquiries. These forms lead the practitioner through a much more succinct process for undertaking and recording their intervention with the voice of the person and their family/representative at the heart of the enquiry record. The roll out of the forms was accompanied by training and learning for those who are completing them, refreshing practitioners understanding about the expectations for their completion, what good looks like and encouraging professional curiosity. There is also accompanying guidance for practitioners within and external to the form to support them to undertake and record a thorough section 42 enquiry.
The outcomes of the review and recommendations were not provided to the subjects of the review.	It is good practice that at the end of a section 42 enquiry, the outcome and recommendations are shared with all parties subject to the review. The local authority accepts that in this case, this did not happen as expected. This has been addressed with the individual practitioner and lessons learned have been disseminated with the team. Since this section 42 enquiry was concluded, as described above, the service has implemented new paperwork that supports the worker to ensure that they share the outcome and recommendations with relevant parties. The form requires the worker to state who they have consulted as part of the enquiry and who they have shared the outcomes and recommendations with. As well as taking steps to ensure this important process is followed by practitioners, embedding this in the forms gives the service the opportunity to monitor and audit practice and raise quality in relation to this expectation.
The importance of Safeguarding reviews must not be underestimated. They are in place to	Since this section 42 enquiry was undertaken, East Riding of Yorkshire Council have implemented a new service model for

identify concerns and prevent any such issues occurring in the future. The procedure conducted needs to be looked at to avoid any impact on anyone else.	Safeguarding Adults inclusive of the new paperwork mentioned above. The new service model sees a dedicated safeguarding adults hub focussing on managing incoming concerns and mitigating the immediate risks to people, enabling robust decision making around actions to be taken under Section 42 of the care act. Where a case is progressed to a section 42 enquiry, the work is allocated to the most appropriate practitioner, usually within a locality based assessment team or the review team who are likely to have an established relationship with the person and those providing care, enabling a more person centred approach and alignment with other social care processes such as annual review and contract monitoring and compliance with providers. To support high quality safeguarding adults enquiry practice, the services practice development team has implemented a training programme of practice workshops accompanied by a weekly practice forum with the safeguarding adults hub where cases can be discussed and practitioners can receive guidance from the safeguarding adults leadership team. The service also leads a safeguarding champions programme bringing professionals from within and external to the local authority together to share good practice and develop consistent responses to safeguarding across the sector. The service has also launched a safeguarding audit to enable us to measure quality and identify themes and trends for improving and developing safeguarding adults practice further. This is overseen by the principal social worker and presented as part of the quarterly audit report to the practice development board where recommendations can be made to the Executive Director and their leadership team and to ensure collective oversight of actions taken and any required mitigations.

Further actions to be taken:
Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs) under section 44 of The Care Act 2014. Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work across the system partnership, in order to highlight good practice, learn lessons, continually improve, and pertinently protect adults from harm. As a partner of the East Riding Safeguarding Adults Board the Council will make an application to the Board

for a Safeguarding Adults Review to be considered for Janet Brown Townend.

All applications are considered by a multi-disciplinary team of senior leaders from across various agencies such as Humberside Police, Integrated Care Board, Humber Teaching Foundation Trust (mental health) City Health Care Partnership and the Council.

The meeting is called the Safeguarding Adults Review Group (SARG) and in order to ensure equity to each case the group follow a decision-making framework which also ensures proportionality.

The Pretention of Future Deaths report will be included in the application which will be considered by all parties and recorded in the official Minutes of the meeting.

Following the decision being made it is common practice for the Boards Independent Chair to write to the family members and alert them to the outcome and advise them of next steps, whilst offering assurance and being sensitive to the complexities of the case. If the family do not wish to participate that is their right, but the Board will continue with the piece of work in an anonymised manner without participation from the family to ensure lessons learnt and continuous improvement.

If the SARG agree to progress a SAR an Independent Reviewer (IR) will be commissioned who will lead the review, following this the IR will host a formal feedback and recommendations session with all agencies involved. All agencies will then be required to evidence the actions they have taken to improve practice and mechanisms implemented to safeguard against future concerns reoccurring, activity is overseen by the Boards Actions and Assurance sub-group, where overall feedback is then given the Independent Board Chair within a full Board meeting, along with the Annual Assurance Conversation, which is also reported to the Councils Cabinet Members.

Any specific recommendations for the Adult Social Care & Health Directorate in the Council will be escalated to the Practice Development Board where the Principal Social Worker and Executive Director and their leadership team will have collective oversight of actions taken and ongoing mitigations.