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Establishing the Evidence Base for a Pilot Project Developing a Forensic Service in Safeguarding Adults

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Executive Summary

This report details the findings of an evaluation of a Pilot Forensic Service to support safeguarding adults, which is operational in the East Riding of Yorkshire and North Lincolnshire, and funded by the Clinical Commissioning Groups for East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire and Hull.

The aims of the Forensic Pilot were to:

Provide an examination service for adults at risk of harm who may have suffered a non-accidental injury (NAI) as a result of physical abuse or neglect.

Such examinations are for the purpose of documenting and interpreting injuries, and contribute to inquiries conducted under Section 42 of the Care Act and any consequent safeguarding plans. They are conducted by trained Forensic Medical Examiners (FMEs) who are drawn from clinical, patient facing roles.

The project scoping exercise commenced during 2020/2021 and the pilot became operational in May 2022. The service was delivered by the Forensic Lead, who is a Named GP for Safeguarding Adults within the two geographic areas served by the Pilot. It was supported by a multi-agency steering group, with representation from health, the local authorities, and the police.

The delivery of the pilot

The Pilot has worked to fill practice, policy and training gaps in respect of forensic examinations in adult safeguarding and has developed resources which can be drawn upon to support similar projects elsewhere.

The Pilot has developed an inter-agency policy, which determines the process to be followed when NAI is suspected.

Training for FMEs has been developed by the Forensic Lead in partnership with the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM), filling an identified training gap for forensic examination in adult safeguarding. Training has also been delivered to social workers in the Safeguarding Adults Teams to support them to recognise NAI and ensure that referrals to the Forensic Service are appropriate and within the scope of the service.

From its inception in May 2022 to March 2023, 55 individuals have been referred to the Pilot. The majority of those referred were older people who were identified as frail, were people living with dementia, or both. A substantial majority lacked capacity to consent to their referral. Almost three quarters lived in care homes.

Two approaches to accessing forensic information were employed 1) physical examination of individuals' injuries 2) the examination of photographic evidence. Both have provided evidence which has informed adult safeguarding practice.

Evaluation findings

The Forensic Pilot was found to be valued by social workers and managers from the Safeguarding Adults Teams in both local authorities, and to have contributed to safeguarding practice and decision making.

Social workers valued having access to a knowledgeable expert practitioner who could interpret forensic information; this complemented their own professional knowledge and expertise. They reported that this information enhanced their safeguarding decision making and confidence. Forensic information helped to identify how injuries were likely to have been sustained and whether they were accidental or non-accidental. This information helped guide decisions about the actions required to protect individuals from further harm. Where injuries were identified as occurring non-accidentally actions taken included recommending staff training, updating care plans; suspension of care staff; change of residence, Where injuries appeared to have been sustained accidentally, more nuanced care plans could be developed to reduce the risk of ongoing harm and further injury.

A social worker summarised the ways in which the pilot supported their practice:

It definitely helps us to look at the wider picture….look at things more in-depth….. It helps our learning and what we need to be looking for, what we need to be doing, what we should be looking at, it helps us to….decide where we're going to take that concern….it also provides information on the enquiry reports, so we can then make the decision to share that with providers and say this is what we've found, this is why we're going to be taking this forward and this is the professional medical opinion that we've sought to support that decision….it definitely helps how, why and where we're going to take our decision making for the next stage or whether we're quite satisfied that we can close it there and be assured that we know that people are safe.

In an area of practice that is recognised as complex and challenging, and in which high (and increasing) numbers of referrals are made to Safeguarding Adults Teams, support to identify with confidence those which require further inquiry and action is an important resource.

Interagency relationships have been identified as an important element of adult safeguarding practice. The relationships between the Forensic Lead and the safeguarding social workers were positive and appeared to be based on trust and appreciation of the skills and knowledge each bring to safeguarding. There also appeared to be positive relationships with health colleagues. The relationship with the police appeared more fragile and there appeared to be an absence of a police 'champion' and single point of contact to support this work.

To date examinations have been conducted by the Forensic Lead; this is identified as unsustainable over the long-term. There is a need to expand the number of FMEs and to explore the optimal number required, to ensure that there are sufficient to cover the service (and respond quickly when referrals are made), while also ensuring they have the opportunity to conduct sufficient examinations and to maintain their forensic skills. The examiner role was found to be emotionally demanding, due to the exposure to sometimes distressing injuries and circumstances. Therefore, support for those undertaking the role is important, and as further FMEs are recruited it will be important to confirm that the support in place, and the training delivered, continue to meet their needs.

The evaluation highlights the dedication and commitment of those who worked to establish and deliver this new service, and who have worked to demonstrate the feasibility of implementing a forensic service for adult safeguarding. This new service was found to have supported safeguarding decision making and activity in the early months of its operation; suggestions for further research are provided, to strengthen the evidence base over time for the delivery of forensic support for adult safeguarding.

Acknowledgements

We would like to thank all those who contributed to the evaluation and shared their experiences and perceptions.

Introduction and background

The abuse and neglect of adults with care and support needs is well-documented. Experiences of abuse may have significant and enduring impacts (Rowsell et al., 2013) highlighting the importance of approaches to prevent abuse or respond effectively when abuse occurs. However, adult safeguarding is characterised by challenges and complexity, and is underpinned by *contested accounts, vague or retracted disclosures, deception and inconclusive evidence* (Thacker et al., 2019), challenging identification and responses to abuse and neglect. Further, the volume of adult safeguarding referrals made to local authorities is significant, and is rising (NHS Digital, 2022), highlighting the importance of assisting practitioners to identify with confidence those that require further attention, and those which do not need to progress to further investigation.

Physical injuries are important signifiers of physical abuse and neglect; yet injuries may arise both by accident and non-accidentally, meaning that signs of abuse and neglect may be ambiguous and the causes of injuries unclear. However, there is emerging knowledge which can assist in identifying patterns of injuries associated with non-accidental injury (NAI) (Wiglesworth et al., 2009; Mohd Mydin et al., 2020; Van Houten et al., 2022) by trained and skilled practitioners.

Within health policy the importance of such approaches has been recognised. The need to equip health staff who have safeguarding responsibilities with forensic understanding has been mandated in the *Intercollegiate Document* (Royal College of Nursing, 2018), which outlines safeguarding roles and competencies for health practitioners. Within this report there is also recognition of the need for:

Access to appropriate high quality clinical and forensic advice on adult safeguarding from dedicated named/ designated professionals or equivalents (Royal College of Nursing, 2018, p27).

However, in reality there is currently little recourse to the skills of a trained forensic physician, in contrast to child protection in which Child Protection Medical Examinations (CPMEs) are available in cases of suspected maltreatment, for the purpose of examining and documenting injuries and determining potential causes (Garstang et al, 2021).

Background to the Forensic Pilot

The case of 'Adult A' in North Lincolnshire was instrumental in shaping recognition of the need for more robust forensic examination which led to the establishment of the Forensic Pilot. Adult A (Alton et al., in press), a man living with dementia, was admitted to hospital with extensive injuries and a safeguarding alert raised. He had significant bruising which was considered by medical staff to be inconsistent with the accounts given of a recent history of falls. No detailed forensic examination of his injuries appears to have been undertaken and no expert opinion sought, and consequently the case was not pursued by the police and the cause of his injuries was not established.

The Safeguarding Adults Review (SAR) undertaken following Adult A's death concluded that:

If this had been a child protection enquiry under Section 47 Children Act (1989), the indication of the allegation of non-accidental bruising would have been examined and resulted in a request for a child protection medical, the findings of which would be shared with the social worker and the police (Rees, 2022, p29):

Further, it observed that:

No such service is available for adults who present with unexplained bruising either nationally or locally. This means that doctors may well be concerned regarding patterns of bruising, but without a forensic medical training and/or background, would be unlikely be able to give the definitive forensic medical opinion that this case required and is a gap in the system to safeguard adults.

An awareness of these inequalities made a significant contribution to the drive locally to address this practice gap for adults at risk of abuse and harm.

The Pilot Forensic Service

The Pilot Forensic service was launched in May 2022. It is currently operational in the East Riding of Yorkshire and North Lincolnshire, with an expectation of delivery in Hull and North East Lincolnshire when the service is more fully established and resourced.

The aims of the pilot were to:

Provide an examination service for adults at risk of harm who may have suffered a non-accidental injury as a result of physical abuse or neglect.

The purpose of the service is to examine, document and interpret injuries, and to contribute to inquiries conducted under Section 42 of the Care Act and any consequent safeguarding plans. They are not intended to provide medical treatment.

Over and beyond the provision of forensic examinations the pilot seeks to demonstrate proof of concept for a forensic service; assess levels of need for such a service and the workforce requirements to meet this need; to develop policy and guidance to support similar projects nationally.

The pilot received funding of £10,000 from the four Clinical Commissioning Groups in the local area (East Riding of Yorkshire; Hull; North East Lincolnshire; North Lincolnshire).

The examinations are conducted by trained Forensic Medical Examiners (FMEs), who are drawn from clinical roles. Although FME training has been delivered to health practitioners, during the early pilot phase the examinations have been undertaken by Dr Elisabeth Alton, a General Practitioner and Named GP for Safeguarding Adults. Elisabeth Alton was instrumental in developing the pilot in response to her experience of contributing to the SAR for Adult A, and is the Forensic Lead for the Pilot; this activity is undertaken as an extension of her role as Named GP for Safeguarding Adults. A second trained FME works within Hull University Teaching Hospitals NHS Trust (HUTH); their role primarily involves providing advice and support to ward staff to enhance the quality of information and documentation of injuries provided on referral to the Safeguarding Adults Teams when NAI is suspected. This strengthens the quality of the evidence available to the Forensic Lead.

The Forensic Pilot is overseen by a multi-agency Steering Group, which holds monthly meetings. This includes membership from the participating local authorities; Safeguarding Adults Board Managers; Safeguarding Adults Team managers; Designated Nurses; Humberside Police. This inter-agency membership was intended to ensure a range of different skills and perspectives informed the work of the group and the Pilot. The Chair described the steering group as providing a forum for *open dialogue and critical friend conversations, challenge conversations [within] a structured format where everybody had a place round the table, everybody's voice would be heard.* The steering group supported the development of the Pilot and continues to provide oversight of its ongoing operation and provides a forum for confidential discussion of individual cases, identifying learning points and development needs.

Considerable work was undertaken prior to the launch of the pilot to fill policy and training gaps. This included work to scope support; develop policies; convene the steering group; develop and deliver training. Work was also required to promote trust in the proposed new service, as there was *an edge of nervousness…..about the project itself (Chair).* This included concerns about the available resources, the level of demand, how the pilot would fit into existing services, whether FMEs would have the skills and time to conduct the examinations.

Early work to develop the pilot was undertaken by the Chair and Forensic Lead, with support from colleagues across multiple agencies, including the steering group.

The Chair has undertaken the role of Senior Responsible Officer, described as being *that go-to person for the pilot (Chair),* and a strategic lead with local partners as well as with NHS England. This was an important role in respect of ensuring *conversations in the right forums to get senior buy-in from executive*

colleagues, ensuring discussion of the Pilot at Board meetings and promoting awareness and trust in the project and its governance.

The engagement of the two Safeguarding Adults Boards was identified as important from the outset, enabling ongoing discussions and updates to be provided, as well as ratification of the interagency policy. The Safeguarding Board managers were recognised as providing significant support for the pilot, and being *a key link* between the Safeguarding Adults Teams and the Forensic Lead.

The Forensic Lead has undertaken multiple roles in the early development of the pilot, including scoping support, convening meetings, supporting policy development, scoping, developing and delivering practitioner training.

The evaluation

The evaluation of the Forensic Pilot was commissioned by NHS England, and conducted by researchers in the Faculty of Health Sciences at the University of Hull.

Evaluation aims

The aims of the evaluation were to collect qualitative and quantitative data to address the following questions:

- How does the Forensic Service Pilot facilitate improvements to adult safeguarding policy and practice in respect of adults who have experienced NAI?
- What activity is undertaken by the Forensic Service and multi-agency partners?
- How does the Forensic Service assist safeguarding practitioners?
- How do Forensic Medical Examiners collect evidence on NAI?
- What works well within the pilot service, and what developments and improvements are needed?

Evaluation methodology

The following data collection activities were undertaken:

Data collection with the Steering Group

The researchers attended the monthly steering group meetings, for discussion of non-confidential items, to gain an in-depth understanding of the work of the Forensic Pilot, how it was developed and evolved from the initial inception, and the policies, procedures and training developed. They also conducted interviews with the Forensic Lead and the Steering Group Chair to explore these matters.

Analysis of data collected by the Forensic Lead

Anonymised data was collected from the Forensic Pilot in respect of the demographic characteristics and circumstances of those referred and the activity undertaken by the service.

Interviews with FMEs.

FMEs were invited to participate in interviews to explore how they conduct the forensic examinations. Interviews included questions about how they work to uphold the rights, dignity and needs of individuals before and during examination, as well as the training and supervision they receive and any further developments required. Interviews with the Forensic Lead, also explored these questions.

Interviews with Safeguarding Practitioners

Safeguarding practitioners responsible for safeguarding decision making and actions (safeguarding social workers and managers, and the police) were invited to participate in the evaluation. This data collection focused on how the Forensic Pilot supports them to analyse and understand individuals' injuries and the actions required; how information from the forensic service supports safeguarding decision making and responses; examples of safeguarding actions undertaken following forensic examination; any difficulties and barriers experienced.

Interviews were carried out online using MS Teams. Prior to interview all participants were provided with written information about the evaluation and asked to sign a consent form. All interviews were recorded; recordings were shared with a transcriber external to the University, with a confidentiality agreement in place. Transcripts were anonymised during or after transcription.

Participants were asked to give consent to the inclusion of anonymised quotes in reports and publications; all agreed to this. In the case of the Forensic Lead and Steering Group Chair, who were potentially identifiable, it was agreed that they would have sight of and the opportunity to agree to any quotes prior to their inclusion in the final report. Where quotes are included we have sought to

remove any identifying information; where individual cases are discussed we have substituted gender neutral terms to further protect individuals' identities.

Steering group members were informed by the researchers that they would make written notes (but no recordings) during the meetings; however, participants were assured that no quotes from steering group meetings would be included in reports.

Adults who have experienced NAI and their families and other supporters

The perspectives of those who have experienced a forensic examination and their families are of the utmost importance, in order to understand how the examination is experienced, how individuals are supported and their dignity upheld; their views about any outcomes or actions undertaken in response to the findings of the examination and safeguarding inquiry. However, this represents an ethically and emotionally sensitive piece of work, which requires time and careful navigation. Challenges were anticipated regarding the extent to which individuals would be able to participate in interviews (and the best ways of supporting their participation); the risks of causing further trauma or distress to people who had been abused; the risks to any emerging criminal investigations. Under these circumstances it was decided that the perspectives of these groups should be considered in future evaluations, with time and resources made available to ensure that appropriate and sensitive support can be provided, and with a clearer understanding of the issues and challenges informed by the current evaluation.

Data analysis

All qualitative data (interview transcripts and notes from steering group meetings) were analysed using Thematic Analysis (Braun and Clarke, 2006) to identify key themes within the data. Findings are presented with reference to the questions the evaluation set out to address.

Research ethics and governance

Research ethics approvals were provided by the University of Hull Faculty of Health Sciences Research Ethics Committee (June 2022).

Research Governance approvals were provided by both local authorities, (East Riding – August 2022; North Lincolnshire – November 2022), enabling the data collection to be undertaken with safeguarding social workers and managers within both local authorities.

Research participants

The following groups participated in the data collection, with interviews conducted from August 2022 – January 2023.

- The Forensic Lead was interviewed at three timepoints to provide data about the evolution and delivery of the Pilot, as well as their experience of conducting forensic examinations.
- The Chair of the Steering Group participated in a single interview.
- Six safeguarding social workers and managers participated from the East Riding of Yorkshire and North Lincolnshire.
- FMEs were invited to participate in the research whether or not they had undertaken examinations, allowing exploration of the training received and the reasons they were not involved in the examinations. One FME was interviewed for the evaluation.

The researchers contacted Humberside Police and initiated email contact with 8 officers, and had email or online discussions with 5 of these. Despite this, we were unable to identify anyone who had both knowledge of the Forensic Pilot and who was willing and able to participate in an interview. Consequently, we have been unable to include a police perspective in this evaluation.

Evaluation findings

The evaluation sought to address five key questions and the findings from the data are presented in respect of these.

Question One - How does the Forensic Pilot facilitate improvements to adult safeguarding policy and practice in respect of adults who have experienced NAI?

The evaluation explored the policy developments undertaken by the Pilot, as well as the training and other awareness raising activities delivered to develop and support safeguarding practice.

Policy developments

The Forensic Pilot is governed by an Interagency Policy ratified by the Safeguarding Adults Boards for the East Riding of Yorkshire and North Lincolnshire.

This policy outlines the processes to be followed where it appears that a forensic examination is required to support a S42 inquiry. In brief, the policy determines that the following steps will be undertaken:

Raising initial concerns. Where there are concerns that an adult with care and support needs has been abused or neglected a concern is raised with the Local Authority Adult Safeguarding Team in line with Care Act requirements and local policy. Concerns about potential NAI may be raised by referrers, or this may be recognised by the safeguarding social workers who triage incoming referrals and queries. It is at this point that a referral for a forensic examination is made by the Local Authority Safeguarding Adults Team.

Strategy meetings and discussions. Where there are concerns that an adult may have sustained a non-accidental injury, a strategy meeting will be convened. These are chaired by Senior Safeguarding Social Workers or a Team Leader, and are attended by multi-disciplinary colleagues. The strategy meetings explore the concern which has been raised; the immediate safety of the person and others; other concerns in respect of the individual and potential risks to others; whether an inquiry is required and who should lead this.

Although detailed in the policy, strategy meetings did not always take place. Social workers often consulted the Forensic Lead with concerns prior to the strategy meeting, and sometimes discussions took place in lieu of the full strategy meeting.

The examination. If, following the strategy meeting, a forensic medical examination is indicated it is expected that a social worker will attend alongside the FME. In most instances it is inappropriate to ask the person to move to another location for the examination, and therefore the FME and social worker will meet with the individual at home or in the place where they are receiving care. Consent is required for the examination; if the individual is assessed as lacking capacity to consent to the examination, Best Interests processes are followed, in line with the Mental Capacity Act 2005.

Subsequent to the examination a report is written by the FME which contributes to any S42 report.

A further strategy meeting may be convened following the examination.

Training to support professional practice

Training was developed and delivered to potential FMEs and to safeguarding social workers within the two participating local authorities.

Training for FMEs

Ensuring practitioners have the skills, competence and professional confidence to deliver forensic examinations was a pre-requisite to the introduction of this new service. However, despite the

stated requirement (see above) for health staff with safeguarding roles to have forensic understanding and the ability to access forensic advice (RCN, 2018), no courses could be identified within the UK to address forensic skills for adult safeguarding (Alton et al, in press). Therefore, an early task involved collaborative working between Elisabeth Alton and the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM) to develop training in forensic examination, as well as Elisabeth Alton undertaking forensic training herself.

Training for potential FMEs was delivered to practitioners across the region. An initial course consisting of 2 half day sessions was conducted in January/February 2021, and was funded by NHS England and NHS Improvement; this was followed by a second course in October/November 2021, funded by the CCGs for the Humber region. The training included:

- Outlining the need for a forensic service
- How to document injuries
- Report writing
- History taking with people who have cognitive impairments.

The training was delivered by Professor Margaret Stark from the FFLM, Elisabeth Alton, as well as a forensic psychiatrist; an old age psychiatrist; a representative from Humberside Police; a social worker. Preparatory reading and 'homework tasks' were set.

The training was open to practitioners with clinical backgrounds and patient facing roles such as doctors, nurses and Advanced Clinical Practitioners (ACPs), all of whom can potentially undertake the FME role; some places were also made available to social workers to extend their knowledge, although this professional group do not undertake examinations.

Feedback about the training received was provided by the FME who participated in the evaluation:

I was very satisfied with the training and I think [the FFLM's] input was really, really interesting and also they provided lots of examples that you could relate to, so photographic examples that obviously [the FFLM] was able to share and so that was really, really helpful because I'm very visual learner (FME1).

In addition to providing training and skills development, the need for support for those undertaking the FME role was recognised. A peer support network which meets quarterly has been established at the FFLM. This provides a forum for case discussion and shared learning. This was well received by the FME who participated in the evaluation:

It's helpful because we're able to discuss cases and then review and reflect on what happened, whether there's anything else that we didn't think about, whether there's anything that could be done differently (FME 1).

Additionally, the FFLM now have a dedicated space on their website for adult safeguarding, which signposts to useful resources.

Training and awareness raising for social workers

The Forensic Lead also provided training to the Safeguarding Adults Teams in the East Riding and North Lincolnshire. The aims of the training were to enable safeguarding social workers to recognise potential NAI and to ensure that referrals to the Forensic Service are appropriate and within the scope of the service.

A social worker confirmed that such training is:

Absolutely crucial, especially when we're picking up safeguarding concerns to triage, it's really important for us to have that training so that we can identify when something may be a non-accidental injury (SW4).

Social workers who had participated in the training identified that this had been 'useful' and 'helpful', and had enhanced their understanding and confidence, and influenced their practice.

It's certainly helped with my thought process and screening and triage….when we did the training and we listened to all the information from Dr Alton, that certainly is in my head whilst I'm triaging things ….. I think it just adds that other dimension to your decision making on triage because you can have those thoughts in your head and you're thinking well I wonder what had happened there….that professional curiosity (SW2).

Awareness raising for other groups

In addition to the training for FMEs and social workers, the Forensic Lead also met with Clinical Leads at the Primary Care Networks to develop knowledge and awareness among GPs of the service and how they should make a referral. Written information was produced for GPs, to ensure that they are aware of the new service, and understand how this can be accessed if they identify or are concerned about NAI.

Quarterly Forensic Lunch and Learn sessions for safeguarding practitioners have also been established to promote wider awareness of key issues and share forensic learning relevant to adult safeguarding among; these were advertised nationally via the NHS Futures platform. Information about the Forensic Pilot has also been incorporated into the safeguarding training delivered by Elisabeth Alton in primary care and for ANPs.

Furthermore, information about NAI and the need to consider a forensic referral has been distilled into summary formats for safeguarding practitioners through the production of 'Seven Minute Briefings' which are available on the Safeguarding Adults Boards' websites, and 'What If' cards, which have been developed primarily for social workers.

A patient information leaflet for people referred for an examination and their families/supporters has been written by the Forensic Lead with support from Healthwatch, in order to facilitate understanding of the purpose of the examination and what it entails. This includes the development of information in an 'easy read' format.

In summary, policy development and a raft of training and awareness initiatives have been undertaken to provide the foundations for the Pilot. These address policy and training gaps nationally, and can be drawn upon to support developments in other localities which wish to establish similar services.

Question Two - What activity is undertaken by the Forensic Service and multi-agency partners?

From its launch in May 2022 until March 2023, 55 people were referred to the pilot service. Their characteristics and circumstances are summarised in Table One below:

Table One – Characteristics of those referred to the Forensic Pilot

Age	Number	Percentage
18 – 19	1	1.8%
20 – 29	1	1.8%
30 – 39	2	3.6%
40 – 49	0	0%
50 - 59	4	7.3%
60 - 69	6	10.9%
70 - 79	7	12.7%
80 – 89	14	25.5%
90+	13	23.6%
Missing data	7	12.7%
Gender		
Male	17	30.9%
Female	37	67.3%
Missing data	1	1.8%
Ethnicity		
White British	36	65.5%
Other ethnic groups	0	0.0%
Missing data	19	34.5%
Local Authority Area		
East Riding of Yorkshire	35	63.6%
North Lincolnshire	18	32.7%
Missing data	2	3.6%
Descriptor		
Person living with dementia	5	9.1%
Frail older person	10	18.2%
Person living with dementia and frailty	20	36.4%
Person with a learning disability	8	14.5%
Person with enduring mental health problems	4	7.3%
Person with long-term neurological condition	2	3.6%
Neurodiverse	1	1.8%
Missing data	5	9.1%
Capacity to consent to safeguarding referral		
Yes	8	14.5%
No	38	69.1%
Missing data	9	16.4%
Type of residence/place of care		
Own home – lives alone	1	1.8%
Own home – lives with family	3	5.5%
Care home	41	74.5%
Supported living	5	9.1%
Hospital	2	3.6%
Missing data	3	5.5%

The data indicates that a substantial proportion (almost two thirds) of those referred were older people who were identified as 'frail', were living with dementia, or both. Over two thirds lacked capacity to consent to the safeguarding referral, highlighting the importance within the pilot of capacity assessments, best interests decision making and knowledge of the Mental Capacity Act.

More than 80% lived in staffed services. This highlights the risks experienced by those living in care homes and other staffed services, as well as the availability of support networks to raise concerns. In contrast, the very low proportion of referrals for people living in their own homes, suggests that this population may be at risk of abuse and neglect going undetected, and that they may be under-represented in the referrals to the service.

Referrals were made to the Pilot from the East Riding (63.6%) and North Lincolnshire (32.7%).

Data on activity conducted following a referral to the forensic service was provided, and is presented in Table Two:

Table Two - Activity following referral to the Pilot

Activity	Number	Percentage
Physical examination	11	20.0%
Examination of photos/records only	24	43.6%
No examination conducted	18	32.7%
Missing data	2	3.6%

In 20% of cases a visit was made to the person who had sustained the NAI and a physical examination undertaken. The time required for a physical examination ranged from approximately 30 to 180 minutes. This time includes assessing capacity; consulting others to make a best interests decision if required; conducting the examination; documenting injuries; discussing the findings with others. Time to prepare a report and travel time were also required, but not recorded; both could be substantial.

However, in the majority of cases, photos and other documentation such as body maps and referral notes were used to inform decision making and no physical examination was conducted. Reasons for the use of photos included:

- Photographs provided indicated injuries which were consistent with accounts given of how the injury was sustained, and no further examination was felt to be required.
- A delay in receiving the referral, meaning that injuries were no longer visible and a physical examination was no longer viable.
- Examination of photos was undertaken as part of a large inquiry. Such photos had been collected over time and represented evolving concerns; physical examination was not possible due to the time since the photos were taken.
- Photos or records indicated that the injury reported was due to factors such as pressure sores, which were directed to District Nursing.
- A colleague requested a professional opinion on whether the injuries documented were consistent with sexual abuse. This was agreed and referred to the Sexual Assault Referral Centre (SARC), as an examination of injuries due to sexual abuse is outside the scope of the service.

In one instance, although no examination of the individual's injuries was undertaken, a visit to their care home was made to examine the environment and whether the account given of how injuries were sustained was plausible.

In almost one third of cases no examination was conducted. Of these, six (11% of the overall sample) were attributed to a lack of FME capacity to carry out an examination, for example, due to illness or annual leave. In two cases the individual referred was assessed as having capacity to consent, and declined the examination. Perceived reasons included suspicions of family coercion and control, which were felt to have influenced the person's responses, and anxiety about *what might come out from the medical and what might be the repercussions (FME Lead).*

Other factors included an individual being transferred to a hospital out of area, making travel to conduct an examination unfeasible.

Question Three - How does the Forensic Service assist safeguarding practitioners?

The evaluation findings outline how the Forensic Pilot contributed knowledge and support to facilitate safeguarding decision-making and actions.

Facilitating safeguarding decision-making

Social workers' training and experience enables them to recognise situations which may be suspicious or worrying. They may become concerned based on their professional insights and practice wisdom, and through looking *at things with a curious eye (SW2).* However, they do not have the medical knowledge to fully understand and interpret individuals' injuries and potentially suspicious or conflicting accounts of how injuries have been sustained:

You sometimes do get an uneasy feeling, you're concerned about something and can't put your finger on it, is that because you don't have the medical knowledge and understanding or is it because there is actually something that there that does need to be worried about? So even just having the reassurance of somebody looking at it from that perspective and saying no, actually it's fine, even that's helpful (SW3).

Working in partnership with the Forensic Pilot encouraged social workers to *delve deeper and to request more information (SW4),* and provided access to an expert medical opinion and expertise which sits outside their own professional knowledge base and training. Recourse to an informed and knowledgeable practitioner appeared to enhance social worker confidence:

I'd have more confidence [than in the past] in knowing what to do with any cases that came up (SW1).

Access to forensic information and expertise helped social workers to better understand how injuries may have occurred and whether they were likely to have been sustained accidentally or non-accidentally. This helped guide their decisions about what steps should then be taken:

It definitely helps how, why and where we're going to take our decision making for the next stage or whether we're quite satisfied that we can close it there and be assured that we know that people are safe (SW4).

Forensic information also helped guide further questions and highlighted additional information required to help identify actions to protect individuals.

Overall, forensic examination appeared to be an important element of the 'jigsaw' of information which informs safeguarding decision making:

That formed part of the evidence that we've got this injury and we've got this other evidence as well, so it's kind of triangulating it all….it just helps support, that we've got this evidence (SW1).

Information from examinations was felt to facilitate *a sounder decision* and a process which *feels much more robust and much more safe (SW2),* and which offered reassurance to practitioners.

Informing safeguarding actions

During interviews we asked for information on any actions undertaken to protect people from further abuse or harm. Actions taken to protect individuals referred for an examination included recommending refresher training for care staff in respect of practices such as moving and handling; updating care plans or moving and handling plans; suspension of care staff; individuals moving to another residence. Such actions were anticipated to improve care quality and safety for individuals:

Her moving and handling care plan was changed,…. improved her quality of care. So she would have had much better care and obviously not been in pain because…it wouldn't have resulted in bruising (SW4).

In cases where it was concluded that injuries had been sustained accidentally, the forensic examination could help highlight potential causes of the injury. This could contribute to the development of more nuanced safety plans, in which the source of the injury was identified and addressed, and referrals to relevant practitioners could be made:

We can then maybe put some actions in place to make sure that….the risk is reduced or … we've put things in place like risk assessments or falls referrals….So even if we get back no, it's all fine we then know that we can then move to right, well this needs to be looked at through the care and support and resolve it in a different way than formal inquiry (SW2).

However, participants were not always aware of what actions had been undertaken to protect individuals following examination, and the Forensic Lead reported that they have not always received information about these. This is important to address, in order to contribute to learning from the Pilot. There were a number of barriers to the identification of actions and outcomes. The relatively short timescales for the evaluation meant that actions undertaken after the data collection was completed will not have been reported; a longer timeframe for the evaluation would have provided richer information. In some instances, the case did not progress (for example, if the person moved out of area or died). The way that safeguarding practice was organised was a further factor; social workers did not always hold individual cases throughout the safeguarding process and therefore could not track cases from the initial concern to safeguarding outcomes.

The perceived clarity and 'authority' of forensic information

Recourse to forensic information was perceived to support a firm evidence base for safeguarding decisions; *it provides clarity and provides evidence (SW6).*

It provided a basis for clearly explaining and justifying to care providers the reason for decisions and the evidence which supported this decision making. Participants also appeared to perceive that this evidence influenced other practitioners. For example, it was reported that the presentation of forensic information at a strategy meeting contributed to a decision that an immediate joint visit by the police and social workers should be undertaken. Others were also perceived to attend to medical opinion, which was felt to have *more weight (SW3*) when making referrals to other practitioners and to influence the process of decision making:

I know that the police listen to the medical professionals as well and you know, that can help with decision making (SW5).

Question Four - How do Forensic Medical Examiners collect evidence on NAI?

Data collected through interviews with the Forensic Lead and safeguarding social workers provided evidence about how examinations were conducted, and how individuals were supported during the examination.

The referral data provided by the Pilot indicates that a substantial majority of those referred to the service lacked capacity to consent to the referral. Therefore, prior to examination consent is

required, and capacity assessments are conducted. The Forensic Lead described how when providing individuals with information about the examination they *start off really gently* and that they *do a slow build with my capacity assessment, starting off really simple and then adding to it if I feel that somebody's understanding me*. In the event that the person is assessed as lacking capacity to consent to the examination, a best interests process is followed, usually involving discussion with families, carers, social workers and relevant others. To date no individual was identified to have had an advocate involved.

Examinations were conducted by the FME, with the support of a person who knew the individual well, usually a paid carer; in some instances other practitioners such as District Nurses also attended. The presence of someone who knows the person well is important, as the examiner is *going in cold, they're not my patients (Forensic Lead).* Carers therefore have important roles in facilitating communication, supporting the person, based on knowledge of their needs, as well as assisting them to move (if required) during the examination.

The approach taken during the examination reflected the need to respect people's dignity and emotional wellbeing while collecting the forensic information required. This approach included providing explanations and seeking ongoing permission for the examination. The Forensic Lead described:

Taking it slowly….just doing one little bit at a time, so you're not pulling somebody around too much….I'm very particular about keeping as much of the patient covered up as I can….not making them feel exposed or naked, and I would <u>always</u> ask regardless of the level of communication - I'm gonna look at your bottom or I'm gonna look at your back. Is it alright if I look at your breasts?....I would always talk about what I'm doing and why I'm doing it.

This approach was also observed by a social worker when accompanying the Forensic Lead:

We'd asked the carer what kept this person calm or what they enjoyed and it became obvious that they wanted to read their book, so we gave them a book…. so they had this book and they were talking to us about the book, what the characters were in it, so we were able to still communicate with them as well to keep them calm and to make sure they were involved and talking them through why and what she was doing, what she needed to look at (Social Worker 4).

The evaluation findings indicate that a careful approach to seeking consent and undertaking examinations was in place, and that a sensitive approach to the examination was taken, recognising the importance of ongoing consent and the potential sensitivity of the examination. The incorporation of the perspectives of those who have been examined and their supporters within future evaluations is anticipated to provide richer data about the conduct and experience of examinations.

Question Five - What works well within the pilot service, and what developments and improvements are needed?

The information identified above highlights that the Pilot successfully created policy and training to underpin the development and work of the service, and that the service provided supported social worker confidence, decision-making and activity. Within this section we consider further aspects of the service which appeared to work well and/or in which further developments were required.

Multi-agency relationships

Multi-agency working was considered an important element of the Pilot, which it was envisaged would work closely with social workers, health colleagues and the police.

Relationships between the Forensic Pilot, Safeguarding Social workers and Health Colleagues.

Working relationships between the Forensic Lead and the Safeguarding Adults Teams were reported to be positive and appeared to be mutually valued. These relationships appeared to be based on a sense of trust and dependability, and an appreciation of the strengths and skills that each bring to adult safeguarding:

We know who to contact, we know what the process is and we know that Elisabeth will do what she needs to do. She'll come to strategy meetings, she'll give a view on how it's happened and what needs to happen (SW5).

It's about knitting together their skills and my skills…..they're really good at looking at care plans, they are really good at looking manual handling, they're really good at looking at environment and….I understand…. how to examine somebody clinically, how to anatomically document injuries, how to think about what might have caused an injury (Forensic Lead).

Further the Forensic Lead highlighted the importance of professional relationships in which discussion and mutual challenge could occur:

I need to be able to challenge them just as much as they need to challenge me….I think that's really important that we have an equal relationship and we can discuss stuff and, and if necessary challenge each other professionally about the decisions we're making (Forensic Lead).

The approachability of the Forensic Lead was also highlighted, with participants noting their willingness to answer questions and explain things in ways which were easy to understand:

She's really approachable….she's really good with the staff and, you know…. there's no silly question that can be asked which is really good when you're trying to do an enquiry (SW5).

Positive working relationships with practitioners within HUTH were also reported. Staff such as learning disability nurses, Mental Capacity Leads and medical staff were all reported to have liaised with the Forensic Pilot to support work with patients and to provide information, and this was felt to represent good collaborative working.

Relationships with the Police

In contrast with the relationships above, those with the police appeared more fragile. Evaluation participants discussed two aspects of their work with the police – their engagement with the steering group, and their ability to contact them about individual cases.

A lack of consistent police attendance at steering group meetings was noted, with different representatives in attendance. This was perceived to reflect a high staff turnover within the police, which was viewed as a barrier to developing effective working relationships and an understanding of the role of the Pilot. The lack of a police champion who understands and engages with the pilot project, and who can raise awareness among their colleagues was highlighted. Without such a champion there was not a single and consistent point of contact and engagement within the police, and lost opportunities for inter-professional working and learning were highlighted.

In seeking to engage with the police to secure participation in the evaluation, a lack of knowledge of the Pilot was observed in which some of the officers invited to contact the researchers had no prior knowledge of the pilot, its aims, or how it functioned. This further underscores the lack of interface between the Forensic Pilot and the police, and the absence of a champion for this work.

The ability to seek the advice of the police was important when a possible crime had been committed. However, while some practitioners reported liaising routinely with the police, others, both in forensic and social work roles, noted difficulties in contacting the police for information and

advice, including uncertainty about who to contact, especially when they required urgent advice. This is in contrast to the accessibility highlighted previously as important. The difficulties of achieving criminal justice for individuals who have been abused was noted and was a source of concern.

There appears a need for further exploration with the police to identify the role of a forensic service in supporting their work and criminal justice for those who have been abused, as well as to explore police evidential requirements and whether the pilot can support these. As such discussions progress it will be important for any future evaluation to explore the police perspective and the extent to which the forensic project contributes to their own safeguarding decision making and responses. Should stronger inter-agency working between the police and the Forensic Service not be achieved, it will be important to explore the extent to which forensic services can support effective adult safeguarding without substantial police involvement, and any limitations to this.

Timeliness of referrals and safeguarding activity

Underpinning the work of the Pilot is the need for prompt actions to ensure that examinations are undertaken before injuries fade, and timeliness was identified as important.

Incoming information about concerns needs to be raised in a timely manner with the Safeguarding Adults Team, and with sufficient detail clearly presented. However, there were examples of delays occurring, minimising the value of the information which could be obtained from an examination:

There has been one recently….where I'd got a photo of the bruising but the photo…wasn't very clear but by the time we'd got given that the bruise had cleared up, so it just shows how important it is to respond really quickly (SW4).

Furthermore, information needs to be shared promptly with the Forensic Service and if an examination needs to be conducted, this needs to be arranged promptly (ideally within 24-48 hours of the referral). This requires social workers and FMEs to be able to contact one another easily, exchange information and arrange visits rapidly, often at short notice. Participating social workers identified that they were usually able to contact the Forensic Lead easily and received swift responses:

We get a fast response if we send emails saying this is what we're worried about, we get a nice timely response back, they're always very willing to come on visits if it's needed and accommodating (SW3).

Social workers reported that they could work flexibly and arrange their diaries to support visits. In contrast however, the Forensic Lead noted that the move to increased home working meant that it was not easy to phone the Adult Safeguarding Team and that they do not have phone numbers for individual social workers and instead often had to contact social workers by email. These difficulties did not always allow for timely information sharing and arranging visits.

Training and awareness raising with practitioners outside the Adult Safeguarding Teams to ensure that information is presented in a timely manner and is of sufficient quality to support effective safeguarding activity may be useful areas for future development. The need to ensure that incoming referrals to the Pilot contain all the information required and highlight the level of urgency of the case were also noted as an area for development. Finally, these findings emphasise the importance of the accessibility of safeguarding practitioners, with clear methods of contact, which enable the service to react to incoming referrals and queries.

Resourcing and staffing the service

While the Pilot had benefitted from the skills and commitment of supportive practitioners, the long-term staffing of the service is an area for development.

Although FME training was provided to practitioners, most did not progress to undertaking examinations. The limited participation from FMEs means that we have little information about why most did not progress from training to conducting examinations. However, interviews with other participants suggest two significant factors, capacity and confidence.

Capacity to undertake the FME role within existing workloads and responsibilities appears to have been a barrier to undertaking the FME role. Challenges were identified in supporting a service in which referrals are made at an unpredictable and potentially uneven pace, and in which both a timely response and time to conduct and document the examination are required.

Confidence to undertake the role was also perceived to be a barrier:

So for some people whilst they might have gone on the training sessions that were put on, not everybody comes away feeling comfortable to go ahead and do that….and we were clear that we weren't going to ask anybody to do anything that they didn't feel was within their skillset and competency because that wouldn't be right (Chair).

Further, interviews with the Forensic Lead highlighted the practical demands of the role. The workload can be onerous, and requires time to conduct the examinations, provide reports and engage in discussions with other practitioners; the demands of the role were such that they reported that they were *doing it either in my own time or squeezing it in onto….what can be a busy day job really,* highlighting the need to explore more sustainable ways of resourcing the service and supporting examiners. Emotional demands were also noted, in a role which exposes examiners to *some really horrible injuries (Forensic Lead)* and which places a weight of responsibility upon them:

There's the responsibility…that you may be making a decision that….could change that person's care….So there's that responsibility of getting it right. And, you know, that's something that I feel quite keenly (Forensic Lead).

Further, working with individuals who refused the examination was also emotionally challenging, as the examiner could want to do more to protect such individuals, while recognising that they were not consenting to this.

Therefore, as more FMEs are trained and begin to undertake examinations it will be important to consider their satisfaction with their training and the support in place, and whether there are any gaps and developments needed.

As a consequence of the difficulties in recruiting FMEs, the service to date has, in effect, been reliant on a single practitioner to deliver and document examinations. Participants were aware of the risks within such a model:

Not sustainable. No resilience within that, not sustainable at all but it's a good way to test the concept of it when there's anxiety in the system of something so brand new (Chair).

Further, the risks of burnout and professional isolation were highlighted, with the importance of access to peer support and clinical supervision noted.

Future staffing of the service

If the service is to develop further and be sustainable over the long-term, there is a need to explore staffing options and the optimal ways of resourcing the service. Participants highlighted the need for more people to undertake the FME role. However, the need for FMEs to undertake sufficient examinations to develop and maintain their professional skills and confidence was also emphasised:

It's a practical skill and you need to keep practising it to be good at it…. to keep your hand in really…. it's striking a balance because you don't want too many, because you need to be well practiced and you need to be confident (Forensic Lead).

Therefore, exploring options which ensure both that there are enough FMEs to cover the service, while also ensuring that they have sufficient opportunities to conduct examinations and maintain their skills is an important area for development. Joint visits by two FMEs were originally envisaged to build practitioner confidence when first conducting examinations. This has potential value, but it also evident that there may be challenges in ensuring the availability of multiple practitioners at short notice.

In addition to resourcing the examinations in a more sustainable way, the importance of staffing other roles was also noted.

During the development of the pilot, substantial work was undertaken by practitioners and managers alongside their existing roles. However, it was noted that resources to employ a Project Manager would have been valuable, and their role would have included assuming responsibility for mapping a project plan; identifying timescales and ensuring these were met; supporting project administration, potentially enabling the preparatory stage to be delivered more quickly:

It's keeping on top of it, chasing people…seeking out updates, it's those things that drift (Chair).

Further, the importance of administrative support both during the development and the operation of the service was identified. To date there has been some administrative support, accessed by the Chair from existing resources, and their own PA. This was valued, however, there is currently no dedicated administrative support for the Pilot. Potential administrative roles identified included logging incoming referrals and documenting outcomes. In the absence of such support the Forensic Lead undertook this work, adding to the time and workload already identified, and meaning that *I'm a very expensive piece of admin sometimes.* Further, it meant that they lacked support to problem solve some challenges, such as identifying effective ways to share documents safely and securely with local authority colleagues, meaning that at times this had been done in person rather than remotely, requiring additional time.

Concluding reflections

The evaluation has explored the work of a Pilot Forensic Service during the early months of operation. It highlighted the feasibility of delivering such a service, and found substantial support for the service among social workers and their managers.

The forensic knowledge available to social workers complemented their own professional knowledge base and expertise and contributed to their understanding of how injuries were likely to have occurred, the most appropriate actions to be taken, and contributed to safeguarding decision making and activity, both for individuals injured accidentally and non-accidentally. In a practice landscape in which abuse is difficult to identify with certainty, access to advice and information from forensic examiners gave social workers greater clarity, confidence in their decision making, and provided reassurance that the most appropriate responses had been made. Although there is a need for further work to identify outcomes for individuals, actions taken to protect individuals from further harm were reported. Adult safeguarding is recognised as a complex area of practice, in which social workers are anxious about the risks of being blamed, and in which levels of referral are rising (NHS Digital, 2022; O'Reardon, 2023); in this context, resources to support practitioners and their safeguarding decision making are valuable.

The pilot service appeared to have potential to contribute to professional curiosity which has been identified as playing an important role in safeguarding and risk assessment (Thacker et al, 2019; Phillips et al., 2022). There was evidence that the training delivered had supported social workers' professional curiosity when triaging incoming referrals, encouraging them to 'delve deeper', request further information, and question potential causes of harm. However, the literature has also identified barriers to professional curiosity. These include the risk of 'professional deference' in which there can be a tendency to defer to the opinion of a 'higher status' professional (Thacker et al., 2019, p257). Although not a substantial theme within our data, there was some indication of the 'authority' placed on forensic information and medical opinion, evidence of the clarity and confidence this afforded practitioners, as well as a sense that others listened to medical practitioners and took more seriously their views. The approachability of the Forensic Lead and their welcoming of professional challenge may help to reduce these risks; however, there is a need for care and caution when developing services which foreground medical opinion and to ensure positive inter-professional dynamics are maintained.

Overall, the evaluation suggests that forensic information can have a positive impact on safeguarding decision making and activity. However, this initiative took place within the context of a single geographic region and caution is required with respect to the extent to which these findings are likely to be transferrable to other settings and areas. This local initiative was dependent on the initiative, dedication and determination of practitioners who shared a collective commitment to the establishment of a forensic service to strengthen adult safeguarding. The development of the Pilot was achieved through the goodwill of those involved, who were willing to support the pilot from within their existing roles, as well as working additional hours to deliver the service. This commitment, energy and passion to develop and deliver this new innovation is commendable, and is a key evaluation finding. However, it also challenges our abilities to determine the likely successes and challenges for similar projects in other areas, especially if they are created as a 'top down' development rather than a grassroots initiative, and to determine the 'real world' costs of delivering a sustainable service. In this context, recommendations for future research are provided overleaf.

However, despite these questions and the need for further research, the findings suggest that the Pilot has, at this early stage, achieved its aim of delivering a forensic examination service, has worked to fill policy, training and practice gaps, and there are encouraging signs that these can support adult safeguarding practice.

Further research and evaluation

To further the evidence base for a forensic service to support and inform adult safeguarding, there are important areas to include within future evaluations. These include exploring the following:

The perspectives of FMEs.

Future research needs to incorporate the experiences and viewpoints of FMEs as further examiners are trained and begin to work in this role. Such research should include an exploration of their experiences of managing the workload demands of a reactive and unpredictable area of practice, alongside other professional commitments; the emotional impact of the role; the adequacy of the support available and any further support required; their satisfaction with their training, and any needs for additional or refresher training. Exploration of turnover in this role over time will also be a valuable area to explore.

The perspectives of those who have been abused and their supporters.

Consideration should be given to exploring individuals' experience of the examination; the information and support received before, during and after the examination; their views about the acceptability and helpfulness of any safeguarding actions and responses.

Safeguarding actions undertaken.

The safeguarding actions undertaken following a forensic examination require further exploration, with sufficient time for decision making and actions to have been taken, recognising that some outcomes (for example, criminal prosecution) may only be evident over the long-term. Longitudinal analysis of selected cases may assist in providing further information about the contribution of a forensic service to safeguarding decision making, actions and outcomes for those harmed. Such work would help overcome the difficulty identified in this evaluation that practitioners may not be involved throughout the safeguarding process, and are therefore often not aware of all safeguarding decisions and actions taken. To develop a fuller understanding, a focus on individual 'cases', as well as on individual practitioners, as was the case in this evaluation, may be beneficial.

The collection of more robust quantitative data

The data provided by the pilot provided a useful overview of the characteristics of those referred to the project, and an indication of the kinds of activity undertaken by the pilot. However, the collection of further data is indicated and future research would be strengthened by the availability of the following:

- Dates of initial referral for a forensic examination and the date of the examination
- The development of clear codes for different kinds of forensic activity, providing greater detail on the numbers of physical examinations, examinations of photographs, use of other supporting evidence, and where a combination of approaches was used. This was omitted when the quantitative data capture was planned (as it was assumed that the majority of cases would result in a physical examination), and had to be added retrospectively from FME records.
- The development of codes to identify whether the suspected NAI was substantiated. Discussion with the Forensic Lead suggests that such categories may include 1) NAI substantiated 2) Accidental injury requiring no further response (that is, an accident which is considered unlikely to be repeated) 3) Accidental injury which requires further response (i.e. injury arising accidentally but which requires further action to reduce the risk of reoccurrence, and in which a failure to act on the safety plans developed would be suggestive of neglect/poor practice 4) Inconclusive.

Any future evaluation needs to have sufficient time and resources to support the data collection. This includes recognising that outcomes may take time to be delivered, and therefore collecting data on the range outcomes delivered cannot be achieved within short timescales. Further, any work to include the perspectives of people who have been abused and their families will require time and sensitivity to plan and deliver. The planning and lead in time for any future evaluations also requires acknowledgement and resources. Research with patients and their families is likely to require more rigorous ethics approvals than were required for this evaluation. The time taken to navigate local authority Research Governance processes also requires attention.

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