



Executive Summary

Serious Case Review

Case AB--2007

Introduction to the Serious Case Review (SCR)

Kent Police recommended this case for a SCR. They described allegations made against a care worker AB working in an NHS Trust care home for adults with a learning disability, as protracted and worrying. The allegations included physical, psychological abuse and neglect which taken together could rightly be described and institutional abuse. The police voiced concerns that alleged practices did not appear to have been addressed appropriately by the management. Specific allegations concerned 5 named residents and occurred between 1st Jan 2002 and 19th Dec 2004. Following police investigation AB was charged under section 127 of the Mental Health Act 1983. The charges were later dropped by the CPS just before the case was to be heard in the Crown Court. The reason given for this action was that although the charges could probably have been proven, it was considered not to be in the public interest to prosecute this care worker when more senior staff and managers who had failed to deal with the abusive behavior had not been prosecuted.

The Purpose

The purpose of the SCR in this case was to establish what lessons can be learned about the way the service initially dealt with abuse concerns reported to them and the way they and local professionals and agencies worked together to safeguard vulnerable adults.

Outline of Review Process

It was conducted to review the effectiveness of procedures and to inform and improve local inter-agency practice and working together to better safeguard vulnerable adults. The following organisations were involved in submitting management reports to the SCR Panel chaired by Professor Hilary Brown in 2007:

- The Crown Prosecution Service
- The Kent and Medway NHS Trust
- Kent Social Services
- Kent Police
- Health Care Commission
- Commission Social Care Inspection

Circumstances that led to SCR

The events occurred in an NHS Trust care home for adults with learning disabilities. The service is now designated for closure and reprovision. The management of the service was weak due to sickness but there was also evidence that management ignored reports of abusive incidents. For six years the Trust had failed to make adequate provision for senior management for the home. The individual acts of cruelty and bad practice that were logged included punching, slapping, force feeding, locking people in toilets, locking people outside in the cold. AB pinched one resident's ear when feeding him to cause him to open his mouth. Management saw this and did not challenge this practice. There was no evidence that the Trust managed the initial abusive incidents in a formal manner. One serious incident concerned AB scrubbing a resident with a toilet brush was dealt with as a disciplinary matter but the worker was not dismissed. However, this was later used as partial grounds for not pursuing the prosecution, which highlighted how processes for redress were not dovetailed. It was evident within the case that AB had received minimal training although there is record of attendance at an adult protection awareness course. There were no records of any supervision of staff or recording by management of any concerns raised about staffs' practice. An adult protection conference held in summer 2004 was said to have identified no criminal offences but the concerns reported at that time would have constituted neglect under the Mental Health Act. The Crown Prosecution Service operated as if the evidence of management failure, along side the fact that AB received minimal training, exonerated AB. The police focused on AB as an individual and did not explore reported issues of management failures as possible grounds for prosecution.

Key Issues from Managements Reports

1. This service was designated for closure and reprovision, and bears similarities to the services in Cornwall and Sutton & Merton which have recently been subject to inquiries by the Health Care Commission.
There is evidence that the abuses of which AB was accused represented some broader failures in service management, policies and practice.
2. The Trust acknowledged that there was a weak management regime but this seems an understatement. Their report points to the fact that one senior manager was on long term sick leave. The Trust should have made alternative arrangements to cover this absence. The evidence from the Crown Prosecution Service suggests more worrying and culpable neglect of their responsibilities.
3. The CPS operated as if this evidence of management failure, alongside the fact that she had received minimal training, exonerated AB. This should not be the case: each employee has to take personal responsibility for their actions and poor management support is not a license to use violence or disregard a client's right to be treated with dignity and respect. What this evidence does do is implicate management.
4. The police have acknowledged that they focused their own investigation on AB as an individual and did not explore whether management failures constituted potential offences under Section 127 of the Mental Health Act. Their report describes how they have instituted a practice of more collaborative working with the CPS from the inception of any similar investigation, allowing for a proper debate about the locus of responsibility and culpability to take place at the outset.
5. The Safeguarding Adults process itself was misconstrued in that it seemed to authorise a single investigative process, in this case a police investigation, to take "precedence" over other processes. The multi-agency process is designed to provide a mechanism for sharing information and decision-making and for micro-managing a series of parallel processes
6. The introduction of a single barring mechanism later in 2008 will provide a route for an employee of a NHS service to be barred from the health and social care workforce, thereby plugging an existing gap which exists with the current POVA arrangements.

Recommendations

- a) In future any investigation into institutional abuse must begin with a proper scoping exercise so that the role of management in the aetiology of any specific reported incident is included in the purview of the investigation and its outcomes.
- b) Preparation for disciplinary hearings should be undertaken in consultation with and in tandem to the Police investigation.
- c) Advocacy should always be available to vulnerable adults in adult protection cases. IMCA's should be provided in cases of this kind where individuals qualify for assistance in making major decisions about accommodation, serious health care *or* in the wake of abuse if they are unbefriended, or if their family are seen to be acting against their best interests.
- d) Standards in services that are designated for reprovision must not be allowed to fall below acceptable standards or to evade regulatory activity in respect of current provision.
- e) Liaison between CPS and Police during investigations involving vulnerable adults should be stepped up and include proper debate about the scope of investigation and the potential negligence of management, and/or appropriateness of corporate negligence as *well as not, instead of*, individual charges.
- f) Arrangements should be put in place for joint Serious Case Review and Serious Untoward Incident Reviews, managed jointly within the Safeguarding Adult multi-agency procedures to be carried out when abuse is uncovered in NHS facilities.
- g) Internal guidelines in all NHS, not-for-profit and private sector services should make it clear that all forms of abuse and specifically hitting a resident, or engaging in any sexual activity with a resident, is an offence and will be dealt with as gross misconduct and as a cause for instant dismissal. Lesser actions leading to disciplinary action should be formally heard and recorded.

- h) The CPS has a commitment to equal access to justice for vulnerable people, but it may not always act in a way that is consistent with the principle that an offence should be seen to be aggravated by the victim's vulnerability, not offset against it. Minimising offences against people with disabilities or other vulnerabilities is discriminatory and the CPS should log these cases so as to monitor whether the criminal justice system is acting in a way that brings about equity with non-disabled people.
- i) Services for vulnerable people that are provided by, or within, the National Health Service should ensure that their own processes work alongside the adult protection process and that they collaborate in the conduct of joint searching inquiries to pursue the root causes of service failures of this magnitude.
- j) Whistle-blowing was delayed in this case: policies and procedures to support whistleblowers should be immediately reviewed and strengthened within this NHS Trust.
- k) These findings should not be lost as the service moves towards the planned handover to local authority management and re-provision plans should be accelerated wherever possible.

Action Plans

Police

- Police report that arrangements for liaison with CPS are now in place

CPS

- CPS should monitor their decisions in relation to cases involving vulnerable adults, to ensure that offences are not minimised or disproportionately stalled and make an annual report to the Safeguarding Adults Committee. (by December 2008)

NHS Trust

- Revise disciplinary procedures to ensure that any confirmed abuse of a resident is treated as a dismissible offence (by December 2008)
- Put in place additional supports to whistleblowers (by June 2008)
- Audit training in relation to awareness and alertness to abuse, but also to challenging behavior, appropriate physical interventions, personal care and produce a report to the Panel indicating the uptake of training among direct care staff (by December 2008)
- A supervision policy should be devised to ensure that it is systematically provided, recorded, evidenced and followed through. (by September 2008)
- HR staff should be given advanced training in conducting disciplinary proceedings where concerns of adult abuse are raised (by September 2008)
- Funding should be provided for advocacy to all residents in this service until its closure (by June 2008)
- A senior manager should be designated as lead for Safeguarding Vulnerable Adults and provided with authority and resources to carry out this role within the context of multi-agency working (June 2008)
- This lead manager is asked to write a short report detailing actions that have been taken in pursuance of these recommendations and submit it to the Chair of the Serious Case Review Panel by 1st September 2008.

Social Services in conjunction with NHS Commissioners

- Review funding and planning for re-provision of this service to ensure that adequate funding is available to maintain the service at an acceptable level (by June 2008)

Social Services

- Ensure that all service users in this service have designated care managers (June 2008)
- Person-centered care management reviews should be conducted as part of the re-provision process (by June 2008)

Safeguarding Vulnerable Adults Committee

- Review and if necessary clarify those parts of the adult protection policy and protocols that deal with the management of disciplinary procedures alongside a police investigation. (by September 2008)

Conclusion

This was a bad model of care, being badly managed and clients were served by inadequately trained and supervised staff. Although the CPS was perceived by some to be acting in a high-handed way by deciding not to prosecute, their view that this incident represented wider problems in the provision of care had some merit. Had the early concerns been addressed in a multi-agency forum, contingency plans might have been put into place promptly to hold this worker to account for her actions while at the same time a broader raft of service improvements and staff training could have been mandated. Senior management should have seen these incidents as a shot across the bows and taken action to intensify supervision, training and a commitment to excellent practice in relation to some very vulnerable and disadvantaged service users.

There are important lessons here for the NHS Trust and the Panel would like to see this report as a springboard for concerted action. It expects the Trust to accept and agree to these recommendations in writing and to agree with the Chair of the Panel arrangements for scrutiny and follow up of the recommendations. By September 2008, the Safeguarding Adults Committee, through the Serious Case Review Panel, would want to see evidence that robust internal safeguarding arrangements including training are in place in this Trust, and that this is reflected in the Trust's commitment and engagement with a multi-agency approach to any further incidents of abuse in its service.