

## Independent Longcare Inquiry

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### Origin of Inquiry

This independent Inquiry was established by Buckinghamshire County Council at the request of the Parliamentary Under Secretary at the Department of Health following the exposure of widespread abuse at two large residential homes for adults with learning disabilities in Stoke Poges. The exposure led to the trial and conviction of a number of individuals with positions of responsibility at the homes. The Inquiry is in three parts. First, it is concerned with Buckinghamshire's role at the time and the decisions that were made by the Authority. Second, it considers how effectively and reliably Buckinghamshire carries out the regulation of residential homes for people with learning disabilities at present. Third, it considers the quality of the services that Buckinghamshire currently provides for these particular groups of people. There are thought to be more than 2,000 people with learning disabilities in the County.

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### Terms of Reference

To examine:

1. The decisions made and the options available to the Authority in relation to registration under the Registered Homes Act 1984, in respect of Stoke Place Mansion and Stoke Green House, during the years 1993 and 1994. These should cover the decision not to cancel registration of Longcare Limited as concerns came to light and the occasions when there were changes in owner, director or manager.
2. The effectiveness and reliability of the current regulation of residential care for people with learning disabilities in Buckinghamshire.

3. The adequacy of the current policy and practice in relation to services provided and arranged by Buckinghamshire County Council for people with learning disabilities. A particular focus will be on their vulnerability to abuse, neglect or exploitation.

## General Conclusions

Our major conclusions, supported by each part of the Inquiry, are that the protection of vulnerable adults depends on openness by proprietors and managers; vigilance by all who have responsibilities towards, or contact with residents; encouragement for the communication of suspicions; and prompt co-ordinated action when information about possible harm to the welfare of residents is received or discovered. Openness requires full disclosure on matters bearing on the fitness of applicants for registration and full investigation of any matters that are doubtful. It requires systems and personal support that provide day care opportunities for residents in the community and integration wherever possible of residents with community activities and the use of community services. Residential homes should never be closed institutions. There should be as much informed and supported choice for the individual as possible. These qualities are most likely to be achieved where residents live in small homes in local communities.

Vigilance is required from all those with a duty to assess and provide the care needs and support of residents. Social workers must ensure that there are competent key workers in place, that care plans are being carried out and that choice and welfare are being protected. They need to consult with residents, families and professionals and to be assured that there is provision for residents according to their needs and rights.

Vigilance is also required from the Registration Authority to ensure that there is compliance with the requirements of the Registered Homes Act 1984 and the Regulations. These requirements must be set out in written form so that owners and managers are in no doubt about the standards expected of them. The Act and the Regulations contain provisions to ensure that there is compliance with the required standards and they must be used promptly if there is a breach of the regulations or a failure to comply with a requirement of registration.

Owners and managers have a duty to consult with and act in the best interests of the welfare of the residents and to inform Inspectors of incidents that adversely affect their welfare. Members of staff, community professionals, policemen, doctors, nurses, carers, family and relatives, friends, teachers, visitors in any capacity and observers in general should disclose what they consider to be against the welfare of a resident.

When concerns are expressed or complaints made there needs to be prompt and professional investigation with appropriate action resulting or explanation why action is not appropriate. Where a number of authorities are simultaneously responsible, there must be agreements in place to ensure that there is structured co-operation with agreed responsibilities and tasks assigned. In joint investigations, for example involving the Inspection Unit and the police, shared information must be constantly evaluated and reviewed by each agency.

Vulnerable people are as much at risk in day care and in domiciliary settings as in residential homes and statutory regulation should be extended to cover these.

## Buckinghamshire County Council and the Longcare Homes (First Term of Reference)

This section of the Report describes the main events that took place from the time that the two homes were first registered as residential care homes in 1983 and 1987 up to the time in early 1996 that Longcare ceased to be involved in their operation. The events between 1991, when the first allegations about the homes were made, and the end of 1994 when attempts were being made to implement a programme of improvements following the exposure of widespread abuse at the homes, are set out in detail. The Report attempts to show what was known to the Authority at each stage and what decisions were made by the Authority on the basis of their knowledge. It comments on those decisions and suggests, where appropriate, what alternative or additional action should have been taken.

Among the conclusions reached are the following:

### 1991 - Allegations of assault

Investigations were made and evidence established, but the Inspector chose not to use the enforcement powers of the Act.

### December 1992-April 1993 - Allegations of multiple abuse

The evidence of abuse increased and the Inspectors accepted that there was a serious case to be answered. But no assessment of the risk to residents was undertaken nor were the police called in to help. Fearing intimidation of staff and residents, the Inspection Unit continued to rely on announced inspection visits.

### 1993 - Joint Police/Inspection Unit Investigation

There was no common understanding of the strategy to be followed. The Inspection Unit decided to take no action unless and until the Police decided not to prosecute. They failed to assess the evidence as it became available and so suspended their duty to consider whether enforcement action was needed.

### 1994 - The Inspection Unit Investigation

This was an extremely complex investigation for which the Inspectors had little experience. They did not seek help from the Health Authority, renew contact with the Police or use other specialist sources. Complaints about specific aspects of the care regime were never properly investigated. Social workers, families and the police were given no information about specific allegations.

### 1994 - Action on the Inspection Unit's Report

The advice to Social Services Casework Sub-Committee not to take enforcement action under the Registered Homes Act 1984 to cancel the registrations in respect of the homes, as summarised in the final report which was put to the Social Services Sub-committee, did not reflect the professional judgement of the Inspection Unit.

## Recommendations

Most of the recommendations in this part of the Report are directed at the Government. Specific recommendations include:

### Registration

Non-disclosure or misrepresentation which materially affects a decision to register should be a statutory ground for cancellation. An intention to deceive in an application to register should be a specific criminal offence. The penalties should be stated on the application forms.

Where a recent employer has not been given as a referee the applicant should be asked to say why not and the explanation investigated.

An application for registration of a residential home for people with learning disabilities must be properly considered with regard to all the requirements of fitness in Section 9 of the Act. Authorities should publish standards for such homes setting out qualifications, experience and training expected for managers and staff, size of home and type of accommodation, expected services and facilities, expected systems of care supervision, residents' finance, medication, health care and records.

Where a manager is not in control of a residential care home, and the person in control is a company, full checks should be carried out on the person responsible for the management of the company.

### Inspection

Inspection should be more focussed on the mental, physical and social well-being of the residents and their care standards. Inspectors should seek the views of residents, their families and their social workers on these matters and pay particular attention to the implementation of Regulation 9 of the Residential Homes Regulations 1984.

The system of appointing an independent advocate for a resident should be encouraged.

### Complaints

An Inspection Unit should be required by the Registered Homes Act 1984 to investigate a complaint received by it concerning a resident in a residential home in its area and guidance should be given on how such complaints should be investigated and reported on.

There should be protection for staff making complaints and for residents during their investigation.

Local authorities should be required to establish Adult Protection Committees and the Secretary of State for Health should issue guidance about the role, purpose and structure of such committees with a view to developing agreements for inter-agency action to protect vulnerable adults including people with learning disabilities.

Necessary skills must be employed in order to interview residents with a view to assessing risk.

#### Enforcement

Enforcement decisions should be taken by experienced professional inspectors who have the Authority's internal legal support to assist them to implement the decisions they have made.

The job description of the Head of an Inspection Unit should impose a duty to refer a registration or enforcement decision which is challenged by line managers directly to the Chief Executive of the Council.

Inspectors should be given power to secure evidence at the home and remove it for inspection.

A solution should be found to the need to operate a registered home in the interest of the welfare of the residents following cancellation of registration by a magistrate's order.

Attention should be given to relaxing the need for competence of a vulnerable adult to give evidence, allowing the use of evidence on video. There should be a review of the rules of hearsay for a vulnerable adult witness whose incapacity prevents attendance.

The Criminal Law should be amended to provide for a specific, arrestable offence of causing harm or exploitation of a vulnerable adult with a maximum penalty of 10 years' imprisonment.

Other recommendations are made in the full Report.

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#### The Current Regulation of Residential Care for People with Learning Disabilities in Buckinghamshire (Second Term of Reference)

This section of the Report describes the organisation, procedures and working practice of the Inspection Unit at the present time, paying particular attention to the degree to which lessons have been learned from the Longcare experience. Starting from a basis described by the Social Services Inspectorate in 1995 as "a significant failure against the SSI standards for inspection units", the reorganised Inspection Unit has taken a number of important steps within the last two or three years to improve the overall level of its performance. Under new leadership the Unit has built constructive relationships with the main stakeholders in the field of residential care - private sector providers, user and carer groups, the Health Authority and the Police. An active Advisory Panel provides a degree of oversight. Within the Social Services Department the Unit has built good working relationships in place of its previous isolation and its judgement is respected on all professional matters.

Regulatory practice has become sharper and more professional. There are published

standards for adult residential homes to provide a consistent basis for announced and unannounced inspections. The procedures in place for registration appear to be thorough. The Unit achieves its annual statutory inspection programme and has the capacity to make additional visits in order to follow up complaints or to look into special situations. Enforcement action, which was avoided throughout the Longcare years, is confidently and successfully employed. To a considerable degree the lessons of Longcare have been learned. Nevertheless there are important steps that the Unit can and should take to make regulation more effective and reliable, particularly as it applies to people with learning disabilities.

## Recommendations

The recommendations in this part of the Report are directed at Buckinghamshire County Council. Specific recommendations include:

### Structural

The Inspection Unit's objectives in relation to the Fremantle homes need to be pursued with energy and determination.

The Inspection Unit must continue to develop its collaboration with the Buckinghamshire Health Authority so that it is as close and continuous as possible.

Co-operative working between Social Services Department and Thames Valley Police needs to be further developed with joint procedures for combating abuse and related training.

A joint protocol between the Inspection Unit, the Health Authority and the Fire and Rescue Service needs to be completed to guide joint working.

### Regulatory Practice

In reviewing residential homes' standards the Inspection Unit should aim at producing separate standards for homes for people with learning disabilities. Until these are available, the generic standards and the associated indicators need to be carefully interpreted.

The Inspection Unit should review their current registration practice to focus it as sharply as possible on the fitness of the applicant, the realism of the proposals and the skills and resources available. For homes for people with learning disabilities the process needs to be particularly thorough.

The effectiveness of the protocol governing follow-up actions for local authority homes should be reviewed not later than October 1999.

Inspections should increasingly be focused on residents' experience, making maximum use of information and views of knowledgeable people outside the home. Reports should describe the extent of resident and staff involvement.

Inspection reports need to reflect the users' perspective more strongly.

The Inspection Unit should consider whether special steps are needed to make complaints procedures fully effective in homes for users with learning disabilities.

The follow-up for statutory requirements in inspection reports needs to be tightened up.

The structure for joint action between the Police and Social Services in investigating possible cases of abuse needs to be properly documented so that a framework exists for acting quickly and decisively in future. An multi-agency forum should be the focus for co-ordination and planning. Joint training between Social Services and the Police should be undertaken.

The Inspection Unit should seize the opportunity provided by computerisation of their database to streamline their administrative procedures so as to free up inspectoral time.

Other recommendations are made in the full Report.

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#### The Services provided and arranged by Buckinghamshire for People with Learning Disabilities: Current Policies and Practice (Third Term of Reference)

This section of the Report sets out the information available about people with learning disabilities, both adults and children, in Buckinghamshire and sets this in the context of national trends and current policies and practice. Special attention is paid to their vulnerability to abuse and the policies needed to minimise the risk of this occurring. The report reviews in turn residential services and supported living; day services; and children's services; and also records views of parents, carers and service users. The Inquiry had to take account of the threat to a number of valued facilities because of Buckinghamshire's present financial position. Against that background the Report considers how these services are managed in the County, including the planning and commissioning processes in the Authority.

The Report finds that in many respects commissioners and providers of residential and day services have addressed the issues of vulnerability and risk from abuse. With the exception of guidance on restraint, appropriate policies and procedures are in place. However, the vulnerable adults policy has only just been implemented: training is required in its use, and lessons will need to be learnt from its application in real life situations

Most people with learning disabilities are in contact with a variety of different activities, workers and friends; some have advocates. These all minimise the risk of abuse going unnoticed, so long as others are aware of the need to be vigilant and report untoward or unexplained events.

The Report finds that the greatest single weakness in Buckinghamshire's services for people with learning disabilities is the absence of strategic direction and visionary leadership within Social Services and jointly with other key agencies. The current Joint Strategy document lacks a clear plan for implementation. However, one of the greatest

strengths is in operational management which has successfully coped with reductions in resource levels while maintaining services and staff commitment. The reductions now required make this balance unsustainable

## Recommendations

The recommendations in this part of the Report are directed at Buckinghamshire County Council. Specific recommendations include:

### Residential Services

Better communication is needed between the Social Services Department and the Fremantle Trust to address both strategic development and operational issues. The problem of staffing levels needs to be tackled in more innovative ways. Guidance on the use of restraint needs to be developed and applied particularly within the Authority's own provision. The Rehabilitation Service also needs to be reviewed to check people's needs against the services available. Advice from other areas and organisations will be helpful. In the longer term, overall residential provision needs to be reviewed, in collaboration with the Health Authority, in terms of people's needs and the type and availability of the services required and currently provided.

### Day Services

A development strategy for day services is urgently needed, both within the Social Services Department and more widely involving other important providers and agencies including education and employment services. A review and planning process needs to be established quickly. Advice and assistance should be sought from other bodies and places where significant developments have been implemented. Developments planned or being planned should be temporarily halted and checked against a broader day services strategy. Ways should be sought to involve parents, other carers and service users in the review and planning process.

### Domiciliary Services

The Inspection Unit should extend its remit to cover these and also day services.

### Services for Children with Learning Disabilities

A Register of Children with Disabilities should be quickly established to provide accurate planning data on children's services. The proposed Specialist Team should be established as soon as possible. A draft Action Plan for day and respite care needs to be developed as a basis for consultation. Current assessment arrangements and eligibility criteria for children's services should be reviewed and the confidence of parents in the basis of assessment established.

### Parents, Carers and Service Users

Buckinghamshire should re-examine its current consultation arrangements and develop a pro-active County-wide strategy on user involvement.



## Advocacy and Self-Advocacy

The Authority should invest in advocacy services to ensure whole County coverage. Such services can play an important role in increasing self-confidence of people with learning disabilities and reducing the risk of abuse. They should always be involved if there is a complaint or allegation of abuse.

## Management Development and Commissioning

Action needs to be taken urgently to give greater strategic direction. A senior officer should be identified to take the lead in determining the future strategic direction of all services for people with learning disabilities, in conjunction with other Departments, the Health Authority and major service providers. Decisions about reductions in service levels should be delayed until a coherent strategy is in place.

Other recommendations are made in the full Report.

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