Taywood Review
Closing Report

A synopsis of the review of the Taywood House multi-agency vulnerable adult abuse investigation.

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1. Introduction

1.1 The Taywood Review was established following the successful multi-agency vulnerable adult abuse investigation into the activities of the owners of Taywood House Residential Care Home for the Elderly in Great Yarmouth.

1.2 Despite the overall success of the investigation there had been a number of challenges along the way. Given that this was the first time new legislation had been used, it was recognised that it would be beneficial to capture the lessons learnt to inform future policy and practice at both local and national levels.

2. Background

2.1 Taywood House was a residential care home in Great Yarmouth, which catered for approximately 14 residents, most of whom were funded by Norfolk Social Services.

2.2 The owners purchased the home as a going concern in May 2000 and their initial registration was undertaken with the Norfolk County Council Inspection Unit which was, at that time, the Registration Authority.

2.3 In August 2002 formal allegations of ill-treatment were made to the police Adult Protection Unit and an investigation was commenced under inter-agency protocols established under the auspices of 'No Secrets'[1] in 2001.

2.4 In November 2002 it emerged that there may have been culpability for one or more deaths at the home and as a result the investigation was reviewed and escalated to become a major investigation (it should be noted that the investigation did not ultimately ascribe culpability for any death to any person).

2.5 In January 2003 a joint operation by Norfolk Constabulary, National Care Standards Commission and Social Services resulted in the arrest of the owners and the closure of the home as a result of the first successful application, nationally, to a Magistrates Court under s.20 Care Standards Act 2000.

2.6 Whilst no charges were brought in relation to any deaths at the home the owners were prosecuted and in October 2004 they were convicted of the following offences:

[1] 'No Secrets' was issued under Section 7 of the Local Authority Services Act 1970, which requires local Social Services to operate under the general guidance of the Secretary of State. It set out to improve the arrangements for dealing with adult abuse by requiring Directors of Social Services to co-ordinate the development of local multi-agency policies, procedures and protocols to protect vulnerable adults and to deal with incidents of the abuse of vulnerable adults.

a) Failure to conduct a business so as not to expose persons not in employment to risk.
Section 3(1) and 33, Health and Safety at Work Act 1974

b) Ill-treatment or wilful neglect of persons who are mentally ill.
Section 127(1) Mental Health Act 1983

c) Administration of a poison or noxious substance.
Section 24 Offences Against the Persons Act 1861

d) Administering a medicinal product other than in accordance with the directions of an appropriate practitioner.
Section 58(2)(b) and 67(2) Medicines Act 1968

2.7 One of the owners was sentenced to a term of 16 months imprisonment and the other to a term of 8 months imprisonment.

3. Multi-Agency Review

3.1 When the owners of the home had been charged, following negotiation by the then Assistant Chief Constable, Simon Taylor, with Lisa Christensen, then Director of Social Services, it was agreed to start work straight away in order to capture the learning whilst it was still fresh in everyone's minds. As a result, having first sought agreement from CPS to address any concerns around sub-judice, work commenced in the spring of 2003 with the involvement of the following lead practitioners from the three main agencies:

- Police – DCI Julian Gregory
- Social Services – Mr Howard Wynn
- National Care Standards Commission (subsequently Commission for Social Care and Inspection) – Mr Steve Briggs

*3.2 **Executive Board***

In order to have some impact, both locally and nationally, an Executive Board was established to oversee the work of the Review. The Board comprised senior people from the agencies involved in the case as well the Chief Executive of Age Concern Norfolk to introduce an independent view and a Senior Lecturer in Social Work from the University of East Anglia to bring an academic perspective to the work of the Review.

3.3 The Board comprised:

Simon Taylor (Chair)	Deputy Chief Constable, Norfolk Constabulary
James Rolfe	Assistant Director Adult Social Services
Norwyn Cole	Commission for Social Care Inspection
Christina Wells	Norfolk, Suffolk & Cambs Strategic Health Authority
Rex Humphrey	Age Concern Norfolk
Ann McDonald	University of East Anglia

Attendees/advisors to the Board were:

Julian Gregory	DCI, Norfolk Constabulary
Howard Wynn	Norfolk Adult Social Services
Steve Briggs	Commission for Social Care and Inspection

Zoe Grace Cozens (from 4/7/05) Vulnerable Adult Protection Co-ordinator

3.4 The Board met seven times between February 2004 and December 2005 in order to provide strategic direction and to oversee the work of the Review.

3.5 ***Methodology***

3.6 In order to provide a robust method of reviewing the events associated with the Taywood case and to ensure that important factors were not overlooked, a process was introduced whereby each of the main agencies produced a timeline of events from the point at which the owners of the home applied for registration to the conclusion of the investigation. These timelines were merged to produce a composite sequence of events, which was then analysed resulting in the identification of the following themes:

- Statutory shortcomings
- Registration
- Appropriateness of placement
- Standards of care
- Crime allegations
- Abuse allegations
- Inter-agency working
- Inspections

3.7 Each of these themes (with the exception of Inspections) was the subject of a detailed paper in which the issues were set out for the Board together with recommendations for improvements.

3.8 At its meeting of 10th February 2004 the Board agreed that the theme of Statutory Shortcomings was the higher priority given the potential impact nationally. These included some issues from the other seven themes.

4. Good Practice

4.1 Whilst the Review was primarily concerned with identifying areas for improvement the Board acknowledged that there were some very positive aspects to the way in which agencies had collaborated to achieve joint aims.

4.2 Overall it was acknowledged that Norfolk had well developed protocols, structures and practices for dealing with adult abuse, with Inter-Agency Strategy Meetings being the focus for agreeing the direction of the investigation and how agencies could undertake mutually supportive roles.

4.3 As a result of this there were some excellent examples of joint work, some of which were ground breaking for the agencies involved. These included:

- Joint Police and NCSC action teams, each comprising a Detective Constable and an NCSC Inspector, to undertake enquiries where joint expertise provided enhanced ability. A good example was the joint work of the NCSC Pharmacy Inspector and Police Pharmacy Liaison Officer in the investigation into the regime for administering medication.

- Use of NCSC powers to seize documentation from the home on behalf of the police investigation.
- Exposure to the working practices of other agencies providing opportunities to develop practice e.g. NCSC gaining an appreciation of the way in which the police manage exhibits to prove continuity and show integrity; Norfolk NCSC (now CSCI) being prepared to take enforcement action where appropriate and leading nationally on this issue as a consequence.
- Use of staff from a range of agencies to monitor the situation at Taywood House whilst sufficient evidence was gathered to arrest the owners of the home and close the home e.g. NCSC Inspectors, Social Workers, District Nurses.
- Joint operational planning for the arrest phase of the investigation and holding a joint briefing which enabled:
    i) Joint Police and Social Services teams, each comprising a Detective Constable and a Social Worker, to deal with individual service users when the arrest phase was implemented. This ensured that the capture of evidence and the welfare of the individual were dealt with seamlessly.
    ii) In the absence of any statutory provision, NCSC to secure written consent, from the owners of the home, for Social Services to run Taywood House whilst they were in custody.
    iii) Social Services to manage the home and plan to relocate residents whilst police and NCSC continued investigative and enforcement activity.
    iv) CSC Inspectors being involved in the downstream monitoring of police interviews with the owners of the home. This enabled them to gather sufficient evidence to make the successful s.20 application to a Magistrate's Court for the emergency closure of the home.

5. Recommendations

5.1 The work of the Review resulted in a number of recommendations for improvement and these fell mainly within the identified themes.

5.2 ***Statutory Shortcomings***

A number of gaps and inadequacies were identified in the legislative and procedural framework within which vulnerable adult abuse investigations are conducted and as a result the following recommendations were accepted by the Board:

1. *We recommend there should be a positive duty on medical practitioners to respond fully to requests for medical references from a statutory regulatory agency.*
2. *Notwithstanding the good aspects of interagency work on this case and the high priority it was given, we recommend that the system should be put on a statutory basis with Inter Agency funding to match the responsibility. This should be accompanied by a statutory duty on Social Services Departments, as the lead agency in Adult Protection, to*

instigate the investigation of allegations and to co-operate with other investigative agencies.

3. *We recommend that a statutory solution introduce a legal duty on all parties to an Adult Protection System similar to the 'welfare principle' in child care cases. That is, for the decision making to be in an overall context of safeguarding the welfare of service users being the first and paramount consideration in reaching any decision. This would put all the agencies on the same philosophical footing, and may help with issues such as 'Primacy' of any one Agency.*

4. *We recommend that there should be a free-standing statutory power for the Local Authority to run a service following a successful Section 20 application and/or following the issue of a Section 14 notice. This could be linked to criteria of breach of the terms of the contract between the Service Provider and the Social Services Department to provide care services paid for by public funds, in those cases where publicly funded people live at the home.*

5. *We recommend that there should be a change to legislation to allow an Authorised Inspector of the Registration Authority to have access to medical records without consent, in serious circumstances where either consent is not given, or cannot be obtained.*

6. *We recommend that more general offence of ill treatment of a vulnerable adult would be more suitable to protect all those in care.*

7. *We recommend that the relationship between employment law and the protection that can be given to those who professionally report abuse should be reviewed, taking into account the registration of care workers with the General Social Care Council and the support this can give.*

Action

The background to the Taywood Review together with a summary of the conclusions leading to the above recommendations were included in a joint letter from Simon Taylor and Lisa Christensen to Dr Stephen Ladyman, Parliamentary Under Secretary (Community Care) in the Department of Health, on 3rd June 2004. The letter was copied to Hazel Blears MP (Minister for Policing), all Norfolk MP's, ACPO, HMIC and other key individuals in CSCI, County Council, Police Authority, the Home Office and Age Concern.

The letter was timed to coincide with a DoH led review on social care for adults under the heading of 'Adult Vision.'

The Member of Parliament for Great Yarmouth, Tony Wright MP, subsequently facilitated a meeting with Dr Ladyman, which was attended by Simon Taylor, Lisa Christensen, Julian Gregory and Howard Wynn. Each of the recommendations was expanded upon in both strategic and operational terms and those attending left with the impression that the recommendations had received a sympathetic hearing and that they would be considered in the work on Adult Vision.

To increase awareness of the issues arising from the Taywood case Julian Gregory delivered a presentation to the Association of Directors of Social

Services National Adult Abuse Network at the invitation of DCC Richard Crompton (ACPO lead for the Protection of Vulnerable Adults).

When the Green Paper entitled 'Independence, Well-being and Choice' was released for consultation, in March 2005, it appeared that none of the recommendations made by the Review had been specifically addressed and that the issue of vulnerable adult abuse did not appear to have been adequately addressed. As a result Simon Taylor and Harold Bodmer (Director, Adult Social Services) wrote a further letter to Dr Ladyman's successor, Mr Liam Byrne MP, on 12th July 2005, to further reinforce the learning from the Taywood case. This was supplemented by additional letters to DCC Richard Crompton (ACPO portfolio lead) and Sue Fiennes (ADSS Older People Committee lead for the Protection of Vulnerable Adults) to seek their support in raising awareness and responding to the Green paper consultation process which was speedily forthcoming.

*5.3 **Registration***

It was concluded that whilst there had been some questionable decisions in the registration process it had been conducted under the Registered Homes Act 1984, which had since been superseded by new legislation. The 1984 Act stated that the Registration Authority shall issue a registration certificate upon receipt of an application unless it had reason not to do so. The burden of proof fell to the County Council to demonstrate that the applicant for registration was '*not a fit person to be concerned in carrying on a care home.'*

There was no statutory definition of 'fitness', no specific regulation about registration requirements and there was no statutory process about what applicants had to show in order to be 'fit' and as a result Local and Health Authorities did different things.

The situation after the Care Standards Act and Care Homes Regulations 2001 had introduced significant improvements, with a national system and statutory criteria. The burden of proof is still on the Registering Authority to show unfitness but the applicant has to go through various statutory processes to demonstrate fitness, including an interview, providing structured information about their plans for the service, personal medical and financial details, qualifications, and requiring a qualified manager if the owner is not qualified. The Care Standards Act 2000 permits the Registration Authority to impose any conditions reasonably required to regulate the registration.

Action

The recommendation relating to disclosure of information (recommendation 1) under Statutory Shortcomings originated from the paper on Registration. As a result of the changes to legislation it was felt that no further action was necessary.

*5.4 **Appropriateness of Placement and Standards of Care***

These papers considered the appropriateness of placing certain individuals in particular care settings and the standards of care administered to them. They acknowledged that some individuals had been inappropriately placed and that

concerns about the standards of care they received were not highlighted as early as they might have been.

The recommendations arising from the paper on these subjects were:

1. *That the Board ask Social Services to consider adopting the approach of reviewing all of the department's clients in a residential home at the same time.*

2. *That the Board ask Social Services to establish a computerised system for collating all concerns on individuals under the care provision of any provider and that a shared database between statutory organisations is established. It was agreed that such an approach should address all service users and not just those funded by Social Services.*

3. *That the Board ask Social Services to review the pre-placement agreement and contractual arrangements to see if these can be strengthened to the point where termination of a contract can be achieved, where serious concerns are held by the Department and other statutory agencies, without penalty.*

Action

Recommendations 1 and 3 were accepted by Social Services and were remitted to them to address. Recommendation 2 was addressed under a new theme of Information Sharing (post).

*5.5 **Crime and Abuse Allegations***

These two papers considered the number and nature of allegations and incidents reported to the police and other agencies. It was acknowledged that not only had individual agencies not collated information from different systems but also that they had not shared information to provide a holistic picture. It was felt that if the number of minor incidents at Taywood House had been taken together then they might have been seen as an indication that something was amiss and there might have been an earlier intervention.

The recommendations arising from the paper on these subjects were:

1. *That the Board ask Social Services Department, Norfolk Constabulary and CSCI to review their mechanisms for collating information that may indicate poor management and/or mistreatment of residents in care settings.*

2. *That the Board ask Social Services to lead in developing a mechanism (database) for information sharing between relevant agencies.*

Action

Both actions were dealt with under the new theme of Information Sharing (post).

5.6 ***Inter-Agency Working***

Whilst acknowledging the undoubted positive aspects of joint working that characterised the investigation it was accepted that there were some significant disagreements, primarily about making an early application to close the home. Having discussed the paper on this subject the issues for development were:

1. *No specific mechanism for dealing with inter-agency disagreement*. In principle it was agreed that an Executive level group (akin to the Gold group used in other inter-agency arenas) would be an appropriate mechanism to resolve issues and provide oversight in complex and high profile cases. The importance of securing the involvement of Health was acknowledged.

2. *Independent chair of Strategy Meetings*. It was identified that money was available for Independent Chairs but that they had not been used as often as they might be (£1,362 spent against a budget of £5k in 2003-04). Whilst the situation has improved and there was usually a positive response when an Impendent Chair was used, there was scope increasing the occasions when they were employed. It was agreed that there should be trigger points for introducing an Independent Chair linked to the proposal for establishing Gold Group in individual cases.

3. *Sharing patient related information*. It was noted that all PCT's are signed up to the Adult Protection Protocol and that a number are providing compulsory training for their staff. It was suggested that the problems encountered with a nurse would probably not be encountered now but that there is still an issue with GP's. This was illustrated by the fact that adult protection does not feature in GP's contracts.

Action

The tried and tested Gold, Silver and Bronze[2] management structure currently used by a number of agencies, including the Police and the County Council, primarily in dealing with serious incidents and disasters has been introduced into Adult Protection and will be written in to joint protocols. In particular, the concept of a multi-agency Strategic Co-ordinating Group (Gold) to improve the response and cohesiveness of agencies in the most serious cases has been introduced with Terms of Reference agreed by all agencies. This has also been picked up by Child Protection in Norfolk as good practice.

The use of Independent Chairs is already established and the procedure for appointment has been further supported through being incorporated as a consideration set out in the Gold Group Terms of Reference.

The issue of sharing patient related information was included in the aforementioned letters, in response to the Green Paper consultation process, to Liam Byrne MP, Richard Crompton and Sue Fiennes.

[2] Gold relates to the strategic management at inter-agency level, Silver relates to tactical management at inter-agency level (currently referred to as the Strategy Meeting) and Bronze relates to operational management at individual agency level.

5.7 ***Information Sharing***

Recommendation 2 from Appropriateness of Placement and Standards of Care and recommendations 1 and 2 from Crime and Abuse Allegations related to the ability of each agency to capture information that could indicate that abuse was occurring and a mechanism for agencies to then pool such information to ensure that a holistic picture is achieved.

Action

Norfolk Constabulary has developed a process whereby information relating to care homes is captured from relevant information systems (Command and Control, Crime and Intelligence, FPU Database) on a monthly basis to check whether there are pockets of information that, taken together, might indicate that something more serious is amiss.

Adult Social Services accepted that there was a need to capture information on a home by home basis as well as an individual basis in order to identify trends and the issue was remitted to them to resolve.

CSCI felt that new protocols on information sharing and their 'traffic light' based system for assessing care homes meant that they were well placed to capture information to identify issues.

Overall, it was agreed that the flow of information needed to be to CSCI as they are the regulatory body. It was also agreed that it was important to be proportionate in responding to issues as agencies did not have sufficient resources to deal with every minor matter. It was felt that the introduction of an IT based system to share information would not be appropriate at this time on the basis of cost and time required to establish and administer such a system.

It was agreed that monthly meetings between the police APU and CSCI would be the appropriate mechanism to ensure that information is shared.

5.8 ***Inspections***

It was acknowledged that the effectiveness of NCSC (now CSCI) inspections were vital to identifying poor practice and abuse. Whilst some work was done on the paper covering Inspections it was not presented to the Board and was dealt with as an internal issue for CSCI.

6. Communication Strategy

6.1 Throughout the lifetime of the Review efforts were made to raise awareness of the learning experienced during the investigation, with the dual aims of securing support for the recommended changes to the legislative and procedural framework under which adult abuse is dealt with and of informing practice at the local level.

6.2 The methods employed included:

- Correspondence to key individuals and organisations (ante).

- Presentations (e.g. ADSS National Adult Abuse Network, Sussex Police, Norfolk VAPC Conference).
- Media briefings (e.g. extensive coverage at the time of sentencing).

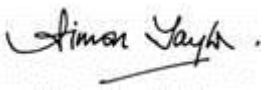
6.3 The success of this is evidenced by the contact made by practitioners from across the country to seek advice and guidance, particularly from police colleagues engaged on similar large scale investigations.

7. Conclusion

7.1 Overall the Review achieved its aim to ensure that the learning arising from the Taywood House investigation was captured to the benefit of colleagues both locally and nationally. It is, perhaps, unfortunate that the issues outlined under 'Statutory Shortcomings' did not receive the consideration that had been hoped for in the Green Paper (Independence, Well-being and Choice), however, the Board did all that it could to ensure that this was fed back into the consultation process by a number of key players and organisations.

7.2 The adoption of measures within Norfolk has been good, for example the introduction of the Gold Group concept bearing early fruit in the management of issues arising at a local hospital providing care to children with extreme learning and behavioural difficulties. Similarly, the progress of similar investigations has been improved as a result of the experience of the Taywood investigation.

7.3 On a final note, it is worthy of mention that Norfolk has, since the publication of *'No Secrets'*, been at the forefront in developing protocols and practices to address Vulnerable Adult Abuse and has been one of the leaders nationally. It is in this context that the success of the Taywood House investigation and the willingness of all agencies to learn from experience should be viewed.



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