Islington Safeguarding Adults Partnership Board

Executive Summary

Medina Road Serious Case Review

Background

Medina Road was a registered care home owned and run by Craegmoor Healthcare, providing placements for four people with learning disabilities and challenging behaviour. At the time of the reported incident, three residents had been placed and funded by Islington Social Services Department and one resident had been placed and funded by Camden Social Services Department.

An adult protection alert was received by Islington Social Services in September 2005. Due to the seriousness of these concerns and the weight of evidence presented, Islington Social Services and the Islington Learning Disability Partnership (ILDP) responded by removing all service users to alternative accommodation within twenty four hours. The residential care unit was vacated and later closed down after the Commission for Social Care Inspection (CSCI) had issued a Section 20 notice. It no longer operates as a care home.

Subsequently, the multi agency adult protection processes were activated, leading to an investigation that culminated in members of Medina Road staff being successfully prosecuted by the police. The Court action concluded in March 2007.

Islington's Safeguarding Adults Partnership Board, commissioned the Serious Case Review under the auspices of its Serious Case Review Policy. The review was conducted by Professor Hilary Brown (an expert in the field of safeguarding adults). The review was overseen by the Islington Safeguarding Adults Partnership Board with the intention of maximising organisational learning, improving the responsiveness of existing systems to early warning signs and concerns, and strengthening multi agency procedures to investigate and respond to incidents where vulnerable adults have been abused.

Summary of review findings

Professor Brown's investigation was thorough and the findings wide ranging. This summary of review findings groups findings under relevant headings for ease of reading.

Service users

- The swiftness with which action was taken following the receipt of the alert eclipsed consideration of the longer term needs of the service users for therapeutic follow up. Work is continuing with service users to ensure their needs are met. Independent advocates will be provided if required.

- There was significant media interest in this case at both national and local levels. The judge's decision to refuse a press embargo allowed the names of service users to be published.

Medina Road Staff

- All staff were suspended following the alert including those who had found the courage to raise their concerns. Support and acknowledgement to those who provided helpful evidence to the investigation should have been more visible.
- Staff at Medina Road did not have the skills, experience or knowledge to work successfully with this demanding service user group. Some did not have sufficient English to communicate successfully at work.
- A number of complaints about racism directed at staff by service users were addressed in the context of the service users' challenging behaviour rather than as a wider organisational issue that may have been best addressed through training and support for black staff in particular.

Professional staff

- Health professionals should have been more alert to adult protection concerns and aware of their professional responsibilities, as laid down by their respective professional bodies, to report concerns about abuse through their clinical and managerial lines of accountability.

Organisational issues

- All of the placements at Medina Road had been made on a "spot purchase" basis. Four individual contracts were in place and reviewed separately by the placing authorities. There was no formal contract monitoring mechanism in place for the whole of this service. Other boroughs were also placing residents in the service and Islington, as the service's host authority, was not exercising this function on behalf of others.
- It proved difficult to obtain information, regarding Medina Road and Craegmoor Healthcare, from CSCI. Papers were only produced after a request under freedom of information regulations was made by Islington Social Services.

Recommendations

Professor Brown presented her findings to Islington Safeguarding Adults Partnership Board (ISAPB) in February 2008.

The recommendations form the basis of an Improvement Plan. Progress against the Improvement Plan is monitored by Islington Safeguarding Adults Partnership Board. As a further safeguard these monitoring arrangements and processes are scrutinised by external partner organisations.

Service users

Advocacy services to support victims of abuse should be made available, especially in the event of legal proceedings. This must include appropriate use of the Independent Mental Capacity Advocacy (IMCA) Service for people who lack capacity to make decisions and are "unbefriended", i.e. have no family or friends able to inform professionals about the best interests of the service user.

The appointment of an independent legal adviser or the involvement of the Official Solicitor should be pursued on behalf of service users, if necessary, in the event of legal proceedings taking place.

Victim support organisations should be invited to take part in the ISAPB and offered places on training, to ensure they are equipped to offer their services on an equitable basis to people with disabilities, of all ages and ethnicities across the borough.

Islington Safeguarding Adults Partnership Board (ISAPB)

The ISAPB should work to establish a protocol for information sharing within the Council and with other partner organisations. It must be robust and responsive in respect of identifying and channelling adult protection concerns to appropriate staff.

A managed repository for quality of care concerns generated by individual reviews should be established to collate data from a variety of sources.

The Chair of ISAPB should again raise the issue of the tension between local regulatory responsibility and national intelligence on national organisations such as Craegmoor Healthcare. There is a need to enable local information to be collated and used appropriately on a national basis.

The ISAPB should promote a non-judgemental, non-discriminatory approach to learning disability through training and other routes.

The ISAPB should ensure that officers, through appropriate training, are confident in calling for all legal remedies to be made available and used appropriately during the course of an investigation.

The ISAPB should share best practice across partnership organisations, for example, through the dissemination of policies and procedures for adaptation and adoption, such as the whistle blowing policy.

Partner organisations

Health colleagues need to be particularly aware of their responsibilities to support service users in failing services. Health colleagues must also ensure they know their responsibilities to raise adult protection concerns.

All care providers and partner organisations should have "whistle-blowing" policies for in-house staff that enable them to identify and channel adult protection concerns appropriately.

These policies should also outline the support that whistle-blowers can expect from their organisations.

A collaborative approach to quality monitoring is required across all partner organisations. Staff must know that failure on the part of a provider to implement professional guidance should be seen as a cause for concern and reported.

Multi Agency Safeguarding Policy and Procedures

The review showed that Islington's whistle-blowing policy was not shared across agencies or owned by the ISAPB. It was not widely disseminated or insisted upon through commissioning for block or spot contracts. A revised policy should be promoted with both staff and public.

The ISAPB should provide advice to staff on the use of photographic evidence in safeguarding alerts and investigations.

Current policy documents define safeguarding processes. However, a thorough review of Islington's Multi-Agency Safeguarding Adults Policy should be undertaken. The review should take into consideration the complexity of cases and develop timescales for responding that are appropriate to the individuals involved.

Training

There should be more training for direct care staff on challenging behaviour and clear plans about how to address difficult behaviour. Maintaining appropriate records of all intervention is an essential activity for care staff and staff should be trained to undertake these tasks.

Accountability should be a theme within all safeguarding adults training.

Housing and Adult Social Services Department

<u>Islington Learning Disabilities Partnership (ILDP)</u>

The ILDP should strengthen its processes for reviewing services, particularly where those services are already causing concern.

Where ILDP is reviewing out of borough placements any adult protection concerns should be reported to Islington's Adult Protection Co-ordinator who will then liaise with the host authority.

The use of appropriately skilled and supported care managers or clinicians to assess and evaluate the outcomes of individual person centred care plans is an essential part of safeguarding.

Commissioning and contracting responsibilities

Commissioners should develop enhanced monitoring arrangements for homes accommodating people with challenging behaviours, paying attention to enhanced contract specifications and policies relating to physical interventions.

Conclusions

Staff in Medina road were ill-equipped and not adequately supported within the organisation to deal with the challenging behaviours of service users.

In the past and at the time of the incident, reports and concerns made and received by various agencies were not properly collated, so the complete picture of poor practice was not seen.

Once the abuse became public, it was investigated and those staff who had perpetrated the abuse were prosecuted. Service users were protected.

Improvements have already been made at local and national levels. Locally the safeguarding process is more developed and more widely publicised, which will support those who are trying to bring this kind of continuing service failure into the open.

This review is confident that there are safeguards in place that make this kind of event less likely in future.

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