EXECUTIVE SUMMARY

Dorset, Bournemouth & Poole Safeguarding Adults Board

Serious Case Review Group

MULTI-AGENCY CASE AUDIT:

Agency responses to safeguarding concerns affecting residents at Purbeck Care Ltd, a registered care home in Dorset for adults with learning disabilities.

Executive Summary Report of Audit Findings

Independent Audit Facilitator: Richard Corkhill

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MULTI AGENCY CASE AUDIT IN RESPECT OF PURBECK CARE LTD

1) PURBECK CARE

Purbeck Care (PC) was a registered care home for up to 52 individuals with a learning disability, whose needs are complex and challenging. It was located in a rural area of Dorset. In November 2012, PC had 40 residents. 7 people had been placed by Dorset County Council and 3 by Dorset Clinical Commissioning Group[1]. The remaining 30 residents had been placed by commissioning bodies from various parts of the country.

2) SUMMARY OF CONCERNS LEADING TO DECISION TO CARRY OUT A SERIOUS CASE AUDIT

In November 2012 a new staff member ("whistle blower"), raised a safeguarding alert about patterns of abusive and neglectful behaviour by a number of staff members, towards residents. Some months earlier (July 2012) there had been a previous whistleblowing incident, when a staff member had subjected a resident to a prolonged episode of physical and verbal abuse. The perpetrator of that earlier incident was prosecuted with ill treatment and neglect, under Section 44 of the Mental Capacity Act. He was convicted and received a prison sentence.

Following the November whistle blowing incident there was a Pathway 4 (whole service) investigation, as there were strong indications that poor governance and management practices had contributed to an organisational culture which had failed to safeguard residents from serious harm. Examples of concerns highlighted included a history of allegations of physical and verbal abuse of residents by staff members; resident on resident violence; incidents of self-harm; financial abuse; physical neglect; lack of choice of diet; poor hygiene in kitchen areas; care plans not in place or not being put into practice; inadequate access to primary health care. Records showed that there were many incidents which should have resulted in safeguarding alerts, where no such alert took place. This was particularly an issue with incidents of resident on resident violence and allegations of theft and financial abuse.

[1] The Dorset CCG was a PCT at the time.

The investigation highlighted that evidence of such concerns had been present for a significant period of time (at least from January 2011, but probably much longer) but had not been properly recognised or effectively acted upon by statutory partners with adult safeguarding responsibilities.

The Dorset Bournemouth and Poole SCR Group considered the circumstances of this case on 28th November 2013. It was felt that the most effective way of drawing out lessons would be through a multi-agency case audit.

3) AUDIT TERMS OF REFERENCE AND METHODOLOGY

The SCR Group established the terms of reference for the audit, which are set out in detail in the full report. This included the following elements:

- The effectiveness of the multi-agency response to safeguarding referrals
- The volume and characteristics of the safeguarding alerts and referrals
- The circumstances and management of the whistle blowing notification
- The existence and treatment of other forms of information that might cause concern
- How commissioners fulfilled their duty of care
- The role of the Care Quality Commission
- The policy, procedures, operational practices and governance of Purbeck Care

The audit included three case audit meetings, facilitated and recorded by independent consultant Richard Corkhill. Participation in these half day events included commissioners, practitioners and operational managers from local authorities (Poole, Bournemouth & Dorset) NHS trusts, Care Quality Commission, Police, Fire and Rescue and Ambulance services.

There were also individual meetings with key partners, including valuable contributions from managers of Dorset Advocacy and Dorset People First, both of which had had significant involvement with PC residents, over a number of years.

SUMMARY OF KEY LEARNING POINTS

The full report provides a more detailed description of events at PC, together with analysis of multi-agency involvement with the service as a whole and with individual residents. The following is a summary of the most important learning points arising from the audit:

Key learning point 1

Low level incidents & cumulative evidence of risk:

There was a history of incidents of resident on resident violence at PC. That the majority of such incidents led to no serious injuries was probably a factor in staff and managers not recognising the requirement for safeguarding alerts. However, if the triage service had received alerts following every incident, this would have provided more cumulative evidence of risk. The risk would not only be from significant physical injury – which in fact did happen to one resident who suffered a fractured hip and arm - but also from psychological and emotional harm to residents who may have been living in fear of violence from fellow residents.

The same principle applies to allegations of thefts of residents' money and other property, including the potential psychological harm caused to residents who do not feel that their money and personal belongings are secure in their home environment. Whilst an isolated and unproven allegation of a theft of a resident's property may have limited significance, when similar allegations are repeated by different residents over a relatively short period of time, this should raise serious concerns about the ability of the service to provide a safe and secure home for vulnerable people. If the triage service is not notified of each incident, the nature and level of risks within the establishment is unlikely to be properly identified.

Key learning point 2

Clarity and consistency of alert thresholds:

There was a lack of clarity - and therefore consistency - around thresholds for safeguarding alerts, notifications and referrals to the Safeguarding triage service. This may indicate a need to revise / clarify the Multi-Agency Safeguarding Adults Policy and Procedure in this area. This problem is compounded by confusion about the terminology used, with terms such as *alert / referral, vulnerable adults referral* being used interchangeably by different agencies. Some commonly agreed terminology and definitions, to be included in multi-agency adult safeguarding training programmes, would assist in establishing more consistent approaches.

Key learning point 3

Need for effective IT data base systems:

One factor in the failure to recognise a body of concern was that the triage team's computerised recording system is apparently unable to extract historical data on alerts relating to an individual residential care home, as the system is only able to search according to the victim, rather than their place of residence. This appears to be a very basic and fundamental design fault, meaning that it is less likely that potentially significant patterns and trends of safeguarding alerts within a residential establishment will result in effective investigation and actions to safeguard vulnerable residents.

Key learning point 4

Risk assessment training, skills and resources

Whilst the above is a key learning point, it is also important to emphasise that this is not simply an IT systems problem. Whatever manual or electronic recording systems are in place, it is essential that staff are sufficiently resourced, trained and supported and skilled to evaluate risk based on all of

the relevant evidence relating to a residential care home, including historical alerts.

Key learning point 5

Whistle blowing policies & procedures

Staff members at PC did "blow the whistle" which may be a positive indication that whistle blowing policies and procedures were effective in this case. It is also noted that this case emphasises the value of regular checks (by contract monitoring staff and through CQC statutory inspection processes) that providers have effective whistle blowing policies and procedures and that staff at all levels have a good awareness of - and confidence in – them.

Key learning point 6

Systematic sharing and collation of concerns:

The Quality Monitoring Group is a positive initiative, aimed at sharing key information and ensuring that commissioned care services deliver the highest quality care possible. The evidence from the audit confirms that many organisations had what may be described as 'low level' concerns about standards of care provided to some PC residents. If all of this information had been more systematically collated and presented to the Quality Monitoring Group, this may have led to more assertive investigations and interventions, at an earlier stage.

Key learning point 7

Cooperation between CQC & local commissioners / contract managers:

This case has confirmed ongoing concerns about a sense of "disconnect" between CQC as the statutory inspectorate for registered care services and local commissioners, contract management & monitoring functions. There is a clear need for all parties to improve levels of communication, cooperation and

sharing of local intelligence. CQC is a key member of the Dorset-wide Care Quality Monitoring Group, which the audit process has identified as an example of good multi-agency practice. However, the evidence reviewed by the audit suggests that there is still major room for improvement in this area, including the need for CQC inspectors to more proactively seek and utilise intelligence from local agencies (e.g. care managers, commissioners, contract managers, adult safeguarding leads, advocacy services) as an important element of the inspection and quality evaluation process.

The audit also found that more continuity of CQC managers and lead inspectors would assist greatly in establishing effective multi–agency approaches to safeguarding vulnerable care home residents.

Key learning point 8

Commissioning local services for local citizens:

The issue of *"local services for local citizens"* highlighted by the Winterbourne View enquiry[2] is of direct relevance to learning from this case. The audit groups expressed a consistently strong view that the model of an institution placing large numbers of vulnerable people with complex needs in a single and geographically isolated location is fundamentally flawed. Although the location for the 10 people placed by Dorset County Council and the Commissioning Group could be described as "*local*", the fact of being in a geographically isolated (from local communities within Dorset) institution with such large numbers of other people with complex needs makes it an extremely difficult environment in which to deliver safe, person centred care and support.

A related concern is that all of the residents at PC, including those placed from other parts of the country require local services, including the Community Learning Disability Team, primary health care, community nursing and hospital services. Similarly, as the chronology clearly demonstrates, PC

[2] Conclusions from the Winterbourne View Hospital Serious Case Review, carried out by Margaret Flynn on behalf of South Gloucestershire Safeguarding Adults Board, 2012

residents also need (and are fully entitled to) significant levels of input from the police and other emergency services. This creates increased demands on local services and resources, which is likely to impact negatively on the level of provision available to local citizens.

Learning point 8 raises the question: Given that people are usually placed at institutions such as PC because they have complex needs, "challenging behaviours" and are "difficult to place", what economically viable alternatives can be commissioned locally?

Key learning point 9

Creative person centred commissioning:

There is no simple answer to the above question. However, one of the audit contributors provided an excellent example of what can be achieved, with input from a skilled care manager and creative person centred commissioning:

A previous resident of PC with challenging behaviours has moved to a community based setting, with an intensive support package. Since the move his individual needs have been more appropriately met, with the result that his behaviour is now significantly less challenging. The cost of the intensive support package is approximately £1500 per week less than his placement at PC. It is anticipated that his support needs may reduce as he becomes more settled in his new living environment.

Other potential commissioning ideas put forward by audit group participants included:

- **Small residential units of 4 to 6 people per unit, with a large majority of residents from the local community, including some crisis beds.**
- **Payments by results contracts which reward positive outcomes**
- **Requiring providers to have family / service user representation on management boards**
- **Ongoing quality checks by advocacy services / experts by experience.**

Key learning point 10

Unmet need for emergency placements:

The audit findings suggest that there is an unmet need for a small locally based service, which could provide short term emergency placements for people with learning disabilities and complex needs who are in crisis and unable to remain in their current accommodation. This would provide a period of respite and an opportunity for a person centred assessment of need, including consideration of the views of family members and informal carers. It would also reduce the frequency with which people are placed at services such as PC by "default", but subsequently stay as a long term resident, even when the service is unable to meet their assessed needs.

Key learning point 11

Listening to / acting on concerns raised by advocacy services:

There is evidence that advocacy services had been raising some very serious concerns about standards of care delivered at PC over a number of years, but little evidence that such concerns were listened to or acted upon, by commissioners. Independent advocacy services going into establishments such as PC and working directly with residents (in groups or 1-1 contacts) should be a major factor in preventing harm and promoting a positive caring home environment. It is important that every care home resident has access an independent advocate, if they need and want one. It is even more important in an establishment such as PC, where most residents are living many miles away from relatives, and informal carers whilst a significant number do not have any contact from relatives.

However, the ability of advocacy services to effectively promote a safe and caring environment depends very much on commissioners listening – and acting assertively – when these services raise the types of concerns outlined above.

Key learning point 12

Devolved management structures & accountability gaps

The devolved management arrangements at PC were an important factor leading to poor quality management practices, for which there was a lack of clear accountability. This was ultimately the responsibility of PC's Board of Directors who had made the decision to contract operational management to another company. However, it was also the responsibility of commissioners and contract managers to be aware of such management arrangements and the potential issues of accountability that may arise from them.

When the new PC management team acknowledged that some residents' needs could not be properly met, this was a very positive sign that the service was now prioritising residents' safety and wellbeing, over income generation. However, it also raises the question of why this had not already been recognised and acted upon, by care managers, contract managers and commissioners.