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.

Serious Case Audit Findings

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# MULTI AGENCY CASE AUDIT IN RESPECT OF PURBECK CARE LTD

## 1) Introduction

Purbeck Care (PC) is a limited company and a registered care home for up to 52 individuals with a learning disability, whose needs are complex and challenging. It is located in a rural area, some distance from the nearest town. It is not well served by public transport and is geographically isolated from local communities. The premises are divided into four accommodation areas and a one bedroomed self contained studio. The home is set within extensive grounds which are well maintained.

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, including 3 London Boroughs. In total, there were 16 different agencies commissioning residential placements at PC.

In November 2012 a XXXXXXXXXXXXXX member of staff at PC, acting as a “whistle blower”, raised a safeguarding alert. The whistle blower XXXXXXXXXXXXXXXX was disturbed by what they were observing on a daily basis. The alert included the following reported experiences of 4 residents, as witnessed by the staff member:

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

*20 year old Male A*

*Male A is to have constant one to one care and self harms if left alone, when he screams or hits himself he is pushed and pulled about and then taken outside no matter what type of weather and on occasion had no shoes or coat on. When self harming he is verbally threatened to be put outside he also has his toys snatched away from him for long periods of time. Certain staff have also sworn at him and told him and myself that "they hate him".*

*34 year old male B*

*Male B XXXXXXXXXXXXXXXXXXXXXXXXX when supported by staff is pulled to go faster and hits himself on doors, tables and entrances. He is then left on his own all day in the corner on his sofa or sometimes just on the floor. He has no activities for the visually impaired and just has to play with Children's toys. He has the habit of hitting and scratching himself to cause self harm and also with spoons when eating. Nobody interacts with him or helps him in any way.*

*44 year old Female C*

*Female C is left either in her room or in the dining room screaming for a number of hours and staff just shout at her to be quiet when she is thirsty and asks for a drink, nobody gets her one as its not time yet and she is left waiting.*

*36 year old Male D*

*Male D gets pushed away and shouted at by staff if he goes to hold their hand or even just places it on their shoulder. If he sexually touches himself, nobody encourages him to wash his hands or even when he has been to the toilet. They have said that he is disgusting and not to let him touch anything or anyone.*

In addition to specific concerns about these 4 residents, the whistle blower also made general observations about conditions within the accommodation unit in which they lived, including:

- Accommodation, kitchen areas and toilets in a dirty condition.
- Night time cover provided by 1 staff member for 7 residents sleeping in bedrooms on 2 different floors. This was despite the fact that one resident needed constant one-to-one care and another resident was vulnerable to fits.
- A staff member falling asleep at work as a result of heavy drinking the previous evening, then being allowed to go home early, because the team leader felt sorry for him.
- The manager of the unit being aware of these concerns, but not taking any actions to address them.

A review of previously reported safeguarding alerts and incidents was undertaken, as part of the investigation into this whistle blowing alert. A matrix provided to the investigator by PC showed a history of 35 safeguarding alerts in the period from January 2011. However, it was noted by the investigator that the matrix did not include a number of recently reported resident on resident assaults, or alleged thefts of residents' money.

Some months before the November 2012 whistle blowing alert there had been a very serious incident. In July 2012 a male staff member subjected a female resident to a prolonged period of physical and verbal abuse. Following this incident, Dorset County Council placed a block on funding any new placements at PC. It is understood that this block remains in place.

The perpetrator of the July 2012 abuse incident was suspended and subsequently dismissed. He was charged with ill treatment and neglect, under Section 44 of the Mental Capacity Act and in April 2013 he was sentenced to 6 months imprisonment.

Other areas of concern were highlighted in the course of the investigation, following the whistle blowing in November 2012. These included:

- A number of allegations of residents being physically assaulted by staff members. Unlike the July 2012 incident, police investigations into each of these allegations had found insufficient evidence for any criminal charges to follow. These allegations related to a number of different staff members and residents.
- Allegations of verbal abuse of residents by staff members. Again, these related to different alleged perpetrators and a number of different residents, but did not result in any criminal charges.
- Historically, there had been allegations of thefts of money from residents. The sums of money involved were unclear, but an email seen by the investigator referred to a sum of £4206.82. The investigator recorded concern that not all of the monies had been repaid to residents since the thefts had occurred, observing that the company were in the process of doing so via BACS only after she made enquiries.
- In one confirmed case, a staff member had made unauthorised withdrawals from a resident's bank account. The offender was successfully prosecuted and in January 2013 received a community sentence.
- Reported incidents of resident on resident assaults, one of which resulted in serious injuries, including a broken hip and a broken arm.
- Reports of self harming behaviour by residents.
- Residents being transported in poorly maintained vehicles, sometimes driven in a dangerous manner by a staff member

A more detailed picture of reported safeguarding alerts and concerns relating to PC residents between January 2010 and November 2012 is provided by the chronology at appendix 1(REDACTED – Not included).

It was decided that PC should be subject to 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. Detailed findings from the Pathway 4 investigation are in the investigating officer's report (appendix 2 – REDACTED –Not included). Areas of concern highlighted in this report include:

- Significant gaps in staff training and knowledge, resulting in staff not being able to work safely or effectively with residents who had an array of complex needs, both physical and mental.
- Lack of clear recording of needs assessments and care planning, resulting in lack of evidence that assessed needs were being met.
- Limited access to meaningful activities.
- Lack of recording of health needs or of evidence that health needs were being met through referrals to specialist health services.
- Lack of planning for the care of elderly residents as they were becoming increasingly frail.
- Overall provision of food and beverages extremely poor.
- Kitchen and dining room areas poorly maintained and dirty.
- 13 members of staff had criminal convictions – two of whom were currently suspended as a result.

21 new safeguarding alerts were generated during the approximate 3 month period of the Pathway 4 investigation. This included a partially substantiated report of inappropriate restraint, where a staff member was observed to intervene with a resident who was attempting to self harm, but where it was acknowledged that further guidance and training in the area of restraint was needed.

There was also a further whistle blowing alert at the Stable Cottage unit of PC. The concerns raised included lack of knowledge around medical conditions, poor care planning and a  failure to share information, an unwillingness by staff to

engage with the service users, repeated use of mobile phones whilst on duty, and repeatedly telling service users to “shut up”, “be quiet” and “sit down”.

The audit process has acknowledged that this was a service accommodating up to 52 people with learning disabilities, some of whom had very complex physical, mental health and emotional needs. Any service of this nature could be expected to generate significant numbers of incidents, alerts and concerns. Indeed, had there been only a very small number of alerts, this might have raised suspicions that incidents were being deliberately covered up by PC staff and managers.

The Pathway 4 investigation also reported some positive findings. These included:

- Evidence that the new management team, which had been appointed by PC following the whistle blowing alert in November 2012, were working hard to achieve improvements.
- Some individual staff members were delivering good quality care.
- Some long term residents described themselves as being settled and happy at PC.
- Two residents in single occupancy bungalows reported their needs were well catered for, staff had a good understanding of their needs and that they had a good quality of life and support from a multidisciplinary community team.
- The newly appointed Interim Director acknowledged that the complex needs of some residents could not be adequately met by PC. This was agreed by the relevant purchasing authorities, who were working to assess needs and transfer residents to accommodation and care services better suited to meet these needs.

**2) Decision to carry out a Serious Case Audit**

The Dorset Bournemouth and Poole SCR Group considered the circumstances of this case on 28th November 2013. The Group were concerned by what had

occurred and felt there was considerable learning to be drawn from it. On this occasion it was decided not to undertake a traditional SCR although the circumstances fulfilled the criteria for an SCR. It was felt that a more effective way of addressing the issues would be through a multi-agency case audit, process overseen by the Serious Case Review Panel.

## 3 Terms of Reference

The SCR Group agreed that the case specific elements to be considered by the audit should include:

**a)** The effectiveness of the multi-agency response to safeguarding referrals in respect of service users in Purbeck Care, measured against the expectations set down in the Safeguarding Adults Board policy and procedures for the management of safeguarding alerts.

**b)** The volume and characteristics of the safeguarding alerts and referrals and whether and how these may have been treated as a body of significant concerns rather than as individual safeguarding episodes.

**c)** The circumstances and management of the whistle blowing notification and the operational effectiveness of the inter-organisational responses to the concerns raised. This aspect will also test the adequacy of existing whistle blowing policies and procedures and their relationship to safeguarding.

**d)** The existence and treatment of other forms of information that might cause concern such as might emerge from:

- General Practice services
- Interventions from secondary services e.g. CPNs and NHS
- Continuing Healthcare reviews
- Reported injuries to patients
- General Hospital attendances

- Police and ambulance notifications/attendance at the site.

**e)** The role of the Care Quality Commission as the regulator of care at Purbeck Care and the effectiveness of regulatory activity, including the operation of the inspection regime.

**f)** How commissioners fulfilled their duty of care in placing, monitoring and reviewing the welfare and progress of individuals at Purbeck Care as well as the contract monitoring and compliance of the provider.
The relevance of, and compliance with, legislative duties and guidance, including the Mental Capacity Act 2005.
Additional areas of examination are likely to include:
The presence of pro-active measures related to the vulnerability of service users, such as the involvement of relatives and carers and access to and provision of advocacy in particular, Independent Mental Capacity Advocates.

**g)** The policy, procedures, operational practices and governance of Purbeck Care; in particular, those that are most pertinent to securing the safety, health and wellbeing of service users.

**4) Chronologies and time parameters**

As specified by the SCR Group, the audit has considered the period from 1 January 2010, until 1 November 2012. Chronologies of contacts and involvement with PC residents during this period have been provided by the following agencies:

- Dorset County Council
- Poole Borough Council
- Bournemouth Borough Council
- Dorset Clinical Commissioning Group
- Dorset Healthcare University Foundation Trust

- Dorset Police
- South West Ambulance Service Trust
- Dorset Fire and Rescue
- Care Quality Commission

**5) Methodology:**

The audit process was led and facilitated by independent consultant Richard Corkhill (report author) with planning and coordination provided by David Buggins, Safeguarding Partnership Officer for Dorset County Council. The process has included the following activities:

**Documentary review / case familiarisation:** This was a review of documentary evidence about safeguarding concerns at PC, during the period in question. Records seen include the initial safeguarding investigation report following the whistle blowing referral in November 2012; a summary report of findings from the Pathway 4 investigations and minutes of safeguarding case conference and strategy meetings, at which these reports were considered. The combined chronologies produced for the purposes of case audit (see section 4 above) have also closely informed the audit process, along with close reference to the Dorset Bournemouth and Poole Multi Agency Safeguarding Adults Policy and Procedures document (October 2013 version). Reference has also been made to CQC reports of inspection findings at PC.

**1-1 Discussions:** The Independent audit facilitator had one-one discussions with:

- David Pennington: Independent Chair of Safeguarding case conferences regarding PC.
- Sally Wernick: Dorset Safeguarding Team: Lead investigator for the Pathway 4 investigation.

- Sue Hawkins: Dorset County Council. Involved in Pathway 4 investigation, specifically around issues of nutritional and food hygiene standards.
- Nicky Mann: Chief Exec. Dorset Advocacy - Provider of 1-1 advocacy services, including work with some PC residents.
- Clare Tarling: Dorset People First – Advocacy services, including working with groups of PC residents and Quality Checkers.[2]

**Case audit meetings:**

There were 3 independently facilitated (half day) case audit meetings, with multi-agency representation from each of the agencies which had provided chronologies, as detailed at section 4 above.

There were between 9 and 11 participants at each of the 3 sessions. The groups were mixed by agency and roles within agencies, in order to promote contributions and joint learning outcomes from a range of perspectives, including:

- Front line operational staff
- Operational and strategic managers
- Contracting and commissioning personnel

Each session followed a similar format and structure, guided by the lines of enquiry as set out in the Terms of Reference. The sessions included small focus group work, feedback and wider group discussions, all of which were informed by an initial presentation of key events and issues arising from the combined chronology. The sessions concluded with the full participant group producing a record of key learning points.

[2] Quality Checkers are "experts by experience" who evaluate services used by people who have learning disabilities.

**Written report of key learning points and recommendations:** This report has been authored by the independent facilitator, based on records of each of the activities outlined above. It draws on wide ranging experiences, views and opinions from across many different agencies and professional groups. As such, it can not be assumed that all of the findings, key learning points and recommendations in the following sections will have complete and unanimous agreement from all of those individuals (and the organisations they represented) who contributed to the audit process. This report is an independent summary and overview, based on the author's understanding of key issues and learning points which were highlighted by the audit.

## 6) Summary of incidents and concerns from audit chronology

The following tables are a summary overview of significant safeguarding concerns and alerts, based on agency chronologies for the period 1/01/10 to 1/11/12. The combined chronology (appendix 1 – REDACTED – Not included) provides additional detail of dates and agency responses.

| ***Staff on resident violence & verbal abuse:*** |
|---|
| ▪ 8 separate allegations of physical abuse, 2 of which included verbal abuse<br>▪ 3 separate allegations of verbal abuse<br>▪ The allegations cover several different service users and staff members<br>▪ 1 criminal conviction following incident in July 2012 (See section 1 / summary of safeguarding concerns<br><br>Some of the above incidents did not result in generation of safeguarding alerts. In total there were 7 alerts / police vulnerable adult notifications for this type of incident. |

***Resident on resident violence:***

- 10 reported incidents
- Mostly minor or no reported injuries
- 1 incident (July 12) resulted in serious injury, when a resident was pushed over and sustained a broken hip and a broken arm.
- Incidents involved several different victims and perpetrators, though one resident was responsible for a number of reported assaults

Most of these incidents had police involvement, but did not lead to safeguarding alerts being generated. There was a safeguarding strategy meeting following the July 12 incident.

I alert for resident on resident violence was raised by PC, in October 2012.
2 other alerts were raised by social workers. 7 incidents appear not to have generated any formal alert.

***Thefts from residents by staff members***

- 9 reported incidents, mostly unconfirmed or with no clear evidence on which to base criminal charges.
- Values up to £3000 (cash / property)
- Unauthorised bank withdrawals – conviction
- Staff member borrowed £25 from resident > alert raised, money paid back

The majority of incidents were investigated by the police but resulted in no further action. Most allegations did not result in any safeguarding alert or vulnerable adults notification, even with reported thefts of up to £3000.

In addition to reports of physical verbal and financial abuse, the chronology highlights a range of other areas of concern:

- 8 reports of self harming behaviour, at least one of which was a serious incident when 32 paracetamol tablets were reported to have been taken.
- An allegation of sexual abuse of a resident by staff member. This allegation was later retracted.
- Fires set by residents.
- Medication errors.
- Concerns about access to primary health care services
- Professional boundaries issues

## 7) Audit findings and key learning points

### 7.1 Introduction

This section of the report provides an overview of audit findings, highlighting key learning points. It is structured to address each of the lines of enquiry, as set out in the Terms of reference document:

### 7.2 The effectiveness of the multi-agency response to safeguarding referrals in respect of service users in Purbeck Care, measured against the expectations set down in the Safeguarding Adults Board (SAB) policy and procedures for the management of safeguarding alerts.

The audit found evidence that the Multi Agency Safeguarding Adults Policy and Procedures were not consistently implemented by all of the agencies involved:

***7.21 Failures to raise alerts when there was evidence of risk of significant harm.*** The following extract from the SAB policy and procedure document clarifies what *should* take place when a manager of a service becomes aware that a vulnerable service user is (or may be) at risk of significant harm:

**3.3.5.1 Procedures - Who should the Manager inform?**
If the alerting manager agrees that harm or neglect has taken or may take place and the following has not already been done, he or she should inform:

The Safeguarding Adults Contact Point in the Local Authority.

The police, if a crime has been or may be committed. Discuss risk management and any potential forensic considerations.

The unit or service manager responsible for the management of the service.

CQC if the adult is receiving care from a registered health or social care provider. Calls should be made to the National Contact Centre on 03000 616161(registered Manager).

The audit has identified a pattern of incidents where there was clear evidence of PC residents being at risk of significant harm, but no record to show that the local authority Safeguarding Adults Contact point (i.e. the triage service) or CQC were informed. For example, the combined chronology shows 6 incidents of alleged thefts from residents and 7 incidents of resident on resident violence, where there is no record of an alert being generated or received by the triage service.

It is fair to observe that only 1 resident on resident assault led to serious injuries and this did result in a formal alert (generated by PC) and a safeguarding investigation followed.

On occasions when the police were notified (presumably by PC staff, though this not clear from chronology entries) of allegations about resident on resident assaults or thefts from residents, investigations followed. The most common outcome was no further action from the police, either due to lack of evidence and / or because it was felt more appropriate to be managed as a ‘single agency matter’ by PC. It appears from the combined chronology that, in most cases of this nature, no referral or alert was received by the Adult Safeguarding triage service. The primary responsibility for raising such alerts was with the provider service, rather than the police. However, good multi-agency practice and

communication would have been for the police to confirm that the provider had raised appropriate alerts with the safeguarding triage service.

**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.**

The audit showed some clear inconsistencies in practice for generating safeguarding alerts and making referrals into the triage service. For example, when it was reported that a member of PC staff had borrowed £25 from a resident, this did (correctly) result in an alert which was sent to the safeguarding

triage. However, other allegations of theft of large sums of residents' money did not result in alerts or referral to triage.

**Key learning point 2**

***Clarity and consistency of alert thresholds:***

**This 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.**

The combined chronology shows 8 incidents where allegations were made that PC staff members had physically and/or verbally assaulted residents, plus 3 other allegations of verbal abuse. The allegations involved a number of different staff members and residents. It appears that[3] most of these incidents were reported to the triage service as safeguarding alerts. Most of the alerts did not lead to formal safeguarding investigations or strategy meetings, but were considered appropriate to be dealt with locally by the provider service.

One allegation resulted in a criminal conviction and prison sentence, thanks primarily to another member of staff who witnessed the incident and acted as a whistle blower. This was a particularly serious incident, involving a prolonged period of physical and verbal abuse. Clearly, the actions of the whistle blower are highly commended. This incident did result in a formal safeguarding investigation.

[3] Due to the limited detail of chronology entries, sometimes with different agencies making reference to the same incident, it is has been difficult to establish whether some incidents did or did not result in alerts being forwarded to triage.

**7.3 The volume and characteristics of the safeguarding alerts and referrals and whether and how these may have been treated as a body of significant concerns rather than as individual safeguarding episodes.**

As already outlined, the chronology shows a significant volume of safeguarding incidents at PC between January 2010 and November 2012. The majority of allegations of physical and verbal abuse of residents by staff members were reported to triage, but the evidence suggests that these were treated as isolated episodes, rather than as a body of concerns. After the very serious abuse incident in July 2012 there was a safeguarding investigation, but this appears to have viewed this as an isolated incident, rather than consider the possible significance of other allegations which had been made in recent months. It is notable from the chronology that a number of these allegations were of physical abuse of the same resident, by different members of staff.

**Key learning point 3**

***<u>Need for effective IT data base systems:</u>***

**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.**

### 7.4 The circumstances and management of the whistle blowing notification and the operational effectiveness of the inter-organisational responses to the concerns raised. This aspect will also test the adequacy of existing whistle blowing policies and procedures and their relationship to safeguarding.

The first whistle blowing notification was in relation to the serious abuse incident in July 2012. The initial response was effective in removing the abuser from any further contact with PC residents and ensuring an effective criminal investigation and prosecution of the offender. However it was not until the subsequent whistle blowing notification in November 2012 that a Pathway 4 whole service investigation was undertaken. Given all of the information from previous concerns and alerts generated during the period *prior* the abuse incident in July 12, this could have been recognised as an appropriate point at which to follow Pathway 4. Had this route been taken, underlying cultural and management problems at PC (for which there was already significant evidence) may well have been identified and acted upon sooner, which could have prevented the issues highlighted in November 2012. A closely related point is that a Pathway 4 investigation following the July 12 incident would have sent a positive message that whistle blowing concerns would be taken seriously.

**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.**

**7.5 The existence and treatment of other forms of information that might cause concern such as might emerge from:**

- **General Practice services**
- **Interventions from secondary services e.g. CPNs and NHS**
- **Continuing Healthcare reviews**
- **Reported injuries to patients**
- **General Hospital attendances**
- **Police and ambulance notifications/attendance at the site.**

It is clear from the chronology that a range of organisations held information of relevance to possible safeguarding concerns at PC. Some examples include:

- The Fire and Rescue Service called to fires set deliberately by service users, resulting in serious risks to themselves and others.
- Ambulance Service raising concern about a resident with pneumonia, questioning whether medical interventions should have been arranged sooner.
- Community Care Officer concerned re weight loss and resident stating they were unhappy with the food offered.
- GP practice reporting medication errors.
- GP practice recording concerns re hygiene and personal care of a resident.

- Advocacy services raising issues about service users not being listened to by staff and a lack of meaningful activities.
- OT concerned that resident unable to attend college due to logistical difficulties raised by PC.
- Contract monitoring concerns re care plans/ recording of supervision.
- A family member raising concerns with a social services care manager about a resident's independence not being actively promoted.
- Community Nurse concerned that she was not allowed access to see patient, without reasonable explanation from PC staff.
- GP concerned re patient taken to surgery after fall at PC the previous day. Patient had possible fracture, referred to A&E.
- Community Nurse concerned about professional boundaries issues after a resident attended a staff member's family party.

This is a small sample of reported concerns, extracted from the composite agency chronology. It is obviously beyond the scope and capacity of the audit process to investigate the detail of all agency responses to each of these concerns. However, this does highlight that many different agencies held information which was of potential relevance to safeguarding issues and investigations at PC.
There is a Dorset-wide Care Quality Monitoring Group, with senior representation including local authority commissioners and contract managers, Continuing Health Care (CHC) commissioners and CQC. A key purpose of this group is to ensure that quality of care issues relating to care providers are shared and that multi-agency strategies are in place to address issues and support providers to raise standards. The existence of this group is an example of good multi-agency practice. However, some audit session participants had previously been unaware of the group, which raised critical some questions about how effective it could be at collecting, collating and then disseminating intelligence relevant to safeguarding vulnerable adults receiving care services.

**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.**

**7.6 The role of the Care Quality Commission as the regulator of care at Purbeck Care and the effectiveness of regulatory activity, including the operation of the inspection regime.**

CQC had carried out inspections at PC in May and October 2009 and rated the service (under the previous rating system) as *"0 star / poor".* As a result of this rating Dorset CC had placed a block on any new funded placements. There were further inspections in April 2010, January 2011 and October 2011, which generally found that quality of service was improving:

The January 11 inspection found the service to be compliant with each of standards against which it was inspected:

- Outcome 1: *People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run*
- Outcome 4: *People should get safe and appropriate care that meets their needs and supports their rights*
- Outcome 9: *People should be given the medicines they need when they need them, and in a safe way*
- Outcome 12: *People should be cared for by staff who are properly qualified and able to do their job*

The October 2011 inspection was only in relation to Outcome 7, *"People should be protected from abuse and staff should respect their human rights"* PC was found to be meeting this essential standard.

CQC carried out a further inspection at PC in August 2012, following the serious incident of abuse of a resident in July 2012. Prior to this inspection, they had attended a multi-agency safeguarding strategy meeting arising from the abuse incident. The inspection (published 17/09/2012) found that PC was non-compliant with each of the essential standards covered by the inspection, as summarised in the report findings:

***From CQC inspection report published 17/09/2012 following an inspection visit on 14/08/2012:***

**Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights**
People did not always experience care and support that met their needs. People were also at risk of inappropriate or unsafe care because the assessment and planning and delivery of care did not meet their health and welfare needs.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**
The provider had taken steps to protect people from abuse. The provider took action when reports of alleged abuse were made. There were suitable arrangements in place to protect people against the risk of unsafe control or restraint .The policy on restraint was not clear on what unlawful restraint was which meant people may not be protected from abuse. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**
The provider had a system to identify, assess and manage risk to people and to monitor the quality of the service and people had the opportunity to give their opinion on the service. This system not as effective as it should be as there was no record that this information was analysed and appropriate action was being taken. Staff did not get structured support to cope when incidents occurred.

The provider was not meeting this essential standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

**Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential**
People were not protected from the risks of inappropriate or unsafe care. Records were not monitored to check the information recorded was accurate and appropriate. Inappropriate language had been used in care records and this had not been reviewed or addressed with staff. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

It is clear that the CQC's August 2012 inspection findings, whilst finding the service non-compliant with each of the standards it was assessed against, did not reflect the level of serious shortcomings and concerns which were highlighted by the whistle blower in November 2012 and confirmed by the subsequent Pathway 4 investigation.

CQC carried out a further inspection in January 2013, which found that the service was non-compliant with the standard, *"People should be protected from abuse and staff should respect their human rights".* The summary of this judgment stated that the provider was responding to allegations of abuse, but people remained at risk of inappropriate restraint. Enforcement action was taken in the form of a warning notice. The inspection also found PC to be non-compliant in the following areas:

- They were not taking appropriate steps to ensure that, at all time, there were sufficient numbers of staff to meet the needs of the people who used the service (Regulation 22)
- They did not have suitable arrangements in place to ensure that staff were appropriately supported through training to provide care and support to people safely and to an appropriate standard (Regulation 23).

Immediately following the Pathway 4 investigation, CQC carried out a further inspection (published May 2013, following an inspection visit on 9 -10 April) which found PC to be fully compliant in relation to the following areas:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Meeting nutritional needs
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Requirements relating to workers

(The only area of non-compliance was management of medicines.)

These findings gave rise to expressions of surprise by those involved in the Pathway 4 investigation, which had only just been completed at that stage and was almost entirely contradictory to CQC's findings. This raised some fundamental questions about consistency of approach, communication, cooperation and engagement with CQC in the Pathway 4 process. This was reflected in the minutes of a multi-agency "Lessons Learned" meeting (August 2012) which reviewed lessons from the investigation process. It was observed that active engagement and involvement of CQC in any future Pathway 4 investigations would be a very positive step. There had been some unsuccessful attempts to engage CQC with this investigation. CQC had been invited to attend the Lessons Learned meeting, but tendered apologies.

**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.**

**7.7 How commissioners fulfilled their duty of care in placing, monitoring and reviewing the welfare and progress of individuals at Purbeck Care as well as the contract monitoring and compliance of the provider.**
**The relevance of, and compliance with, legislative duties and guidance, including the Mental Capacity Act 2005.**

**Additional areas of examination are likely to include:**
**The presence of pro-active measures related to the vulnerability of service users - such as the involvement of relatives and carers and access to and**

**provision of advocacy in particular, Independent Mental Capacity Advocates.**

### 7.7.1 Commissioners and duty of care

The incident which resulted in a criminal prosecution under section 44 of the MCA had clear parallels with Winterbourne View, though the Pathway 4 investigation into PC did **not** find the same *extreme* degree of entrenched poor standards, abusive practices and negative organisational culture, which the Winterbourne View SCR describes. It is also noted that Winterbourne View was (nominally at least) a hospital, selling placements to NHS commissioners, while PC is a residential care home, with placements funded by both NHS and council social services commissioners.

Having said this, the Winterbourne View enquiry made observations about the commissioning of services for people with learning disabilities and complex needs, which are equally pertinent to key learning arising from events at PC:

*"The foundational value of nurturing local services for local citizens, most particularly those who are perceived to be "hard to place" will need to be asserted by Clinical commissioning Groups"*[4]

Clearly, from the perspective of Dorset CCG[5] and Council commissioners, PC *is* a local service, which may raise the question of why the above observation has relevance. A key point is that it is a local service, but is not exclusively for local citizens and is not well integrated with local communities. As such, the business model can be assumed to depend on being a large service, needing to maintain high occupancy levels of people who have complex needs and therefore attract relatively high fees. (It is understood that weekly fees at PC are typically in the

[4] Conclusions from the Winterbourne View Hospital Serious Case Review, carried out by Margaret Flynn on behalf of South Gloucestershire Safeguarding Adults Board, 2012
[5] The Dorset CCG was a PCT at the time.

region of £3000 per resident, though the serious case audit has not had access to any commercially sensitive data).

**Key learning point 8**

***<u>Commissioning local services for local citizens:</u>***

**The issue of *"local services for local citizens"* highlighted by the Winterbourne View enquiry 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 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.**

#### 7.7.2 Relatives & carers

The issue of local services for local citizens already highlighted is of obvious significance in considering the involvement of family members and informal carers when making commissioning decisions for individual service users. Where residents are placed many hundreds of miles away from their families, this greatly reduces the possibility that family members will notice any issues of service quality shortfalls or incidents of abuse or neglect.

There is widespread agreement that commissioners should engage with families and informal carers about wider commissioning plans and strategies, as well as decisions about individual placements.  However, in many cases, the reality has been that PC was the only provider willing to offer a placement, due to an attached “label” of complex needs / challenging behaviour. Audit group discussions with care managers and commissioners confirmed that placements at PC had often been *“Friday afternoon crisis”* situations, following a breakdown in family relationships or a placement breakdown due to behavioural issues. Faced with the reality of potential homelessness and / or criminal justice interventions, a very vulnerable person with only a single option for placement, it is understandable that family and carer’s views about the needs of the individual are not prioritised.

**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.**

### 7.7.3 Advocacy services, Mental Capacity Act and IMCAs

Two local advocacy services had involvement with residents at PC:

**Dorset People First (DPF)** works with groups of people with learning disabilities, to facilitate and encourage self-advocacy approaches. They also have a team of Quality Checkers who are experts by experience. Quality Checkers can carry out

evaluation visits to care homes for people with learning disabilities. **Dorset Advocacy (DA)** provides the IMCA service and a general advocacy service.

Findings from the audit, which included inputs from both DPF and DA, confirmed that there had been active input with individuals and groups of residents at PC, over a number of years. It is also clear that both advocacy services had, over a period of several years, raised concerns with commissioners about the quality of care delivered there. Some of the concerns raised by DPF (for which they have provided some documentary evidence of e mail communications Dorset County Council commissioners) were about specific safeguarding incidents, whilst others were more general concerns about the quality of care and the physical living environment. Examples from correspondence in November 2011 include:

- Issues of physical isolation and lack of links with local community
- Numbers of out of area placements, with no contact from placing authorities
- Staff using disrespectful language when talking about service users, feeling of an “us and them culture” that is often antagonistic
- Elderly resident offered downstairs room which was then allocated to a new placement – suggestion that existing residents are moved / not moved, in order to create more attractive vacancies.
- Maintenance jobs can take a very long time – example of waiting months to have toilet door locks mended.
- Access to parts of peoples’ houses restricted due to staffing – sleep in staff at Stable Cottage have the lounge when their sleep in starts and the kitchen is locked at the same time.

This is a small selection of the concerns which were raised at that time.

**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.**

**7.8 The policy, procedures, operational practices and governance of Purbeck Care; in particular, those that are most pertinent to securing the safety, health and wellbeing of service users.**

There were some clear shortcomings in the governance of PC, which contributed directly to the events leading up to the Pathway 4 investigation and these a re summarised below:

**Operational management responsibility was devolved by the company directors to a care home management company.** The evidence from the

Pathway 4 investigation and contributions made to the audit process suggest that this arrangement contributed to an “accountability gap”, as directors were primarily concerned with monitoring financial performance, whilst responsibility for management of the service – and the safety and wellbeing of residents – was devolved to a separate company.

**Pressure to maintain occupancy levels.** In common with any business, PC’s financial viability and profitability was highly dependent on maximising income. Evidence presented to the audit process suggests that, at times, this imperative led managers to accept new placement of new residents who had very complex needs for which PC was not adequately resourced (e.g. in terms of staff to resident ratios, staff training and qualifications) to meet. Clearly, the relationship between the management company and Directors (see previous point) would have been a key factor. The impression gained from the audit process is that the Directors held the management company clearly to account in relation to income generation, but were less proactive when it came to accountability for the welfare and safety of residents.

To the credit of the Directors, following the November 2012 whistle blowing incident, the management company was discarded and the directors took back full control and responsibility. At this point they appointed their own management team and the early evidence from the Pathway 4 investigation was that this resulted in some significant improvements in how the home was managed. Perhaps most significantly, the new operational manager acknowledged that there were some residents whose needs could not be properly met by PC, and work was undertaken with care managers to identify suitable alternative care and accommodation.

**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.**