Executive Summary from the Safeguarding Adults Review into failures in the care and abuse of residents at a care home in Peterborough

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Introduction

About this report

This Safeguarding Adults Review (SAR) was commissioned by Peterborough Safeguarding Adults Board, on behalf of the partnership of agencies responsible for safeguarding adults-at-risk, in the city. It concerns serious failures in care in relation to older people and explores how a sub-culture of cruelty and disrespect arose that led to the prosecution of 5 individual members of staff and the dismissal of another two. The review focuses on an on-going pattern of verbal abuse and psychological cruelty that either went unnoticed, and/or was allowed to continue unchecked throughout 2013.

This home was also the focus of another significant safeguarding concern in relation to perceived failures in obtaining timely medical care for a specific resident who died in March 2013. Both reviews demonstrated how the home failed to have adequate care plans in place, and they provided evidence of the extreme vulnerability of these residents at the time of the abuse.

About the home

The home is a residential and nursing home and part of a wider network of national provision operated by a private, not-for-profit company. During this time there were a number of difficulties in providing clinical care to the very vulnerable adults living in the home but this was exacerbated by the fact that a small group of staff had formed a clique, acting without respect for clients, taunting them and handling them without using proper equipment or care. One woman was routinely being told, in response to her repetitive seeking of reassurance "Where am I" that she was in a brothel; she was also told that she was going to be killed at a certain time later in the day. This sustained cruelty crossed a line of decency that included abusive behaviour towards a visitor and sexual offences committed against two staff members.

How these issues came to light

The concerns were initially raised in October 2013 by an anonymous whistle-blower who informed a senior member of staff within Cambridge and Peterborough NHS Foundation Trust (CPFT). Mostly the victims were people

who lacked capacity and therefore came within the purview of the 2005 Mental Capacity Act, and specifically of Section 44 that made it an offence for a person to mistreat, or to wilfully neglect, a person who lacks capacity in their care[1].

The allegations were then made the subject of both an internal investigation carried out by a team from the provider under the guidance of ASC's safeguarding strategy meeting *and* a criminal prosecution on charges brought under Section 44 of the 2005 Mental Capacity Act. Seven members of staff were dismissed on the grounds that they had been guilty of gross misconduct. All seven were referred to the Disclosure and Barring Service (DBS) and should not be able to work in this sector again. Five of the seven were prosecuted, four were convicted. The fifth was due to be tried in the Crown Court but on his appearance, no evidence was offered by the CPS and the case collapsed apparently because the prosecution could not access care plans from the home. The CPS are in the process of reviewing their decision-making in relation to this case.

The offences were considered to be so serious that they resulted in custodial sentences, initially ranging from nine months to two years, but subsequently reduced on appeal. There has been considerable local and national interest in the media as a result of the court cases and this has caused reputational damage to the provider agency.

The Panel were keen to know whether there had been "warning signs" that could have alerted the company to the problems, allowing them to step in sooner. We learned from the police report that two of these care staff had a previous history of abusive behaviour and that these incidents had represented significant opportunities to "nip" the abusive behaviour "in the bud". During the investigation, the provider agency refused to share information about self-funding clients,- this was unhelpful and a barrier to safeguarding the very vulnerable people they serve.

[1] An **indictable offence** is more serious than a **summary conviction** offence. **Conviction** of an **indictable offence** exposes you to greater penalties. If you are prosecuted by **indictment**, you are entitled to trial by jury for most offences.

Allegations also emerged about sexual offences committed by one worker against two colleagues at work and he was dismissed after a formal disciplinary hearing on 15/01/2014. Further disciplinary hearings were held for the other staff during February.

Previous incidents

One of the perpetrators of this abuse had been suspended in Sept 2008, in relation to eight incidents of physical abuse that had occurred since Nov 2007 and which became the focus of a safeguarding intervention and case conference at that time. One instance of physical abuse had been substantiated. She was demoted and removed from night duty for a period during which she was offered more training as a pathway to being reinstated. It is unclear whether, at the time of this disciplinary action, she was referred to the Nursing and Midwifery Council (NMC) as her professional regulatory body. She was not referred to the Independent Safeguarding Authority (the forerunner to the Disclosure and Barring Service DBS) at this point. Her subsequent re-employment in July 2009 quite properly triggered an application for a CRB check that showed this history.

The home was fully conversant with the circumstances of her demotion and subsequent application to be reinstated to her nursing position. Any further action was deferred to the home's management, so it was left up to the home to apply whatever sanctions they considered appropriate. This worker's actions were not trivial and constituted offences under the 2005 Mental Capacity Act that had been fully implemented in April 2007. She should have been investigated with a view to prosecution at that time. Her subsequent involvement in these offences suggests, albeit with the benefit of hindsight, that this was a misjudgement. The outcome, including the implications for professional regulation, should have been agreed by this multi-agency group and not left to the home to be decided on as an internal matter.

Another of the perpetrators had also been suspended in 2005 for forcing a resident into, and out of, a chair and for shouting at her. The police were informed but no further action was taken. It is unclear why she was not prosecuted for assault, which this clearly was, and that this opportunity to

remove her from the workforce by reporting this incident to the DBS at that time was not taken.

A zero tolerance approach to abuse would have seen these two members of staff removed from this home, and from the workforce, at a much earlier stage thereby preventing the abuses that came to light during 2013 from occurring. As such the poor decision-making in response to these previous allegations represented failed opportunities to prevent the later, and more entrenched, abuse.

It was noted that the staff member convicted of sexual offences in the home, in speaking to one of his colleagues, said "*she is just a bloody woman*" and this contempt spread to other colleagues, including the manager. Moreover, reading between the lines, this attitude went along with a resistance to being supervised or to following rules, a contempt for management and for fellow team members demonstrated by this man's unwillingness to do his share of the recording and care planning and rumours of his over familiarity with some of his colleagues. We can see that it was the tip of an iceberg, and that below the surface there was a nasty mix of intimidation, manipulation, sexual offending and control

Understanding the causes of abuse in residential homes

People working in this field, whether as police officers, service managers or clinicians, need to have accurate models of how abuse arises in an individual or in a particular setting, to act as a "map" when designing safeguards or investigating allegations. In DH guidance supporting the implementation of the safeguarding elements of the 2014 Care Act, this is referred to as an "incident causation model"[2].

Most abuse in care homes is **"situational"** in that it is, to some extent at least, a product of the demands of the caring environment. In such cases the home bears a large percentage of the responsibility for this abuse by putting the staff into a position where they were bound to become overwhelmed. A poorly performing staff person might be dismissed from such a setting only to find that sooner or later their replacement also either leaves or reacts in similar ways.

[2] SCIE (2014) Guidance to accompany the 2014 Care Act: implementation support

Blaming individuals for organizational failures in such a setting is as ineffective as it is unfair.

But a second configuration of abuse is **"opportunistic"** in that a staff person, motivated by feelings of entitlement or resentment, is tempted by lax supervision or "easy pickings" to take advantage of a vulnerable person or of their employers. For example they may steal jewelry from an older woman who cannot remember where she puts things or steal food from the fridge that was intended for residents of a home. Often in these situations the staff, especially when they are lowly paid and have no professional standing, frame the abuse as a response in part to the unfairness of their own position. A home that values its staff and has good systems of oversight and an assertive commitment to uphold the dignity of patients, will be able to manage these "opportunities" away to a minimum and " help" hard pressed staff to keep within the bounds of good and honest practice.

More rarely, but seriously, some abuse will be **deliberate, planned and targeted** and the abusers will have been *intent on abusing*. Some people seek out this work in order to be in a one-up position from which they can exercise power and control, even if this motivation is unconscious to them and hidden from others. A good home will present many barriers to this happening,- they will recruit with great care, they will have open and accountable regimes, they will ensure "cliques" do not develop and/or are not allowed to work without oversight, and they will foster a staff culture against which any breaches of standards, stand out.

They will also empower staff to report concerns and inspire them with confidence that any such reports will be acted on, fairly and proportionately. No home can be completely proofed against employing a "bad apple" but in a good home that person would stand out and their behavior would not be allowed to become a norm that undermines the commitment of other staff.

It seemed as if in this home a small clique of staff had crossed a line, from light hearted teasing or joshing, they had resorted to "letting off steam" in insensitive and humiliating acts of verbal violence and harassment. Therefore in seeking to understand the aetiology of this abuse it is important to consider both organisational and personal/psychological factors.

The nearest recent parallel to these abuses were those that arose at Winterbourne View involving people with learning disabilities who were also abused by a clique of abusive staff. In both situations there was a small core of staff who should not have been doing this work, working in an environment with too little structure and understanding of the challenging needs of the client group. Other previous inquiries show how personal dynamics and professional isolation breed poor practice.

Working with older people is not well paid, or highly regarded within many sections of society, it is seen almost literally as a "dead-end" job. It is seen as predominantly women's work and in some families or communities as particularly demeaning for a man to be involved in. These perceptions might push a person into presenting a "hard", somewhat defiant attitude to the people they work with.

Working practices, especially when teams or shifts are left to their own devices or are without proactive management, can easily slide into patterns that have a defensive purpose[3]. This is usually unconscious but needs to be brought into awareness through skilled supervision, excellent role models, sound and workable policies and helpful models of interaction. Without a good understanding of the psychological mechanisms behind dementia it might be easy to mock or to become irritated and it is easy to see how a person might push back by bullying or humiliating clients whose vulnerability elicits such painful feelings or unacknowledged fears.

Furthermore the Panel saw no evidence of guidance relating to the way these tasks were allocated and managed. Safe policies help to contain the anxiety-provoking parts of the work as well as to set standards and establish boundaries. Given the sensitivity of these aspects of the work we would expect to see ***same-sex care*** specified in the care plans of at least some residents, with exceptions limited to emergencies. One of the residents abused by this group of staff had become sexually disinhibited as a result of her dementia. The home should have had a ***challenging behaviour policy*** that acknowledged this presentation and that stated firm values about how to

[3] see seminal work by Isabel Menzies Lyth on this issue http://www.moderntimesworkplace.com/archives/ericsess/sessvol1/Lythp439.opd.pdf

work respectfully and safely with a person whose ability to manage their own sexual behaviour had been compromised as a result of their cognitive impairments.

Another indicator that a group may have strayed outside the "official" norms of their organization is if they resist working with new colleagues or with "outsiders" in any shape or form. Of course there may be some people whose working patterns are dictated by their childcare arrangements and transport needs but this should not be allowed to cut across open and transparent negotiations about working hours. Openness is the best defence against corruption, whether of working hours, theft of food or goods, or unacceptable attitudes to residents and their families.

But while this may explain some of the systemic issues, in this case there was also at least one staff member who brought his own criminal propensities to work and exercised a negative influence on other staff. In an ideal world, safe recruitment practice should have screened him out and/or the supervisory process should have picked up and challenged his approach to patient care. On two occasions he could have been given a formal warning, - for leaving work and for slapping a resident. But it was left for a further two years before the full extent of his boundary violations came to light.

From the notes of his supervision sessions it would seem that his manager had picked up the sense that he crossed lines and she had tried to address these matters with him obliquely. She should have had support from senior management and from experts within the professional network to help her reframe her concerns into formal capability procedures.

Other behaviour from this group of staff included teasing a visitor who happened to be blind, by showing her to someone other than her relative's room. This was gratuitous and contemptuous. This group of staff also dressed in clothes of a deceased resident and posted the pictures of this escapade on Facebook: again this is an incident without any possible excuse that was indicative of their lack of professional boundaries or personal sensitivity.

It is clear that there are multiple and interacting factors that add to the risks of abuse and neglect of people in care homes. It should be remembered that

this is a difficult job to do well and that staff are often underpaid and inadequately supported.

Someone witnessing abusive practice will often feel pressured to fit in with the prevailing culture,- they have to laugh at the same jokes, use the same terms, agree to cut the same corners, agree not to tell anyone else that something has gone wrong and if they try to challenge these norms they often become the target of the bullying themselves.

Management should make it a practice to drop in unannounced during out of hours shifts as an essential part of their quality assurance strategy,- this "presence" cannot be replaced by "customer surveys" when working with such vulnerable client groups. Direct contact by senior managers with staff across all shifts is a vital check on the safety of services. So unannounced visits and exit interviews are excellent ways of getting to the truth about abusive practices that have become embedded in the way a particular group operates, especially one that is usually working without direct oversight as for example on nights or in a geographically isolated unit.

When the disclosures were made, a thorough investigation was conducted. The Panel find no fault with the way this was carried out or coordinated. Its outcomes have been open and transparent, and all relevant systems including the DBS and professional bodies were appropriately informed. Disciplinary proceedings were managed by the company's senior and area management.

The roles of other agencies

A number of agencies have formal roles in relation to the commissioning, contracting and monitoring of placements. CQC is the regulator and conducts regular inspections to ensure that the home meets agreed standards. ASC has a statutory responsibility to act as the lead agency in relation to the multi-agency safeguarding function on behalf of the Safeguarding Adults Board.

The police service played a vital role in investigating the allegations and bringing a prosecution against those who had broken the law. The Police service also maintains a register of "intelligence" about homes and allegations that could in theory be used to raise the level of concern about a particular home.

At number of agencies are involved with individuals, because residing in a residential or nursing home does not take a person beyond the purview of mainstream health, social care and criminal justice systems. So every patient will have a GP and if the person has nursing needs while living in residential care these will be met by District Nurses; if the person is living in a nursing home their nursing needs are attended to by the home's internal nursing staff. Local GP surgeries will have systems for managing medication on behalf of their patients in collaboration with local pharmacies and individual home staff will be responsible for administering medication and keeping accurate records.

Residents are frequently admitted to hospital from residential and nursing homes. If any crime is committed against a person living in a residential or nursing home, that person has the right to report directly to the police, and staff of the home should act on their behalf to do so if they cannot manage this themselves.

The role of Adult Social Care's safeguarding function

Safeguarding is "everybody's business" but it is the role of ASC to host and coordinate the input of partner agencies. The initial safeguarding alert in this case was set in motion by a disclosure made by one of the home's staff to a senior safeguarding practitioner within CPFT. Strategy meetings were then held on 5/11/2013 and again on 21/11/2013. The company carried out investigative

interviews leading up to the commencement of a criminal investigation on 27/11/2013. At the first strategy meeting it was decided that all residents funded by a LA or Health body should be visited while those who were self-funding were not. This was inequitable and mechanisms need to be found to avoid this discrepancy in future. These reviews suggested that many aspects of practice, including care planning and record-keeping were not satisfactory and these issues were shared with the provider.

Findings of abuse were substantiated in relation to all of the residents named excepting one for whom an inconclusive finding was recorded. The procedural aspects of the investigation were correctly followed.

Quality Improvement Team

Adult Social Care is also hoping to host a project under its Health and Wellbeing directorate, to drive up quality across all residential and nursing home provision in the city. The Business Case that has been developed covers many of the areas included in this and previous serious case reviews, specifically raising standards around

- Falls,
- Pressure care
- Urinary Tract Infections
- Respiratory tract infections
- End of life care

And bringing together specialist nurses and the intensive nurse management team to support homes in relation to

- Continence
- Diabetes
- Dementia
- Dieticians
- Physiotherapy.

These areas of care, particularly where clients present with multiple co-morbidities, are clearly areas that contribute to staff feeling pressured and perhaps unclear as to how or when to access specialist care and /or hospital

admissions. The driving force behind these initiatives should be to prevent needless and/or emergency admissions, including when a person is in their last days or weeks and to manage discharges from hospital in a timely and seamless way.

Other areas that could be written into this submission might be to include training, development, guidance and consultation for employers about how to manage disciplinary processes including where a nurse's clinical judgments are being questioned.

An analysis of what went wrong in this case and recommendations for stronger safeguards

In relation to the clinical care of very ill residents there was a great deal of confusion about how to contain and manage the process of dying, leading to very frail patients being sent to and fro in a series of acute admissions, rather than patients being offered high quality palliative care in the place that is most familiar to them. Best interest decisions seem not to have been made or implemented in relation to medication, sedation or end of life decision-making. Discussions with relatives seem not to have taken place until the last moment.

The provider made strong representations to the Panel that hospital discharges were being rushed and stated that staff felt pressured to accept patients, or to readmit them, without sufficient assessment or planning. PSHFT did not accept these criticisms saying that discharge difficulties had not been identified in the chronologies they had produced and that practice had been good. No concerns had been voiced prior to the Safeguarding Adults Review and the provider had not made, or escalated, any complaints through the hierarchy of either acute trust until that point.

It is not the case that the clinical conditions and co-morbidities experienced by these patients were in any way unusual. Diabetes, epilepsy, cardio-vascular conditions and infections of one sort or another are all conditions that one would expect to encounter in the care of older people near the end of their lives. They should have been managed more smoothly by the home and by the hospital. Patients should have been accompanied by care staff who knew

them and their medical histories well. Those staff should have been competent to assist in the admission process.

Poor care does not arise in a vacuum. It grows where the staff are under pressure and do not have appropriate knowledge and/or skills to work with difficult patients. This home did not have sufficiently well designed and active systems for recording, medication management and care planning. Its staff did not know enough about diabetes care. There was no adherence to an agreed end-of-life framework such as the Gold Standard Framework advised by the Department of Health. Nor were they being offered sufficient guidance about professional boundaries and what would be considered unacceptable breaches in the care of their patients. They cannot have felt confident to raise concerns about an intimidating colleague or they would have done so sooner. Their first principle should have been to act kindly to their patients out of empathy for their humanity and as soon as it became known that this was missing, the ethos of the home should have come under immediate scrutiny.

Root cause analysis

Root cause analysis is a methodology used widely in the NHS and other organisations to find where, in a sequence of causality, things have gone wrong. In health and social care there are often criss-crossing points because we work across agencies and with more complex interpersonal phenomena. It is sometimes said that in a chain there can be a weak link, whereas in a web, we can weave stronger safeguards.

1. What went wrong in the lead up to these abuses?

1. In 2005 when CW5 was found to have abused a resident she was not dismissed; nor did police investigate her with a view to prosecution

2. In 2008 when CW2 was found to have abused a resident she was not dismissed but allowed to return to work,

3. This decision was left to the home manager seemingly without guidance from the provider agency's regional management.

4. Police did not seek a prosecution under Section 44 of the 2005 Mental Capacity Act even though this had been fully implemented in April 2007.

5. It is unclear whether regulatory action was taken and if so whether conditions of practice were applied and if so how/whether they were lifted

6. One of the staff implicated was appointed despite the fact that

- his immigration papers were false
- he did not have relevant experience or qualifications
- he had gaps in his employment history
- one of his referees said that they would not re-hire him to do a job in a fast food restaurant

7. The management of the home had demonstrated that although they espoused a commitment to a "zero-tolerance" they did not act decisively when faced with evidence of abusive behaviour (2005 and 2008)

8. Supervision in this home seemed to consist of "coaching" and restatement of policies and procedures but did not directly engage with, or challenge, the behaviours, skills or attitudes of individual staff members

9. It seems as if the home manager had been drawn into colluding with abusive practices to the point where she was not able to hold a clear line between acceptable behaviour and significant breaches in professional boundaries

10. The regional management of the provider did not provide sufficient support or training to support their home managers in making difficult decisions and complex judgment calls.

2. What went wrong while these abuses were taking place?

1. A group of staff worked without scrutiny or accountability, forming a clique particularly on night shifts
2. Care plans were not drawn up to direct and sustain the way that care was provided to these patients
3. Patients with challenging needs should have had more intensive care plans in place and staff input to their care should have been more structured and overseen: this should have guided and supported their responses to the patient who for example repeatedly asked where she was.
4. Consideration should have been given to the gathering of evidence via covert surveillance (via CCTV) by police and ASC staff to maximise the possibility of mounting a prosecution and the chances of a successful conviction.
5. As soon as police became aware of the sexual offences committed by one of the staff against others in the team they should have

   a. Informed ASC, which they did not
   b. Mounted a sensitive investigation into the possibility that residents might also have been victims of his behaviour which they did not
6. Regional management was not providing sufficient support to the home manager to help her to explore the difficulties she was experiencing in managing her staff: her difficulties were not a reflection of personal or professional weakness but reflected to some extent a process of gender based intimidation
7. Whistle-blowers reported their concerns to CPFT not to the management of the home or the company, or to the police and/or to Adult Social Care whose responsibility it is to investigate potential abuses. This suggests either a lack of knowledge, or a lack of confidence, in the formal safeguarding structures signalled in the Peterborough Safeguarding adults-at-risk policy.

3. What has gone wrong/right in the response to these abuses?

1. Successful prosecutions have been brought against four members of care staff and significant custodial sentences imposed, although these were subsequently reduced on appeal.
2. The provider did not cooperate with the police to ensure that information about vulnerable people who might also have been victims, but who were self-funding, could be considered in the course of the investigation
3. The provider have found it difficult to collate and summarise information about the way in which their corporate structures and management culture had impacted on the abuse that occurred in this particular home.
4. The provider was not able to produce salient care plans and this led to the failure of the prosecution in relation to one of the alleged perpetrators.
5. Corporate offences, including potential breaches of health and safety legislation, were not canvassed in the scoping of the police investigation into these abuses.

Summary of recommendations

These recommendations will be passed to the SAB who will ask each agency to turn them into a realistic action plan, set out as SMART goals that are achievable within a specified time scale.

Issues of concern	Salient recommendations
End-of life care	1,2,3,
Use of the Mental Capacity Act 2005	5,6,10,
Conduct of safeguarding interventions	4,9,13,17,18,28,29,32,33,36, 37
Collaborative working between staff of residential and nursing homes and ward staff in acute hospitals	3,7,8
Training for managers and senior managers in residential and nursing homes	11,14,22,23,24,25,26,27,31,33,34,35,37
Training and supervision for staff in residential homes	12,24
Policies in residential and nursing homes	12,15,16, 25, 36
Record-keeping	14, 17, 18, 33
Safer recruitment in the residential and nursing home sector	20,21,22. 31

Addressing bullying and harassment in the workforce	22,23,24,25,26

Recommendations 1-3 refer to end-of-life care in residential homes including admission to acute hospitals

1. All residential and nursing homes should adopt a systematic approach to end of life care including

- **a. a timely review of, and/or assessment of eligibility for, Continuing Health Care**
- **b. the adoption of the Gold Standard Framework,**
- **c. an on-going training programme for managers, and**
- **d. a rolling programme of training in each residential home.**

2. All residential and nursing homes should be able to conduct timely, skilled and sensitive discussions with older people and their family members about how they want end-of-life care to be approached; this should include whether they wish to have a DNAR notice attached to their notes or not.

3. When a person with advanced dementia is admitted to hospital from a nursing or residential home, whenever possible they should be accompanied by a member of the home's staff who will remain with them until such time as a proper handover can be completed and should bring with them a copy of a current and appropriately detailed care plan and/or handover sheet.

Recommendation 4 refers to the involvement of clinicians in safeguarding enquiries and reviews

4. When clinicians are asked to conduct reviews or assessments as part of a safeguarding investigation, conducted under Section 42 of the Care Act 2014, they should be given a very clear briefing about what to look for and how to pass salient information to the team responsible for the enquiry.

Recommendations 5 and 6 refer to making, and acting upon, best interests decisions made within the framework of the Mental Capacity Act 2005 in residential and nursing homes

Recommendations

5. Best-interests decision-making should be clear and the process should bring together clinicians, family members and staff of nursing and residential homes in order to determine

- **how best to manage end-of-life care but also**
- **how to manage refusal to take medication, nutrition or other health care input.**

6. If someone who lacks capacity refuses medication, there should be a clear care plan about how to proceed within the framework laid down by the 2005 Mental Capacity Act. While any restraint or coercion should be used sparingly, and only within strict individualised guidelines, it is extremely unlikely that it is ever in a person's best interests to go without pain relief or, in certain circumstances, sedation. In such circumstances their stated views should not be confused with an informed decision and should not take precedence over what is considered clinically to be in their best interests. A Deprivation of Liberties application should be made if the situation is likely to be on-going.

Recommendations 7-10 refer to steps that each home should take to facilitate the work of other agencies

7. Where there are separate units within a home or complex, signage should be clear and premises well-lit so that ambulances and taxis can see where to collect and deliver patients.

8. When liaising with acute hospital staff, nursing and residential home staff should clearly indicate which unit a patient is to be discharged to, and the person's room should be prepared for them. Units sharing the same campus should be kept informed if a person is returning home so that they can promptly redirect anyone coming to the wrong door.

9. Where there are safeguarding concerns, information about self-funding clients should be shared, particularly in the context of a large-scale investigation; the responsibility to do so is set out in Section 45 of the 2014 Care Act and should be referenced in contracts drawn up by PCC and the CCG.

10. Exceptions to this rule would be where an individual who had capacity decided to withhold information after being given salient information and appropriate assistance as set out in the 2005 Mental Capacity Act; or if a relative holds a Lasting Power of Attorney relating to these matters, where an adult-at-risk lacks capacity the case for sharing such information would almost always be seen to be in their best interests.

Recommendations 11 -16 focus on prevention of abuse through training, appropriate policies and guidelines to cover difficult areas of the work, improved record-keeping in relation to staff and patients and making use of appropriate regulatory frameworks

11. Training, especially that provided for home managers, should focus on difficult areas of safeguarding practice covering complex presentations of abuse, difficult to manage employees, and both organisational and psychological factors that have a bearing on abuse and abusing.

12. Challenging behaviour, in the absence of clear and supportive guidelines, can be a trigger to abusive responses: all clients with challenging needs, including difficult sexual behaviours, should have detailed care plans in place including at the point of discharge from hospital if applicable, and these should be held constantly under review. Training should be provided across all agencies to ensure that these plans are effective so that they provide safety for clients and containment to staff.

13. Adult-at-risk meetings should always consider referring matters of clinical negligence or of mistreatment to the NMC when registered nurses are involved. Other disciplines should also be referred to their professional bodies in the event of neglect or abuse.

14. Records of supervision or one-to-one meetings should specify how the person has worked since their last supervision, citing particular incidents, work done, targets met (for example care plans written up), training completed or residents allocated. Any concerns about the person's practice should be spelt out together with any remedial action that the person has been asked to adopt.

15. Residential and nursing homes should have same gender care policies where this is appropriate for individuals and/or where they indicate a preference. There should also be multi-disciplinary training on safe and dignified personal care.

16. Provider agencies that oversee the care offered by a number of registered homes should record the contact between their senior management teams and individual home managers.

Recommendations 17 to 19 emphasise the importance of securing records in the context of safeguarding enquiries and reviews

17. Providers must keep adequate records relating to staffing, rotas, clinical decision-making, medication, care given, re-positioning and routine observations.

18. When serious matters are at issue and/or at the point where a safeguarding enquiry is instigated police, social workers or care providers must secure all salient records.

19. The Safeguarding Adults Board will explore with partner agencies how to apply sanctions, including the possibility of criminal proceedings, if records are deliberately withheld or destroyed in such a way as to obstruct, pervert or defeat the course of justice, or hamper the functions of the board in holding agencies to account.

Recommendations 20 to 22 refer to safer recruitment practice including appointment to senior posts and will require the SAB, in collaboration with the Quality Assurance Team, to provide guidance and training in support of good practice in this area.

20. The Safeguarding Adults Board should satisfy themselves that homes are recruiting staff safely, this should include waiting for DBS checks, taking up appropriate references and interrogating an applicant's previous employment record, including any gaps.

21. The Safeguarding Adults Board should satisfy themselves that provider agencies are making staff appointments in accordance with current legislation and regulations: they should know how to scrutinise and validate proper immigration documents, work visas and other employment papers.

22. A system of appraisal should be put in place in all residential and nursing homes to maximise the potential for fair and informed appointments to all roles, including more senior positions.

Recommendations 23 to 31 refer to staff supervision and the management of workplace bullying

23. Workplace bullying is a serious issue in staff teams that has the potential to spill over into abuse of service users: Safeguarding Adults Training offered in Peterborough should address this and senior managers across the sector should undertake training about how to address it.

24. Home managers should meet regularly with all staff on a one-to-one basis and they in turn should receive regular supervision and support from senior managers 10-12 times per annum: any concerns including issues arising as a result of bullying or intimidation should be raised during these sessions.

25. If a home manager reports concerns about workplace bullying or intimidation, the *senior* management should put in place a plan of action that is designed to limit

the damage this person does to patients, to other staff and to the ethos of the home: it should be monitored and acted upon diligently.

26. Managers of residential and nursing homes should regularly drop by unannounced during night shifts and weekends to monitor standards at the home, ensure people are working when they say they are and provide support to staff on all shifts

27. Training should be offered to assist managers across all agencies in the conduct of routine exit interviews as an additional safeguard and means for quality assuring these services: the SAB will facilitate a discussion about how to fund and coordinate this.

28. When investigating sexual crimes committed by someone who has access to adults-at-risk, a multi-agency team should always look into the possibility that vulnerable people might have been affected

29. In the course of any serious safeguarding investigation a formal consultation should take place between ASC, health providers and the police, to consider under what circumstances, and with what formal safeguards, evidence should be gathered.

30. All nursing and residential homes should display strong statements, stating that sexual harassment will not be tolerated at work and displaying the numbers of responsible managers within their organisations and external, independent agencies that individual members of staff can contact directly if they are being victimised in the course of their work.

31. Managers of residential and nursing homes should receive training to ensure that they know how to validate the papers and immigration status of all persons seeking employment within their organisation.

Recommendation 32-37 refer to the conduct of safeguarding interventions and disciplinary proceedings including the support of whistle-blowers and first line managers

32. A formal professionals' meeting should be held at the conclusion of all safeguarding enquiries, and particularly service wide or large-scale investigations, to ensure that all appropriate information has been shared and all outcomes followed through.

33. Senior Managers, and external advisers, should work alongside Home Managers when addressing serious disciplinary issues to ensure that they go through proper formal channels and leave robust paper trails; senior managers should be alert to the potential for intimidation and provide appropriate back up

to any manager who is at risk of being undermined in carrying out their responsibilities: in single establishments, managed by the owner, the Safeguarding Adults Board should act as a resource if owner-managers find themselves dealing with complex situations of this nature.

34. Provider agencies should keep careful documentation of any discussions between senior management or external advisers and internal home managers, especially where these relate to difficulties they are experiencing in relation to staff management within their units

35. Senior managers within all provider agencies should take capability / disciplinary proceedings against any home manager who, with the requisite support, is not able or willing to hold their staff to account using formal channels when this is appropriate.

36. All Safeguarding policies in residential and nursing homes should contain an explicit clause stating how staff can escalate a concern or allegation to an independent safeguarding professional if they feel or fear that their line manager will not take the matter seriously

37. Safeguarding training in Peterborough should address these managerial tasks across all agencies and types of service.

Concluding remarks

The abuses that took place at this care home during 2013 were extremely serious. We cannot know how vulnerable residents were impacted by these events but it would seem that this clique of staff created an intimidating atmosphere that would have made their lives misery. CW1 also committed serious sexual offences against two of his colleagues, which made this an unsafe workplace as well as an unsafe place to live.

Staff at the home called on the rhetoric of "zero-tolerance" but did not practice what they preached. On at least five occasions they had information that would have justified dismissing staff but did not do so. Collusion between the unit manager and this clique of staff created a lack of confidence in staff who might otherwise have blown the whistle earlier. The provider's area and regional management were not sufficiently involved to pick up warning signs or to support and work with the home manager in tackling this very difficult behaviour. Not enough attention was paid to the gender dynamics in the relationship between in-house managers and the staff especially given the troublingly sexualised culture that emerged in this group. The service did not have sufficient supervision, oversight, or training in place. Nor did they have helpful

and containing policies and guidance to support the provision of personal care or the management of challenging behaviours including those involving sexually disinhibited behaviour.

Eight people should be commended for coming forward to "blow the whistle" about the abuses that were continuing in the home. The provider should provide them with excellent references for their integrity in doing so. But the company's area managers should have been working into this service consistently and proactively so that they felt they could report the abuse sooner. Moreover, independent clinicians, were not up to date with all their routine reviews and while this cannot be seen as a major factor in the abuses that took place, each represented a potential window onto what was by then a failing service. ASC Safeguarding Unit also needs to publicise its work more widely and provide points for third party reporting of concerns and direct reporting.

We cannot create services in this hard pressed sector that are 100% safe and it may not be possible to screen out all potentially abusive members of staff. Some people are unsuitable to care for vulnerable people because of their own personal histories, psychological difficulties or malicious intent. But there should always be safe and well-publicised pathways to allow staff with integrity to report such abuses at the earliest opportunity and when they do so managers should be supported by the senior management of their corporate bodies and by statutory agencies so that firm and containing action can be taken and appropriate values restored.

Appendix A - List of agencies contributing to the review

Appendices

Agencies represented on the Panel

Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire and Peterborough Foundation Trust

Cambridge Constabulary

East of England Ambulance Service

Peterborough and Stamford Hospital Foundation Trust

Peterborough City Council – Adult Social Care

Agencies asked to submit an Internal Management Review

The managing company

Two GP practices

Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire and Peterborough Foundation Trust

Cambridge Constabulary

East of England Ambulance Service

Peterborough and Stamford Hospital Foundation Trust

Peterborough City Council – Adult Social Care Team