Gloucestershire
Safeguarding Adults
Board

Gloucestershire Organisational Abuse Procedures

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Contents

Acknowledgements

With thanks to South Gloucestershire and Cornwall Councils on whose policies these procedures are based.

Introduction

This document provides guidance for dealing with concerns in relation to the organisational abuse of adults with care and support needs. Its purpose is to help staff give better informed and more effective support to people who need an adult safeguarding service because of organisational abuse. It also provides guidance regarding a co-ordinated response to widespread quality concerns about a service provider.

Definition

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect

The Care Act 2014 statutory guidance (14.9) makes it clear that Safeguarding is not a substitute for:

- providers' responsibilities to provide safe and high quality care and support;
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care including the duty to take enforcement action when standards are breached;
- the core duties of the police to prevent and detect crime and protect life and property.

Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.

The Care Act Guidance defines Organisational Abuse as:

> Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Not all abuse that occurs within care services will be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that arise largely from an organisation's practice and culture (particularly reflected in the behaviour and attitudes of managers and staff), together with the organisation's policies and procedures and how these are used.

Organisational Safeguarding applies to all service providers who work with adults with care and support needs, regardless of who is funding their support or whether they are regulated by CQC or not.

Indicators of whole service concerns

Where there is an indication that a service, as a whole, has safety and quality concerns, not adhering to regulatory standards and a risk to the health and well-being of residents, a Whole Service Concern referral can be instigated to prevent abuse from occurring and improve standards of care, or where abuse has occurred and actions must be taken to safeguard residents. These indicators include:

- A pattern of individual safeguarding concerns, which seen collectively, indicate serious organisational issues;
- A pattern of complaints made against a service provider from a variety of external agencies and/or carers and relatives;
- A serious single incident indicative of systemic and organisational abuse, such as that involving a death of a service user;

- A large scale enquiry involving a high number of service users where abuse is suspected;
- A report of systemic and organisational abuse;
- Lack of contract compliance which indicates poor care and/or lack of leadership skills or commitment in complying with contractual requirements;
- Poor CQC inspection report identifying non-compliance with major safeguarding concerns in one or more essential outcome areas (**CQC Key Lines of Enquiry - KLOE**).

The above list is not exhaustive; the sharing of information between partners assists in identifying a more holistic picture of concerns about a provider.

Indicators of organisational abuse include:

- concerns about management and leadership;
- concerns about staff skills, knowledge and practice;
- concerns about adults' behaviours and wellbeing
- concerns about the service resisting the involvement of external people and isolating individuals;
- concerns about the way services are planned and delivered;
- Concerns about the quality of basic care and the environment

Whistleblowing

A whistleblowing referral may be the catalyst for identifying wider concerns about a service. Whistleblowing should be distinguished from a complaint in that a whistleblowing referral will be made typically by an employee of the organisation. The person may or may not have tried to raise the issue with their managers. Ideally they should have done but clearly there are times when an employee will feel too intimidated to do so. Where a whistleblowing referral is actually a safeguarding concern about an individual, this should be dealt with initially through individual processes to ensure that the person is safe. Where there are wider implications these may need to be followed up through organisational safeguarding processes.

It is essential that information is taken carefully from whistleblowers whatever their motives appear to be. Just because someone has fallen out with an employer does not necessarily mean that the information they are passing on is not valid. As with any other enquiry the information given by a whistleblower will need to be balanced with other information.

Where the whistleblowing relates to an internal Gloucestershire County Council (GCC) service, or a service commissioned by GCC, reference should also be made to GCC guidance on whistleblowing.

The Care Quality Commission National Customer Service Centre can be contacted on: 03000 616161

Organisational Safeguarding Enquiries

Partnership Working: Key Points

Responding to large scale concerns about a provider is likely to require complex co-ordination of different organisations both for information and for direct involvement in the enquiry. Drawing upon the knowledge and expertise of the Clinical Commissioning Group, Care Quality Commission and Police partners will be an important early step in formulating an effective approach. It is important that everyone involved is aware of their respective roles and responsibilities and their duty to cooperate in the enquiry.

The Local Authority should lead and co-ordinate whole service enquiries but multi-agency knowledge, skills and information sharing are essential for best practice, sound decision making and securing positive outcomes for adults.

Involving the service provider

The relevant senior managers of a provider organisation must be involved in planning the enquiry unless they are regarded as complicit in the alleged abuse, or directly responsible for a service where institutional abuse is alleged to have taken place, or are suspected of committing a criminal offence with regard to these matters. Once the

terms of reference for the enquiry have been agreed these will be shared with the service provider at a separate meeting, if they have not been asked to attend the planning meeting. The Service Provider will need to be given the opportunity to give an account of what has been alleged. They should also be afforded time to provide a response to allegations. If the allegation leads to a criminal investigation led by the police, they should provide guidance on how the provider is to be involved.

In some circumstances a two part meeting might be convened, with the service provider being invited to the second part, where the terms of reference can be communicated. Each part of the meeting will be separately minuted, with the provider receiving minutes for the parts of the meeting they attend.

Subsequent adult safeguarding meetings should routinely involve service providers when the enquiry relates to services, but possibly for only part of the meeting if this is deemed to be appropriate by the Chair. Where it is considered that the provider should not be involved in these meetings, alternative arrangements need to be made to meet and/or provide updates.

Who Leads?

Where there are concerns about organisational abuse, these should be reported to the Safeguarding Adults team for discussion with GCC Commissioning teams regarding whether a large scale/ whole service meeting is required.

Meetings will be chaired either by a member of the Safeguarding Adults team or a member of the Commissioning teams, depending on the circumstances of the case. For example, in some instances the concerns will relate in the main to the quality of the service provision, in which case a representative from Commissioning is the most appropriate lead. In exceptional cases (e.g. concerns of a particular complexity or where there is likely to be media attention), the Head of Safeguarding Adults should be consulted regarding the most appropriate person to chair the meetings. Each participating agency should nominate a lead to support the enquiry.

Early consideration must be given to the involvement of the Police in any whole service enquiry. Where their involvement is indicated, arrangements will need to be

confirmed for each individual enquiry. The balance is between preserving evidence and enabling the police to pursue their investigation and ensuring that all adults are safe within the setting.

Active participation and co-operation from the service provider is expected and essential. Depending on the type of concerns and the level of staff involved it may or may not be appropriate for the provider to actively make enquiries. This will need to be decided in each situation by the local authority as the body with overall responsibility for the safeguarding enquiry. It will be important to understand the service provider's own mechanisms, for example disciplinary procedures, and how any intention to deploy these relates to the safeguarding concern and aligns to the safeguarding plan. It is key that the service provider takes responsibility for the abuse and the impact of it. Where their internal procedures are likely to have set/allowed a culture where abuse can take place it is essential that this become part of the enquiry.

It is essential that, where providers are undertaking enquiries, arrangements for what these should cover, timescales and how they will be fed back are clear. Where these are not adhered to, consideration must be given to how to escalate the concerns to ensure they are managed.

When an investigation involves a number of people who have experienced abuse, or are at risk of abuse, the issues are often complex, involving standards of service as well as a series of individual enquiries.

A large scale enquiry may require a series of individual safeguarding adult enquiries to address allegations of abuse specific to each individual. Under the Care Act 2014, the Local Authority has lead responsibility for adult safeguarding issues however it can cause enquiries to be made by other appropriate agencies. In carrying out this responsibility the Chair will co-ordinate the overall enquiry and ensure that all relevant agencies are involved.

Strategic Oversight

In most instances the process outlined below will be sufficiently robust to ensure a full

and thorough enquiry can be undertaken and arrangements made to keep people safe. However there may be a small number of situations where it becomes evident that the degree and severity of the safeguarding and the complexity of the situation requires additional strategic oversight. In such instances GCC, as the host authority, will initiate a strategic management group inviting placing authorities, CQC, police, health, legal etc. to identify the most appropriate person to attend. This group would provide oversight to the process ensuring all areas are followed through (see ADASS guidance on Out of Area Safeguarding Adults Arrangements June 2016 for further details).

Key Partners

Police – required when the safeguarding concerns are a potential criminal matter (see Appendix 3). The Chair should liaise with the Police as appropriate.

Care Quality Commission - must be informed of any concerns relating to a regulated service.

Local Authority Commissioning & Contracts - must be informed of safeguarding concerns relating to any provider, irrespective of whether services are commissioned.

Health - where services are commissioned by the Clinical Commissioning Group, NHS England or public health e.g. via Continuing Health Care (CHC), Funded Nursing Care (FNC) or as part of a joint package, the Clinical Commissioning Group must be informed.

Other Local Authorities - where placements are commissioned by another commissioning body for example, another local authority or CCG, they should be notified of the referral and involved throughout. While GCC as the host authoirty retains the lead safeguarding role for all safeguarding concerns, placing commissioning bodies retain a duty of care towards the adult and should be expected to fulfil this role in co-operation with the safeguarding enquiry.

The provider - whether an internally or externally commissioned service, an understanding of the specific contractual requirements of the provider i.e. their own policies and procedures will be an important reference source.

Where safeguarding issues relate to a council provided service (provision or

assessment etc.) then care must be taken to ensure that there is a clear separation of interests i.e. all staff involved in the safeguarding enquiry should have no direct relationship to the matters under enquiry.

Depending on the seriousness of the concerns the following will need to happen:

For the most serious situations where serious harm has taken place or is suspected:

- Decisions will be needed about communication to senior managers to ensure appropriate involvement and support from services.
- where criminal offences may have been committed it is crucial that the first enquiries are done by or with the police
- the initial internal resources to co-ordinate and undertake the enquiry/assessment, including legal advice, must be identified.
- organise a strategy meeting to agree an 'Enquiry/Assessment Plan' covering both individual allegations and the organisational setting
- identify and implement a clear communication strategy and ensure the media teams from relevant agencies are informed.
- ensure the potential need for advocacy informs the enquiry

Whole Service/Large Scale Enquiry Meetings

A strategy meeting should be called as soon as possible after the concerns have been raised. Depending on the level of risk and the complexity of the concerns a balance may be needed between ensuring the maximum number of partners round the table and ensuring people's immediate safety. Where the situation is extremely serious an immediate strategy meeting/discussion may be necessary to start the enquiry process. This should be a rare occurrence but it is expected that all partners will respond when this is required.

The strategy meeting will need to undertake a preliminary risk assessment based upon existing knowledge and agree an interim safeguarding plan covering both individual concerns and the care setting. This must include a plan to keep existing adults safe. The interim risk assessment should also include the option of

suspending further placements. See Appendix 3 for details of what should be covered in the Strategy Meeting.

Follow up meetings will be needed to ensure that actions are followed up and plans revised as required, including:

- implementation of the enquiry / assessment plan
- report(s) completed by investigator(s)
- evaluation of enquiry /assessment activity and evidence obtained
- determining if abuse/neglect has taken place covering both individual concerns and the care setting (organisational abuse)
- consideration of the circumstances and potential needs of perpetrator(s)
- agreeing an ongoing Safeguarding Plan which is likely to have both short and medium term actions
- agreeing time scales for review of Safeguarding plan
- agreeing circumstances where re-evaluation of the situation will be required
- agreeing an action plan for the service provider
- monitoring and review of the action plan for the service provider
- debrief and consideration of learning points and wider implications
- receiving feedback of follow up by provider e.g. disciplinary processes, referral to Disclosure and Barring Service (DBS) and/or appropriate professional bodies such as Nursing and Midwifery Council (NMC), or the Health and Care Professions Council (HCPC)
- consideration of a referral to the Gloucestershire Safeguarding Adults Board (GSAB), Safeguarding Adults Review Sub Group (SAR) or other actions across the safeguarding partnership
- case closure – (see below)

It is essential that all participants are aware that meetings are confidential and will be minuted. Minutes and communications about Whole Service Enquiries must be carried out securely, in line with information governance policies.

Organisational Safeguarding Closure

It is important that the decision to end the Organisational Safeguarding Enquiry is agreed by the whole meeting membership. It is therefore essential that key agencies remain involved in the safeguarding process. The multi-agency meeting will need to be satisfied that:

- all required safeguarding actions have been undertaken;
- there is evidenced reduction in risk
- victims/involved adults have received feedback
- any necessary notifications to regulatory bodies e.g. Disclosure and Barring Service, Nursing and Midwifery Council, have been undertaken
- any remaining concerns can and will be managed through contract monitoring, care management processes etc.
- lessons learned have been identified and taken forward

All placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed.
Senior management should be notified as appropriate.

Publicity and Media

Public and media interest may arise in safeguarding cases. Individual professionals should not respond directly to enquiries from the media but refer them to their local communications team. Co-ordination with other organisations' media teams may also be necessary. Where media interest is likely the Head of Safeguarding Adults will proactively manage this with the Communications team, coordinating with other organisation's media function where necessary. The Head of Safeguarding Adults will also ensure that the Director of Adult Services and appropriate elected members are kept informed.

Appendix 1

Early Indicators of Concern in Care Services Checklist

It is important to note that this is not a definitive checklist. Other indicators may be identified that do not appear on this list. Equally abuse can happen when indicators of concern have not been identified.

1. Concerns about management and leadership

The manager of the service

• The manager leaves suddenly and unexpectedly

• The service has not had a registered manager in post over an extended period

• Arrangements to cover the service while the manager is away are not working well

• The manager is new and doesn't appear to understand what the service is set up to do

• A responsible manager is not apparent or available within the service and has little involvement with the adults

• The manager leaves staff to get on with things with little active guidance or modelling of good practice

• The manager is very controlling

Management Culture

• The service is not being managed in a planned way, but reacts to problems and crises

• The service does not respond appropriately when a serious incident has taken place

• The service fails to learn from previous incidents and does not appear to be taking steps to reduce the risk of a similar incident happening again

• Policies, procedures and practice guidance are absent or inadequate

The management team

• Senior staff have been in post a long time and have a high level of authority and entrenched views

• There is a high turnover of managers

• The service is experiencing difficulty in recruiting and appointing managers

• There is a lack of leadership by managers, for example managers do not make decisions and set priorities

• Managers appear unaware of serious problems in the service

• Managers do not appear to be attending to risk assessments or are not ensuring that risk assessments have been carried out properly

• Managers do not appear to have ensured that staff have information about individual adults' needs and potential risks to adults

• Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through

• There is a lack of effective monitoring by senior staff – including support to night staff and checks on them

• The managers know what outcomes should be delivered for adults, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'

Staffing

• Staff who raise issues are not listened to

• Staff are not being deployed effectively to meet the needs of adults

• There is a high turnover of staff

• Staff are working long hours

• Staff are working when they are ill

• There is poor staff morale

• Recruitment processes are inadequate

• The service employs high numbers of family/friends

• There is a failure to identify concerning behaviour by staff e.g. stressed staff behaving unusually, growth of cliques, failure to work to best practice, cutting corners

• The managers have low expectations of the staff

• Staff have poor pay and conditions of employment

2. Concerns about staff skills, knowledge and practice

Supervision and Training

• Staff receive little/no supervision, appraisals or opportunities for development

• Induction processes are inadequate

• Poor quality or no training is provided

• Staff appear to lack the information, knowledge and skills needed to support the people the service is set up to support

• Staff lack training in how to use equipment

Recording

• Record keeping by staff is poor

• Staff do not appear to see keeping records as important

• Risk assessments are not completed or are of poor quality. For example, they lack details or do not identify significant risks

• Incident reports are not being completed

• Records are value laden and judgemental

Mental capacity and DOLS

• There is non-adherence to the principles of the Mental Capacity Act

• There is a lack of understanding of DOLS

• DOLS referrals are not being made resulting in people being unlawfully deprived of their liberty

Interactions with Adults

• Staff appear challenged by some adults' behaviours and do not manage these in a safe, professional or dignified way

• Staff perceive the behaviours of adults as a problem – and blame the adults

• Staff blame adults' medical condition for all their difficulties, needs and behaviours; other explanations do not appear to be considered

• Adults are punished for behaviours seen to be inappropriate

• Staff treat adults roughly or forcefully

• Staff ignore adults

• Staff are impatient with adults

• Staff talk to adults in ways which are derogatory/not complimentary

• Staff shout or swear at adults

• Staff do not alter their communication style to meet individual needs. For example, they speak to people as if they are children, they 'jolly people along'

• Staff use negative or judgemental language when talking about adults

• Staff do not see adults as individuals and do not appear aware of their life history

• Staff do not ensure privacy for people when providing personal care

• Staff tell adults to use their incontinence pads rather than assist them to use the toilet

Culture

• There is a particular group of staff who strongly influence how things happen in the home

• Staff informally complain about the managers to visiting professionals

• Staff appear to lack interest and commitment

• Staff appear to lack concern for the adults

• Staff appear unable to relate to a particular adult

• Staff are complacent about the quality of care they provide and appear defensive when challenged

3. Concerns about adults' behaviours and wellbeing

Individual adults

• Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs carefully or properly, or the development of pressure injuries due to lack of or inappropriate use of pressure relieving equipment)

• Appear frightened or show signs of fear

• Behaviours or appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance

• Moods or psychological presentation have changed

• Behaviour is different with certain members of staff/when certain members of staff are away

• Engage in inappropriate sexualised behaviours

• Do not progress as would be expected

• Experience sensory deprivation – e.g. going without spectacles or hearing aids

• Experience restricted mobility by being denied access to mobility aids.

• Experience restricted access to toilet/bathing facilities

• Lack personal clothing and/or possessions

General Service concerns

• The overall atmosphere is flat, gloomy or miserable

• There is a high number of low level incidents such as medication errors or falls

• There is a high number of incidents between adults

• There are a high number of upheld complaints about the service

• There is evidence of inappropriate restraint methods or misused restraint, including the inappropriate use of medication

• The care regime exhibits lack of choice, flexibility and control

• The care regime appears impersonal and lacks respect for individual's privacy and dignity

4. Concerns about the service resisting the involvement of external people and isolating individuals

Information sharing

• The service has few visitors/minimal outside contacts

• The service does not report safeguarding concerns

• The service does not communicate with or report concerns to external practitioners and agencies

• The service does not liaise with families and ignores their offers of help and support

• Managers and/or staff do not respond to advice or guidance from practitioners

and families who visit the service

• Managers do not appear to provide staff with information about adults from meetings with external people, for example reviews

• Staff or managers appear defensive or hostile and concerned to avoid blame when questions or problems are raised by external practitioners or families

• Managers or staff give inconsistent responses or accounts of situations

Staff

• Staff work alone on a one to one basis with adults

• Staff work in silos e.g. night staff who never work days

• Staff are hostile towards or ignore practitioners and families who visit the service

Adults

• There are adults who have little contact with people from outside the service

• There are adults who are not receiving active monitoring or reviews (e.g. people who are self-funding)

• Adults are kept isolated in their rooms and are unable to move to other parts of the building or outside independently ('enforced isolation')

• Adults have restricted access to visitors or phone calls

• Adults have restricted access to health or social care services

5. Concerns about the way services are planned and delivered

The nature of the service

• The service does not have a clear philosophy/purpose

• The service does not appear able to deliver the service or support it is commissioned to provide. For example it is unable to deliver effective support to people with distressed or aggressive behaviour

• Decisions about what service is commissioned for an individual are influenced by a lack of suitable alternatives

• The service is accepting adults whose needs and/or behaviours are different to those of the adults previously or usually accepted

• The service is accepting adults whose needs they appear unable to meet

• Adults' needs as identified in assessments, care plans or risk assessments are

not being met. For example adults are not being supported to attend specific activities or provided with specific support to enable them to remain safe

Person-centred care

• Staff are task focussed and not providing person-centred care

• Adults are treated en-masse

• The service follows strict, regimented routines – for mealtimes, bedtimes, etc

• Adults lack choice about food and drink, dress, possessions, activities and where they want to spend their time

• Members of staff are controlling of adults

• There are misunderstandings about confidentiality

Resources

• There is a failure to provide and/or maintain correct moving and handling and other equipment such as pressure relieving mattresses

• The service is under resourced – whether staff, equipment or provisions

• There appear to be insufficient staff to support adults appropriately

Audits

• There is a lack of audits of practice and process

• There is a failure to follow up on issues raised by audits

• There is a failure to monitor the use of call bells including checking they have not been disabled – especially at night.

6. Concerns about the quality of basic care and the environment

Person-centred care

• There is a lack of privacy, dignity and respect for people as individuals

• There is a lack of provision for dress, diet or religious observance in accordance with adults' individual beliefs or cultural backgrounds

• Adults do not have as much money as would be expected

• Adults lack basic things such as clothes, toiletries

Support for adults to maintain personal hygiene and cleanliness is poor and they appear unkempt

• Adults are not getting the support they need with eating and drinking, or are not getting enough to eat or drink

• There is poor or inadequate support for adults who have health problems or who need medical attention

• Staff are not checking that people are safe and well

• There are a lack of activities or social opportunities for adults

• There is a lack of care for adults' property and clothing.

Resources

• There appear to be insufficient staff to meet adults' needs

• The service does not have the equipment needed to support adults and keep them safe

• Equipment or furniture is broken

• Equipment is not being used or is not being used safely and correctly

Environment

• The service is not providing a safe environment

• The environment is dirty and shows signs of poor hygiene

• The quality of the environment has deteriorated noticeably.

Appendix 2

Evidenced Risk Summary

It is important to remember that one risk indicator domain does not in itself indicate that the organisational safeguarding concern needs to be addressed using the organisational abuse procedures. Research (Hull 2012) has shown that a spread of concerns across three or four domains are more likely to indicate the need for an organisational abuse enquiry. In considering impact it is important to think about the impact across all using the service, or across adults with a specific need, rather than about the impact on an individual. Evidence for likelihood of recurrence will include previous adult safeguarding concerns (in the last year), lack of improvements despite service improvement or safeguarding plans, or inability to complete previous quality assurance/CQC action plans.

Indicator of concern	Evidence for assessment
Concerns about management and leadership	
Concerns about staff skills, knowledge and practice	
Concerns about residents' behaviours and wellbeing	
Concerns about the service resisting the involvement of external people and isolating individuals	

Concerns about the way services are planned and delivered	
Concerns about the quality of basic care and the environment	

Level of concern	Summary

A worked example:

Indicator of concern	**Evidence for assessment**
Concerns about management and leadership	Previous QA action plan requirements to train all staff in manual handling are not complete, currently the service is 60% compliant. All adults in the service need careful manual handling and five require the use of specialist manual handling equipment. The manager has cited inability to release staff from the rota as a reason for non-completion. The manager is unable to ensure that trained members of staff are always on rota.

Concerns about staff skills, knowledge and practice	40% of staff are unskilled in manual handling of people, three substantiated adult safeguarding referrals in the last two months relate to poor use of equipment or injuries sustained during manual handling. A fourth referral has just been received regarding unsafe use of a hoist and consequent psychological harm to the adult concerned.
Concerns about residents' behaviours and wellbeing	Three service users have been injured during poor manual handling. Relatives and visiting professionals have expressed concerns about the dignity, emotional wellbeing and safety of other adults.
Concerns about the service resisting the involvement of external people and isolating individuals	None noted, however the service has not responded to requests to remedy concerns from visiting professionals or relatives and has not complied with the CFA QA team action plan.
Concerns about the way services are planned and delivered	Further staff have not been released to attend manual handling training and there is no evidence of plans to adjust rotas to allow this to happen. It is not yet known whether rotas can allow for sufficient flexibility to respond to other training or service requirements.
Concerns about the quality of basic care and the environment	All adults currently at risk as the service is not providing a safe environment; systems to promote safety; i.e. manual handling equipment, is being used in an unsafe way; adults are being moved unsafely and as a result are being injured.

Level of Concern	Summary
Major	All adults in the service are at risk of harm as all staff working with them are not sufficiently qualified to undertake correct manual handling. The manager is aware but has not acted to remedy this. Harm continues to be caused by shortfalls in the service. The impact of harm is high, and the likelihood almost certain as untrained members of staff continue to be on rota. Although other aspects of the service appear compliant, for example the staff are caring and other aspects of the care and environment good, the risk of injury or even death in a frail population from unskilled manual handling, coupled with a loss of confidence in the management and leadership of the service to remedy the shortfall, place these concerns in a “Major” category.

Appendix 3

The Strategy Meeting

Members of the Strategy Meeting will:

1. Agree the scope of the enquiry (as enquiries are to identify evidence to inform safeguarding risk assessments about service users currently receiving a service, the enquiry will focus on evidence relating to current care provision and will not routinely look at records more than three months old; unless a longer view is clearly required);
2. Assess the risk to service users from available information and consider what steps may be necessary to manage this risk. This must include discussion of any specific individuals where there are allegations of abuse or Neglect as well as wider organisational concerns;
3. Plan all aspects of the enquiry and clarify the respective roles and responsibilities of organisations and individual professionals;
4. Set clear timetables for tasks agreed;
5. Where action plans indicate further information is required to inform risk assessment and planning, the meeting will need to consider what information is required and which agency/agencies are best placed to gather the information;
6. The plan will outline where and from whom workers will seek evidence for example visits to the service, viewing of records, contacts with service users, contacts with service users' relatives etc.

7. Identify any specialist staff needed to support the enquiry officers where this is required, such as sensory loss, health needs (for example tissue viability), mental health or learning disability specialist staff;

8. Arrange for any further health and social care planning actions or reviews needed to be carried out by health or social care staff in their service;

9. Agree a communication strategy to avoid raising unnecessary anxieties or prompting destruction or manipulation of evidence. It is important to be clear what has been communicated to whom within a service and what information is permitted to share with service managers, providers, service users etc.

10. Agree Safeguarding Plan for affected individuals and organisational risks;

11. Consider whether it is necessary to make a referral for involvement of Independent Mental Capacity Advocates where any residents may lack capacity to make decisions for their care and safety. This can be the case even where the individuals have family members;

12. Where previous safeguarding concerns have been investigated, outcome known and closed, a Whole Service meeting will not reopen discussion on these individual cases;

13. Agree the date of any further meetings.

Appendix 4

Potential Criminal Offences in provided services

This appendix is **not** a definitive statement of the law. The police should be consulted before any other enquiry takes place about an adult safeguarding concern which may indicate a potentially criminal act.

1. Physical abuse

Offences against the Person Act 1861

Section 18 - Wounding with intent to do grievous bodily harm.

Section 20 – Inflicting bodily injury with or without weapon.

Section 47 - Assault occasioning actual bodily harm.

Criminal Justice Act 1988

Section 39 – Common assault and battery - offence of common assault relates to any physical contact.

Case study: A care worker becomes frustrated with an older man in his care who is slow to eat. The care worker picks up the piece of bread the man is eating and rubs it into his face and eyes. When the man gets up and shouts the care worker pushes him, causing him to fall and crack his head on the table. The man has an eye injury and bruising.
Although the care worker did not intend the man to be injured he is still arrested and a charge is made of common assault and assault causing actual bodily harm (ABH). An ABH investigation may only require an intention to apply unlawful force to someone, not an intention to cause actual bodily harm. The older man's injuries are evidence of the harm caused.

The charge of common assault relates to rubbing bread into the man's face.

Mental Capacity Act 2005 Section 44 – offence of deliberate ill treatment or willful neglect of a person who lacks capacity.

Case study: A care worker is arrested on a charge of deliberate ill treatment of an elderly man with dementia. The man had fallen to the floor. The worker dragged him to his feet and threw him onto his bed. As a result, he sustained a shoulder injury, was bruised and shaken. A colleague witnessed this and reported this to her manager. The care worker said that she had thought the man had "put himself on the floor" and did not "deserve" for her to use a hoist to lift him.

Criminal Justice and Courts Act 2015

These offences can be committed against people who have the mental capacity to make decisions about their care as well as those who do not.

Section 20 – offence of ill treatment or willful neglect by a care worker. Care worker" means an individual who, as paid work, provides—

(a)health care for an adult or child, other than excluded health care, or (b)social care for an adult,

including an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care.

- Section 21 Ill-treatment or willful neglect: care provider offence. A care provider commits an offence if:

(a)an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or willfully neglects that individual,

(b)the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

(c)in the absence of the breach, the ill-treatment or willful neglect would not have occurred or would have been less likely to occur.

Case study: A man has died in a care home for disabled people in need of nursing care. The cause of death is established as hypothermia. The care home provider was aware that the central heating was broken and that there would be no heating in the Home. The provider had taken no steps to address this or mitigate any risk. Although the Home was short staffed the provider had also refused to authorise any bank or agency staff. The man appeared to have fallen from bed during the night and was not found until the day shift came on duty at 8am. Individual care workers were initially charged with neglect, but subsequently the registered manager and owner were charged with offences under section 21 of the Criminal Justice and Courts Act 2015.

Theft and fraud

Theft Act 1968

- Offence of dishonest appropriation of property belonging to another, intending to deprive the owner of it permanently.

Fraud Act 2006

- Section 4 - Fraud by abuse of position.

Case study: A support worker has been arrested after using the bank details of a man she was supporting to set up numerous loans and internet shopping accounts. The worker had access to account details after offering to support him to administer his own finances.

Sexual Offences:

Sexual Offences Act 2003

- Sections 30-44 – offences against persons with a mental disorder;
- Sections 30-33 - offences against people who cannot legally consent to sexual activity because their mental disorder impedes their choice;
- Sections 34-37 - people who may not be legally able to consent because they are vulnerable to threats, inducements or deceptions because of their mental disorder;
- Sections 38-42 - care workers and their involvement with people who have a mental disorder.

Offences include:

- 'Touching' in a sexualised manner (offences are not all about penetration);
- Causing people to engage in sexual activity which does not involve touching by threats, deception etc.

Case study: A healthcare assistant is arrested after colleagues reported concerns that he was seen to carefully wash the breasts of patients on the unit for women with learning disabilities. Further enquiries found that he had pornographic pictures on his phone which he showed to the patients "for their education". None of the patients could understand what was happening or make reports themselves.

Neglect

See above, Mental Capacity Act 2005 and Criminal Justice and Courts Act 2015.

Case Study: Two night care staff workers are arrested when they "downed tools" following a dispute with their manager. Day staff arrived to find the eight older people on the unit were cold, and in wet and soiled bedding or out of bed semi clothed. Both workers were given eight month prison sentences once convicted of "willful neglect" under section 44 of the Mental Capacity Act.