West Sussex Safeguarding Adults Board
Making Safeguarding Personal

West Sussex Safeguarding Adults Board

Provider Learning Review

Learning from investigation of provider concerns – "we must not stop being shocked"

This review explores the system response and learning following a police investigation relating to the investigation of organisational abuse and neglect across a large provider of residential and nursing care in West Sussex. It explores the changes that have occurred as a result of this learning and identifies priorities for further change locally, regionally and nationally for preventing and responding to organisational abuse.

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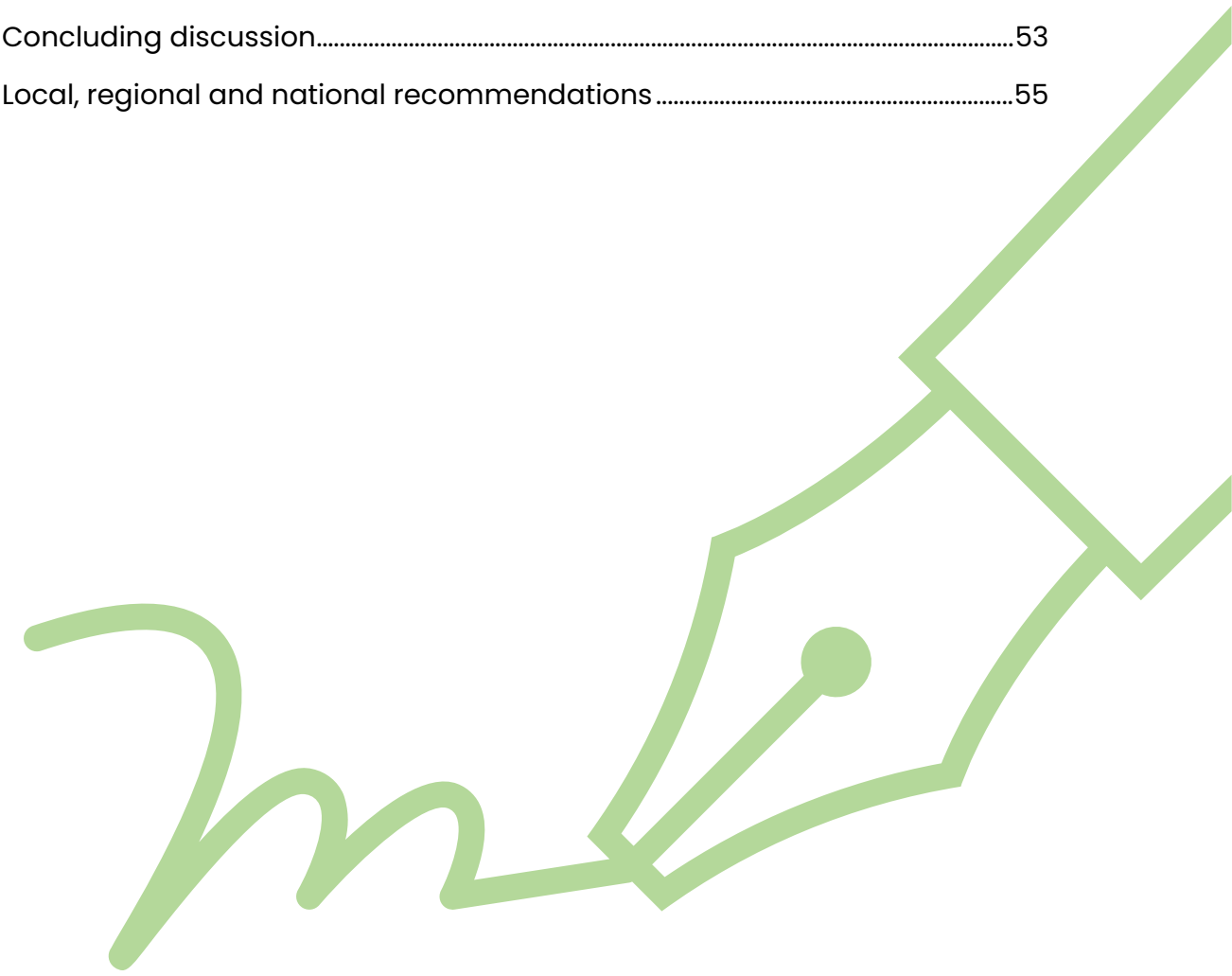
Contents



Foreword

On behalf of the West Sussex Safeguarding Adults Board I would like to thank Professor Michael Preston-Shoot for his comprehensive report and for his approach to meeting and working with relatives and staff who were available and able to take part. It was important for the Safeguarding Adults Board to hear and understand the experiences of relatives and of staff and managers during such a difficult and stressful time. We want to thank them and value hearing their contributions and views.

The report helps us understand events as they unfolded and the necessary work going forward to build on the significant improvements already made, reducing the risk of recurrence across services. The work undertaken in all services since these events has made progress and the outcome of that is acknowledged.

The report recognises the establishment of the Board's Quality Assurance Safeguarding Information Group (QASIG), which reports to the Safeguarding Adults Board, and which works proactively with other Board subgroups to make sure all services are aware of providers' needs and risk in order to work proactively with providers to improve, thereby addressing and reducing risk.

We, as a Safeguarding Adults Board, would like to offer our sincere condolences to families, carers and friends of the adults involved.

We will continue to monitor the improvement work taking place and will, as the recommendations require, work regionally and nationally to share our experience in order to influence change and improvement for working with the provider market.

Annie Callanan
West Sussex Safeguarding Adults Board Independent Chair
March 2025

Introduction

Prior to the commencement of this review, as the independent reviewer, I was told that the staff involved might be very worried and nervous. I have not detected this in my conversations with those involved. I was also told that the experience of involvement in the provider concerns process that was to be the subject of this review had been emotionally demanding and traumatising for some staff across the agencies involved. I have listened to accounts of what it felt like to be involved at the time, and the impact that this involvement continues to have. Emotionally demanding and traumatising it has certainly been. I have been reminded once again of the important but complex, challenging and demanding work that practitioners, managers, regulators and commissioners across health, social care and uniform services undertake. I am very grateful to everyone who has shared their lived experience of work, often painfully having to recall episodes and events. I must emphasise, however, that other staff, whom I have not had the opportunity to meet, either might have experienced their involvement similarly or differently.

This is the latest in a disturbingly long line of reviews into organisational abuse. Despite many recommendations, care has not been transformed for adults with complex physical and mental health difficulties, and learning disabilities. I am grateful to those family members who also shared their experiences with me, often again having to relive painful events. One family member asked me directly whether I felt recommendations from this review would mean that "this never happens again." I can highlight in this review the positive changes that have occurred, particularly locally in West Sussex, as a result of the learning from the police investigation. However, in keeping with other Safeguarding Adult Reviews (SARs) that have focused on organisational abuse, change nationally is required in terms of practice, policy for practice, and the law relating to safeguarding, quality assurance and regulation of providers, and investigation of provider concerns. That is why most of the recommendations for service improvement are directed to national health and social care bodies, and to government.

Readers of this review should be left in no doubt about the feelings of sadness, disappointment, even outrage, that were shared with me, and that I also experienced because we are here again. The quotation on the front cover was given to me by one of the practitioners involved. It is a challenge to us all in whatever roles we occupy in the safeguarding space. The determination to improve care quality in West Sussex, which I do not doubt, needs to be matched by a willingness nationally to do better. Recommendations have been co-produced by those involved in this review and are highlighted in the text. The final section will reorder these recommendations as they apply locally, regionally and nationally, and will additionally identify those that are directed to the West Sussex Safeguarding Adults Board and those where the responsibility for action rests with other agencies/organisations. My expectation is that these agencies/organisations will provide updates for the West Sussex Safeguarding Adults Board regarding the implementation and outcomes of these recommendations.

Professor Michael Preston-Shoot
Independent Reviewer
November 2024

1. Context

1.1. West Sussex Safeguarding Adults Board commissioned this Safeguarding Adults Review (SAR) following a referral from Sussex Police. It has been described throughout as a Provider Learning Review in order to clarify its primary focus, namely how agencies responded to concerns about quality of care at the time and how lessons learned have been translated into practice and procedural change. The independent reviewer accepted the commission to facilitate the review at the beginning of April 2024 and has been supported throughout by a panel of senior representatives from the agencies involved.

1.2. The background to this review has been summarised in the terms of reference, as follows. "Between 2016–2019, concerns were raised across the [West Sussex Safeguarding Adults Board] partnership about the care of residents living at homes run by a provider which is no longer in operation. This led to around 1000 concerns being raised, some of which were separate issues of concern for the same adult. Of these, around 86 adults had safeguarding enquiries opened with some having multiple separate enquiries. Also, there were two police criminal investigations. One was related to one care home and a conviction was secured. The other was a large-scale investigation looking into the deaths of 13 adults with complex needs/learning disabilities. The large-scale investigation concluded with no further action in 2023 as the Crown Prosecution Service determined that the threshold for criminal prosecution was not met."

1.3. At the time of the concerns, 19 services were registered with CQC under two different provider legal entities, mainly in the West Sussex area, providing around 600 placements for adults with a range of needs including older people, dementia, neurological and profound and multiple learning disability (PMLD) needs. The provider shared in-house services such as physiotherapy, speech and language therapy (SaLT), hydrotherapy, dieticians, [and] nursing care. The use of different legal entities was a decision taken by the provider.

1.4. Concerns at the time across the homes related to staffing, medication management, wound care, personal care, manual handling, risk assessments, equipment and the provision of in-house specialist support services. Key issues impacting the partnership response have been described as including:

- "Breakdown in working relationships across the partnership and with the provider.
- Volume of concerns and lack of a large-scale partnership provider concerns response.
- Lack of alternative care providers available to accommodate placements for people with complex/learning needs.
- Commissioning of in area and out of area placements." And
- How adult safeguarding referred under section 42 (Care Act 2014), provider concerns procedures and CQC inspections come together when concerns emerge.

1.5. The SAR referral further delineates the provider concerns that emerged during the large scale police investigation as encompassing:

- Failure to provide speech and language therapy, dietitian and physiotherapy
- Inadequate staffing levels
- Inadequate staff knowledge/experience to deal with residents with profound learning disability needs
- Widespread poor practices around the administration of medication
- Culture of non-reporting/lack of transparency
- Failure to implement a system for recognising deteriorating health
- Management of PEG/PEJ feeding
- Management of aspiration among PEG/PEJ fed clients
- Lack of recognition of medical deterioration by staff
- Inadequate care and nursing reviews/notes (generic and repetitive not bespoke and meaningful)
- Inadequate procedures around reporting injuries, falls, and safeguarding issues
- Poor manual handling
- High number of vacancies in managerial/registrant roles.

1.6. The SAR referral outlined several potential areas for multi-agency learning, as follows. "Lack of alternative care providers available to accommodate placements for people with complex physical disabilities and complex health needs led to a 'dependency' of sorts on [the provider]; clients placed from other local authority areas at [the provider] fell through the cracks in terms of safeguarding, monitoring of welfare and ensuring delivery of services that were being charged for; CQC inspections not being appropriately directed/led/informed by concerns held by local professionals who were going in to [the provider's] homes on a daily basis; [the provider] being able to build and open residential homes that were based on an outdated 'institutional' style model; volume and content of safeguarding referrals not being acted upon."

1.7. The initial key lines of enquiry (KLOEs) were therefore defined as follows:

- The partnership response to the rising volume of concerns at the time.
- What was learnt and measures put in place following this to minimise future risk?
- What systemic and strategic resources/processes exist now to support a partnership response?
- What else could be achieved to support the partnership to best respond to any future provider concerns of this scale?
- Following discussion with panel members, it was agreed to focus also on:
    - Prior to 2016, what was/was not in place in terms of responding to provider concerns?
    - How to capture the experience/views of adults, including residents, families and staff.
    - Roles and responsibilities of placing commissioners.
    - Achieving best evidence, in terms of what good care looks like.

1.8. It was agreed that invitations to contribute to this review be sent to family members of the 13 individuals on whom the police investigation centrally focused. At the time of writing, relatives of four individuals have responded to the initial invitation. Their contributions are included in this report.

1.9. Prior to the appointment of the independent reviewer the West Sussex Safeguarding Adults Board had determined that the provider would not be involved as it had ceased operation. However, a representative of providers in West Sussex has been a member of the panel supporting this review. Information was initially obtained from the agencies involved by means of a questionnaire that asked how they were involved at the time, the learning

obtained from that involvement, resources and processes now in place to respond to provider concerns, and finally what else might be needed. Information was received from the following organisations:

- West Sussex Safeguarding Adults Board
- West Sussex County Council
- Sussex Police
- South East Coast Ambulance Service
- Sussex Partnership NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- NHS Sussex Integrated Care Board
- Care Quality Commission

1.10. These agencies also responded to questions that the independent reviewer asked after reading their initial submissions.

1.11. Invitations to provide initial information were also sent to the placing commissioning authorities for the 13 individuals where these were outside West Sussex. To date, three responses have been received from London Borough of Hillingdon, NHS Kent and Medway, and Surrey County Council in relation to four individuals.

1.12. Owing to the impact on all staff involved at the time and still today, which was described by panel members as “vicarious trauma”, ”frustration and sadness”, the independent reviewer has met, either individually or in small groups, with practitioners from across health, police, commissioning, regulation and inspection, and social care. These have proved to be very informative and helpful but at times distressing conversations, highlighting the emotional weight and trauma of these events.

1.13. A well-attended half-day learning event was held to provide practitioners and managers with an opportunity to reflect further on how concerns about the quality of care within the provider were responded to at the time, the learning taken from these events, the policies and procedures put in place as a result, and recommended priorities for further strengthening practice locally, regionally or nationally for preventing and responding to organisational abuse.

2. Families speak

2.1. For one family their relative was only resident with the provider for four weeks before they died. The family had no concerns about the quality of care during that time. However, although they knew about the outcome of the police investigation relating to their relative, they were unaware of the final outcome of the police investigation as a whole. They had also been told that the coroner would be in contact but have heard nothing since.

> **Commentary:** this family stating that they did not have concerns at the time is an important reminder, given what follows in this section of the report, that not all families shared the concerns being expressed by practitioners who entered the provider's homes or who saw residents outside the provider setting.

2.2. A second family had been informed that an inquest would happen after the conclusion of the investigation but had heard nothing since. The police had told this family about their concerns. A safeguarding practitioner had also visited the family and is reported as having said that "I cannot believe what I have found." This family had been told that "lessons will be learned" and sought reassurance from the independent reviewer that this would indeed happen. This family were clear that what happened "could have been avoided."

2.3. A third family found the police very informative at the beginning but subsequently only occasionally. As with the first family, they knew that their relative's case would not be taken forward but they were uncertain about the final outcome of the corporate investigation. In their case they knew that a coroner had described the death of their relative as suspicious but did not know whether or not a Regulation 28 prevention of future deaths notice had been issued.

2.4. A sister responded on behalf of a fourth family. She described the entire process as "incredibly traumatic" and said that her father and another sister had felt unable to speak about the process again. "Not to recount but to let it rest." The sister had also been hesitant about reopening what had happened but the imperative to contribute to learning was strongly felt.

2.5. As reported by other families, the sister thought that the investigation was still ongoing. Throughout the process, and even now, there was a "fear of what will be disclosed" and of what had previously been unknown to the family. The family had been given assurances that there had been no abuse/neglect in their daughter/sister's case and there had been a strong reluctance to "reopen emotional torment" and to revisit what she might have experienced.

> **Commentary:** family feedback highlights the importance of family liaison and information-sharing throughout an investigation and on its conclusion. Sussex Police have reflected that all families could have received a closing communication after the conclusion of the whole police investigation. They have observed that updates were more frequent earlier in the investigation when there was more information coming to light. Usual practice had been to inform families when to expect a further update.

2.6. The trauma experienced by these families at the time and subsequently emerged very clearly during the interviews with the independent reviewer. One family described clearly the psychological impact of poor care, and neglect/acts of omission, of what they witnessed. This family had other relatives who would in all probability require residential nursing care, a prospect that now carried considerable fear. This family also described how upsetting a meeting at the provider had proved when a manager was very evasive. Another family had been emotionally torn. Their relative had not wanted to leave his friends and family members were split about whether or not to move them. Ultimately they had "put their relative's happiness first" but now continued to feel that they had "let them down."

2.7. Three families expressed concern about the knowledge and skills of staff. One family had been told by the provider that staff were capable of dealing with the severity of their relative's disabilities but had seen advertisements stating that "no experience was necessary" and had been in a meeting when provider managers admitted they had not got the facilities that had been advertised. They knew that their relative required properly trained nurses to avoid medication errors, risk of falls and choking. However, their relative sustained serious injuries following a fall and there was a significant delay in getting them to hospital. At this time family members who visited were not allowed to see their relative. The family believe that an accident report was not completed immediately, that provider staff were dishonest and that recollections and reports were changed. Other relatives had also been placed with the provider and "they had clung to each other." When

their relative was in hospital before they died, they said “home hurt.” One surviving relative had been moved and was now living in “a good setting and a completely different atmosphere.”

2.8. A second family described how their relative had been living in a “fantastic” placement but required a greater degree of nursing care. They had chosen the provider because their relative had friends there, “it seemed lovely” and “wonderful care was promised.” The family were told of a consistent staff group, without reliance on agency workers, for example for night duty. The family believe that they witnessed agency staff being transported into the setting. They had been told that residents were monitored closely overnight but this did not happen. On one occasion, during the night, their relative had been assaulted by another resident. Family members visited frequently, sometimes staying overnight. They reported occasions when their relative’s mouth was dry, with cracked lips. They had not been given suction. Their relative was non-verbal and arrived at the provider with an adapted iPad to facilitate communication. This was stolen but the provider did not report this to the police. Subsequently, someone in a carer’s uniform was known to have used the iPad but no action was taken other than the provider finding a replacement.

2.9. Their relative was funded for 1-2-1 care but this never materialised. Keeping their weight on an even keel was an important part of the care plan but their relative lost weight and the family question whether an onsite dietician was ever involved. The provider are reported to have admitted that it did not have one. Their relative was funded for hours of physiotherapy but this was not forthcoming. The family were told there were not enough staff to provide what was required even though this was necessary to keep their chest clear. When the family complained about these incidents, a manager told them that it would be sorted. The family always went to provider managers and felt “fobbed off.” “Management did not get back to us.”

> **Commentary:** these accounts raise a question as to whether family members know how and where to raise concerns externally and whether sufficient information is provided at the commencement of a placement about pathways for complaints and concerns. Mindful of the key line of enquiry regarding out of authority placements, this family recounted that there was no external review of the lack of 1-2-1 care for some time. When a review was held, the commissioner apparently confirmed that "funding had been there from day one." The question of the adequacy of monitoring by placing commissioners will feature later in this report. *When placements are commissioned, individuals and their families must be given details about how to raise concerns and to submit complaints.*

2.10. This family described several incidents of poor care, neglect/acts of omission. On one occasion their relative arrived very late for a medical appointment without a change of clothes or incontinence pads, wearing someone else's clothes[1] and with a urine bag on show. "He was not treated as a human being." This lack of care was also demonstrated because their relative arrived soaked in urine and staff had not responded to a bleeping feeding pump. No food had been delivered.

2.11. When staff from his previous care setting had visited, they expressed concerns that their communication system had not been used by the provider. They were apparently told that "we know how to communicate with [named resident]." The family believe that this demonstrates management arrogance.

> **Commentary:** other SARs[2] have highlighted how the knowledge and experience acquired over time by family members and previous care services have been discounted or ignored by a new provider.

2.12. Prior to their relative's final admission to hospital, the family were told that an ambulance had been called as a precautionary measure. The family were on their way to visit at the time. No-one from the provider called back whilst the family were travelling. When they found their relative in hospital, it was "devastating." No-one from the provider was there. Their relative was in a terrible state, in a condition that could not have happened immediately, as the provider alleged, but that had been developing for some time. Their relative was critically ill and died shortly afterwards. Their relative required feeding through a tube and was nil by mouth but it appears that they had

[1] They described their relative as very particular about clothing.

[2] For example, Bristol SAB (2018) SAR Christopher.

been fed, although the provider denied this. It is possible that there had been a choking episode. A hospital consultant had told the family that "something is not right." The family believe that the provider "swept evidence under the carpet," were dishonest and that "record keeping was awful[3]."

2.13. One family's feedback focused on how the police handled the investigation and how this could have been improved. Initial contact had been six months after their daughter/sister's death and "threw the family." This contact was experienced as "abrupt and quick." No details of abuse/neglect were shared, nor who had identified her, nor why a cause for concern had not been activated previously.

> **Commentary:** Sussex Police were not notified of deaths at the time they occurred. This might account for this family's experience of a delay between the date of death and police contacting the family.

2.14. The meeting with other families to explain the investigation had not been helpful. There was a divide between those who had reported abuse/neglect and those who had not. Everyone had to listen to "horrible accounts." It was experienced as "very damaging." The press had been able to get into the meeting and some details were learned through the media rather than from the police.

> **Commentary:** both beforehand and at the meeting Sussex Police had asked families to respect the privacy of the meeting, which was designed to explain the investigation and the coronial process and to enable relatives to ask questions. However, one family invited a member of the press who did not identify themselves at the time. Sussex Police complained to the Independent Press Standards Organisation when an article subsequently appeared in the press. Factual inaccuracies in the press report were corrected and an apology was received.

[3] The family stated that feed and medication charts were incomplete and questioned whether at times their relative was not fed.

> **Commentary:** the independent reviewer understands from Sussex Police that only generic information about the type of poor care being uncovered was given rather than specific details about individual cases. A careful balance had been attempted at the meeting between acknowledging and responding to the trauma and anguish being experienced by families, alongside avoiding tarnishing any evidence that families might be asked to give in court and recognising that not every family wished to engage with others.

2.15. The family were allocated a liaison officer who had to be chased as this role appeared to be additional to their day job. A consistent response was that there was "nothing to update you." The family continued to feel that no details were being shared and that communication with them was poor. The family had been told not to talk with other families and, consequently, felt isolated[4]. Despite their daughter/sister having been a resident for fourteen years, the family were told not to speak to care staff. This unsettled the relationship that the family had established with some care staff. The family "went through devastating things mentally." The family accepted the offer of counselling but "we did not know enough about what had happened to be able to access this support." It was only towards the end of their contact with the police, after over three years, that the family was told what the concerns were and reassurance was given about their daughter/sister.

2.16. In relation to the care that their daughter/sister received, "we were her voice" as she was non-verbal. She was not checked and monitored frequently, apparently because of lack of staff capacity. "We would turn up unannounced to check she was looked after and there was "hardly anyone there." She had been neglected in a previous home and this "added to the trauma." "We removed her from that home, hence the unannounced visits. We thought she was being looked after." There was no CCTV in shared spaces, which the family felt should have been installed to monitor residents' safety. The family did not feel that staff had been vetted properly, linking this to CQC reports. The sister observed that "this baffles me." Finally, the sister observed that the provider had been able to accept placements whilst under investigation, commenting that "this should not be allowed."

[4] Sussex Police have told the independent reviewer that they did not issue such a direction.

Commentary: these family accounts align particularly closely with concerns being expressed at the same time by West Sussex healthcare practitioners. A question to be answered by all involved across health and social care, including government departments, is how, after so many reviews into organisational abuse, everyone can be best prepared and resourced to prevent, anticipate, intervene and respond to organisational abuse. This ability to respond well is multi-faceted and includes having effective legal remedies, and national and local policies and procedures in place, alongside strong multi-agency relationships, knowledgeable and skilled staff and the resources to support their safeguarding, provider concern, registration, inspection and commissioning work.

3. KLOE: learning from the partnership response at the time

3.1. "Some things worked well; there was some learning." This is how one individual who was involved in the investigation summarised the partnership response.

Out of area placements

3.2. Only 45 residents across the provider's 19 services were the responsibility of West Sussex commissioners. From documentation provided by agencies across West Sussex three interconnected issues emerged, namely the apparent "indifference" of some placing authorities[5], the lack of compliance with statutory guidance that outlines the roles and responsibilities of placing commissioners, and the impact for residents when no-one is advocating for them. One practitioner in an interview described this simply as "negligence." It was suggested to the independent reviewer in interviews and at the learning event that the focus for some commissioners appears to have been on sourcing a scarce placement, given limited alternative options, rather than on homeliness. As a result, the provider was not challenged.

> **Commentary:** these are repetitive issues, having been reported in the second national analysis of SARs (2019-2023) and subsequently[6], and escalated to Department of Health and Social Care as a national service improvement priority. Indeed, West Sussex Safeguarding Adults Board's Review in Rapid Time of Darlington Court found that the Clinical Commissioning Group (CCG) was unaware of which NHS commissioners were responsible for contracting beds at the home.

[5] For example, *"[named placing authority] never showed."*

[6] Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. with Spreadbury, K., Taylor, G., Hopkinson, P. and Rees, K. (2024) *Second National Analysis of SARs (2019-2023)*. London: Local Government Association and ADASS. See also, for example, Staffordshire and Stoke SAB and Cheshire East SAB (2024) SAR Clive.

3.3. Documentation referred repeatedly to a lack of placement reviews and questioned the effectiveness of reviews that did take place and the guidance associated with them. Occasionally, the attitude of placing authorities was described as "aggressive" when concerns were raised; more often it was poor engagement and "lack of interest" that were highlighted. The case might be "on a duty list," inviting questions about whether commissioners knew that what had been commissioned based on need was actually being provided, or whether they were relying on assumptions about care quality.

> **Commentary:** this is a repetitive issue highlighted in SARs[7]. Continuing evidence of lack of placement oversight should be a service improvement priority for Association of Directors of Adult Social Services (ADASS), Integrated Care Boards (ICBs), NHS England and Department of Health and Social Care (DHSC). There is ample evidence from SARs that statutory guidance[8] and practice guidance[9] on out of authority placements carries insufficient weight. Practitioners across all services in West Sussex were clear that a more robust follow-up of out of area placements is required. *One recommendation to emerge from the agencies involved is that there should be a legal requirement on placing health and social care commissioners to notify the host local authority and/or ICB. Primary legislation rather than statutory guidance should delineate the duties on placing commissioners and host agencies, for example regarding placement reviews and maintaining a dynamic support register of people placed out of area that can then be the focus of assurance reports to Safeguarding Adults Boards.*

3.4. Not all residents had family members who were able to visit regularly. As the previous section has highlighted, not all families knew how to raise concerns external to the provider. Agency documentation observed that residents placed by commissioners outside West Sussex experienced different levels of support and some had no in-person review for some considerable time. An offer of advocacy would then have been beneficial, as the following two separately received observations emphasise. "This is a fundamental learning point that had already received recognition from the Winterbourne enquiry and has only been further underlined by [the police investigation]. It

[7] For example, East Sussex SAB (2017) SAR Adult A and SAR Ben (2022). West Sussex Safeguarding Adults Board (2018) SAR Matthew and Gary.
[8] DHSC (2024) Care and Support Statutory Guidance.
[9] For example, ADSS (2016) Safeguarding Adults Policy. National Guidance on Out of Area Safeguarding Adults Arrangements.

is absolutely paramount that service users from distant funding local authorities (especially those with little or no family visitor contact) have advocacy. This cannot be stressed enough. Without any sort of independent oversight in relation to the suitability of such placements (and to ENSURE funded services ARE being delivered) it is all too easy for providers to marginalise these clients. Especially in the current climate of the care industry with the well-known budgetary pressures under which all providers operate." Again, "it would be reasonable to say advocacy and human rights is an area for improvement within the care sector. It is not unusual for Deprivation of Liberty Safeguards (DoLS) to be inappropriately applied for and capacity assessments not to be carried out correctly. We acknowledge there is a shortage of independent advocates. Improved learning about what this is, how it supports people's human rights and how to access it is needed."

> **Commentary:** these observations invite a question about who advocates for those residents who cannot rely on a family circle of support. There were no Healthwatch enter and view reports for the timeframe considered in this review. West Sussex local authority could not fund advocacy for residents placed from out of area due to contractual arrangements for funding. Statutory rights to advocacy might not extend to the quality of care and treatment experienced by residents. This gap in advocacy provision has been noted in other SARs, for example focusing on learning disabled people in supported living[10]. *Statutory entitlement to advocacy should be extended to embrace those individuals in placements where there is no other circle of support.*

3.5. Only three local authorities and one ICB responded to the request for information regarding individuals included within the police investigation for whom they were responsible. Three referred to their policies, protocols and processes for responding to provider concerns, and to conducting regular reviews. One local authority did not believe that they had been informed of the outcome of the police investigation. Another had not been notified of a cause of death. Two stated clearly that no safeguarding concerns had been identified by their practitioners. However, the ICB did observe that safeguarding concerns had been received and that "nurses did not appear confident in managing [the individual's] complex needs; they were reactive rather than proactively managing their needs; this did not improve despite

[10] SAR Bill and Jim (2024) Somerset SAB.

safeguarding concerns being raised. Staff did not follow instructions from specialists."

> **Commentary:** there is clear alignment between this response and what practitioners in West Sussex had observed.

Model of care

3.6. From submitted documentation, interviews and observations at the learning event, several inter-related concerns have emerged. Firstly, those involved have questioned how this provision was permitted to develop. It was seen as an institutional model, "like a hospital", "too big and too clinical", "and "not offering a normal adult life." Everything was generic and generalised rather than person-centred, a graphic example being the use of a shower trolley even for people who were independently mobile. The model of care was seen as outdated, as "wrong." Residents were "hidden away." There was no community presence, compassion or empathy. There was "nothing in people's timetable." The focus for commissioners, it was suggested, was on "finding a bed, not a home."

3.7. Several interviewees highlighted a potential conflict of interest at the time, with an elected member being on the provider's board. At the learning event it was suggested that potential gatekeepers (those responsible for planning permission, alongside health and social care commissioners, ICB and Adult Social Care (ASC)) had not been aligned; decision-making had not been collaborative as the provider expanded.

3.8. Secondly, as the provider was expanding, a shared understanding was lacking across partners and commissioners of what care should have been provided and how. CQC statutory guidance had been published initially in 2017 and revised and retitled in 2020.[11] Practice guidance has also been published[12]. Awareness of this guidance remains variable, with doubts expressed about whether it has been embedded in practice. One interviewee questioned what had happened to earlier policy initiatives[13].

[11] CQC (2017) Registering the Right Support. CQC (2020) Right Support, Right Care, Right Culture.
[12] For example, Preston-Shoot, M. and Lawson, J. (2019) Making Safeguarding Personal for Commissioners and Providers of Health and Social Care: "We can do this well." Local Government Association and ADASS. Also, Preston-Shoot, M. (2020) Practical Examples of Making Safeguarding Personal from Commissioners and Providers of Health and Social Care: "we are doing this well." Local Government Association and ADASS.
[13] HM Government (2001) *Valuing People*. DH (2010) *Valuing People Now*.

3.9. Thirdly, the lack of alternative placements for people with specialist needs had resulted in a power imbalance between commissioners and providers. "Power sits with the provider." As a large provider, it was suggested that the provider wielded "a huge amount of power" in the local care economy. Health and social care practitioners felt that they had to "be careful of your career."

> **Commentary:** the impact of the shortage of placements has already been escalated to DHSC by the National Network for Safeguarding Adults Board Chairs (NSCN) as a result of learning from SARs.

3.10. Several respondents have talked about how "terrified" some relatives were. Some had prior experience of other care settings being closed. Others did not express concerns, with commissioners and the provider responding along the lines of "families are happy, so we are happy." The views being expressed between "this is the only service" and "we have no concerns" meant that those practitioners and agencies raising concerns were blamed, were seen as "the enemy." Some families were angry; some wrote to CQC asserting that the regulator's conclusions and actions were wrong. Safeguarding was complicated and challenging as a result. "We were trying to stop poor care."

3.11. One further aspect of the model of care that drew considerable criticism and concern was that staff lived on site. This was felt to run the risk that staff would feel unable to complain or express concerns because of the risk of being made homeless. Another further component of the model of care that attracted concern was the employment by the provider of its own healthcare and GP provision. Some concern was expressed that what was being advertised was not actually available, such as physiotherapy, which aligns with what one family has reported to the independent reviewer. Concerns were also expressed about the use of ward rounds rather than individual appointments for residents, for example with GPs. "Everything was in house; it was an incredibly closed system." However, this model of care also resulted in lack of clarity about roles between onsite provision and external healthcare practitioners visiting, with the risk of contradictory advice being given. It has been suggested that West Sussex healthcare services were inconsistent about whether they would undertake direct clinical work and, where this was provided, it might have masked concerns. Some healthcare practitioners have also suggested that some information was deliberately withheld and some practices covered up, for example about nutrition and feeding, with records and charts not being completed

contemporaneously. What has been called into question is the "truthfulness of the provider."

Quality assurance

3.12. Once again, from the learning event, interviews and submitted written reflections, unanimity of perspective emerges. Despite its marketing, the provider did not have the necessary expertise. Staff had insufficient knowledge and experience, and some lacked confidence and training. "*Staff had insufficient experience of looking after people with complex needs; they were trying but were doomed to fail.*" Record keeping was poor. Questions have been asked of CQC and of commissioners in terms of how the qualifications, knowledge and skills of staff at all levels within the provider were assessed and reviewed. It has been suggested that there was over-reliance on organisational self-assessment, and that expectations of providers were not always clear in writing.

> **Commentary:** West Sussex Safeguarding Adults Board's SAR Orchid View contained a recommendation on strengthening arrangements for checking of staff qualifications and competence. CQC Regulation 19[14] is relevant here. This requires the provider to have robust recruitment procedures that include relevant checks, for example of a person's qualifications and competence. CQC cannot prosecute for breach of this regulation but can take regulatory action. *Current regulations for checking qualifications and competence should be reviewed and strengthened, to include minimum standards of knowledge and skills, and documented auditing of performance against these standards.*

[14] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 19 covers skills, competence, knowledge and experience of staff to carry out their roles. It also includes recruitment processes to ensure they are fit and proper for the role they are being employed. Regulation 18 covers staffing levels and the provision of training and supervision.

> **Commentary:** West Sussex Safeguarding Adults Board's SAR Matthew and Gary also highlighted inadequate checks, this time of agency staff in particular. As reported in the previous section of this report, one family expressed particular concern about the use of agency staff. The independent reviewer has also been told in an interview that two types of agency staff were employed. Where agency staff were explicitly employed by the agency, that organisation held responsibility for their training and qualifications. Where the agency only made an introduction, responsibility for training, induction and qualification checks would have been the provider's responsibility. It was suggested to the independent reviewer that the provider did not appreciate this responsibility for some time and that care workers whose practice was poor were moved between the different settings within the overall provision.

3.13. For quality assurance to be truly effective, it must be vigilant 24/7[15]. At the learning event, the lack of checks on quality and the lack of oversight or quality assurance were highlighted, in a context where it was felt that the provider had little idea of what they were doing to address the complexity of residents' needs. Staff employed by the provider did not, it was suggested, have access to clinical supervision. Those employed from overseas did not have sufficient background in learning disability services.

> **Commentary:** these observations further reinforce the importance of Regulations 18 and 19. CQC did take enforcement action with respect to breaches of these regulations. "The focus on staffing became more rigorous due to the concerns being raised." Inspectors tested knowledge and skills not just by looking at certificates but by talking with staff about how they would approach particular scenarios. CQC inspections were always unannounced and on one occasion inspectors witnessed staff being sneaked into a location from elsewhere via a backdoor.

[15] Margaret Flynn, personal communication.

> **Commentary:** in an era of financial austerity, a 24/7 approach would be challenging. However, the observation reinforces the importance of information-sharing and planning between all those agencies whose practitioners and inspectors are visiting a provider. Agencies have been candid in reflecting that, at that time, such a system was not securely in place. It took time, months in fact, to bring commissioners, safeguarding and regulators together in a combined, collaborative approach.

3.14. Vigilance was also made more difficult by the provider, whose approach was experienced at times as "hostile", "aggressive", "intimidating", "litigious" and "very insular." "Every time we went in, people were out. Residents were hidden from us." "It all felt very controlled and defensive." "We were shown around by senior managers", "we were followed around" and conversations were often "very corporate" with senior managers taking reviews. It took "considerable skill" and "tenacity" to enable a more open conversation. West Sussex Safeguarding Adults Board SAR Kingswood also found evidence of disguised compliance, of the care home obscuring poor care quality.

3.15. West Sussex safeguarding staff also were hampered by the architecture of the legal rules. There is the section 42 duty to enquire but there is no immediate recourse if this is not enforceable, especially when most residents were placed and funded by health and social care commissioners from outside West Sussex. There were also occasions when the provider refused entry because West Sussex staff were wanting to see an individual for whom they had no funding responsibility. Moreover, practitioners were sometimes uncertain about how to respond when there was no improvement in quality of care, resulting some have suggested in "learned helplessness." Several of those interviewed expressed doubts they held at the time about whether "we were doing more harm than good."

3.16. "How do we get under the skin of a closed culture?" At the time some staff who were involved have suggested that there was limited recognition of the signs of a closed culture[16] and/or how to respond to such indicators as staff living on site, a context in which they would feel inhibited in raising concerns[17]. Other practitioners and managers have observed that they were aware that they were working with a closed culture but felt that they did not have any way of dealing with it. At the time opportunities to discuss signs of

[16] CQC guidance on closed cultures has now been published.

[17] At the learning event it was suggested that provider staff who did raise concerns were moved on. In interviews and at the learning event, practitioners recognised that some staff provided good care but often left quite quickly.

closed culture and indicators of organisational abuse across Adult Social Care, primary and secondary health services and CQC were limited. A forum had not existed where intelligence could be shared.

3.17. All these factors made it difficult to appreciate the full extent of the concerns and/or to determine how best to respond.

Safeguarding

3.18. The independent reviewer has been told that practitioners raising concerns did not feel listened to and that recognition that concerns required robust investigations was late in coming. "There were struggles with the local authority to focus attention on [the provider]; concerns did not generate a robust investigation initially." Some agencies have reflected that it took time for safeguarding concerns to generate momentum, for example with Adult Social Care and CQC. Various hypotheses have been advanced to answer the question "why?" One suggestion is that referred safeguarding concerns were lost in translation, with a consequent need for healthcare practitioners to interpret their concerns through the lens of section 42, and safeguarding practitioners to understand how referred concerns about poor health and care in an institutional setting might equate to neglect/acts of omission, or organisational abuse. It certainly appears that for some time there was insufficient recognition of clinical expertise and that more credence needed to be accorded to the "voice" of healthcare practitioners visiting the provider's settings. Equally, those referring and those in the local authority and CQC receiving referrals and concerns have acknowledged that concerns were not always clearly articulated and evidenced, making it difficult to discern how the criteria in section 42(1) or for enforcement action had been met. "We got to evidence eventually." Moving from an undertone of concerns about the provider to pinning down actual and specific evidence was, it has been suggested, made more difficult by the provider's defensiveness, by "being kept at arm's length."

3.19. At the time, how adult safeguarding was organised impeded the identification of patterns. West Sussex Safeguarding Adults Board's SAR Kingswood had previously identified that no pattern within concerns had been identified or responded to. Section 42 referrals went to different teams at that time, with different levels of knowledge. This impeded the identification of patterns and also resulted in a lack of consistency of response. There might also have been some lack of understanding about care standards, and a missing procedure to formally escalate concerns

when safeguarding referrals did not result in an enquiry. As a result, escalation was experienced as difficult and slow. This produced a level of frustration. Interviewees have commented that systems at the time did not facilitate tracking and oversight of diverse sources of evidence. As a result, for some time, there appeared to be a lack of "*clear evidence*", with the situation remaining "*misty*." The signs were "*soft*."

> **Commentary:** the identification of patterns of neglect/acts of omission, and of organisational abuse/closed cultures, is especially important since section 42 (1) criteria focus on individuals – those with care and support needs, experiencing or at risk of abuse/neglect, and unable to protect themselves because of their care and support needs. West Sussex Safeguarding Adults Board's Review in Rapid Time of Darlington Court (2021) also observed the challenge involved for multiple agencies in identifying and escalating concerns, and in creating a shared understanding of them and responding collectively. West Sussex Safeguarding Adults Board's SAR Orchid View (2014) also found the need to collate safeguarding concerns and to identify and respond to patterns.

3.20. There was not a provider concerns process at the start and therefore reliance was placed on individual section 42 enquiries. Nor was there threshold guidance. These were developed as a result of learning from previous reviews and from this investigation. Consequently, at the time, it was difficult to review the outcomes of enquiries and whether changes had been made in a context that included the volume of new concerns coming through and the difficulty of engaging with the provider, making it so challenging to complete individual enquiries with a clear outcome. The volume of safeguarding work that operational health and social care teams were dealing with related to this provider, on top of "normal business," was a real barrier and challenge. "Services were completely overwhelmed." Other observations shared with the independent reviewer have included the absence of feedback about referrals or enquiries, a missing inquisitive mindset, and the impact of placement shortage and/or CQC ratings. Some have questioned whether the thresholds for interpretation of the three criteria in section 42(1) were set too high. Others have suggested that there was no plan, agreed in a multi-agency meeting, for what would happen if practice after an enquiry did not change.

3.21. At the learning event in particular, the challenge was noted of having raised safeguarding concerns whilst needing to continue to work with the provider in an attempt to improve care quality. Some practitioners had also had the

experience of family members requesting that safeguarding concerns not be raised because of the shortage of placements elsewhere and the potential fallout from having been seen to have complained. Some practitioners also reported that staff had requested that safeguarding concerns not to be raised, again because of potential fallout. "*We kept giving them chances*." Disconcertingly, some practitioners also commented that they had been told to be "*helpful and supportive*."

3.22. Noteworthy here, and additional hypotheses to answer the question "*why?*" is that the provider did not raise concerns and that CQC inspection ratings might have diluted the concerns being expressed.

> **Commentary:** notifications to the CQC are required by law concerning events that impact on quality, safety and continuity of care. Notifications are required, for example, with respect to deaths, allegations of abuse and serious injury. CQC did scrutinise the notifications received from the provider. This scrutiny, alongside analysis of concerns by safeguarding practitioners, enabled a clearer evidential picture to emerge.

Resources

3.23. Several learning points have emerged that highlight the need for resources to prevent organisational abuse and to investigate when concerns emerge. Services were not set up to investigate the volume of concerns that emerged and under-estimated the time and resources needed when the scale began to be appreciated. For some of those involved in responding to concerns that were emerging regarding the provider, and the subsequent investigation and transfer out of residents, this work was additional to their other responsibilities, which added to the stress they experienced. Several agencies increased resources when it became clear that teams were struggling with the sheer volume of the task.

3.24. Sussex Police were not set up to investigate crimes of this magnitude and earlier involvement of a senior investigation officer and major crime team was required. Sussex Police have also identified the need to have secured sufficient analytic resources. Some have questioned whether the Crown Prosecution Service (CPS) had sufficient experience of this type of abuse/neglect. More positively, however, CPS nominated a lawyer early on to liaise regarding the police investigation. West Sussex County Council also had staff working with the police daily on the cases.

> **Commentary:** West Sussex Safeguarding Adults Board's SAR Orchid View recommended that CPS should seek expert advice about neglect and safeguarding in order to understand expected practice and procedures. The independent reviewer understands that CPS have a unit for complex case work.

3.25. CQC established a dedicated, separate team to investigate this provider. The independent reviewer has been told that this was the first time such a team had been established. The team comprised staff with both regulatory and learning disability backgrounds. Specialist advisers and experts by experience were also involved with the team. What followed were "dozens" of enforcement actions at location and provider levels. Information was shared with the police "at least weekly."

3.26. Agencies have been very candid in recognising the need to have acted more quickly. It took too long to establish collaborative working, partly because of tensions between partner services that originated in part from a lack of understanding about the roles, responsibilities and legal powers available to the different agencies involved. Again, more positively, the decision to co-locate practising social workers and health practitioners within the police investigation team proved very beneficial, as did police knowledge of, and willingness to learn about safeguarding. Co-location helped with the interpretation of emerging evidence.

3.27. It has also been emphasised that West Sussex is a net importer in terms of individuals and families seeking placements in residential and nursing care settings. The independent reviewer has been told that there are at least 10,000 beds in West Sussex and more than 300 registered provider locations. However, funding does not follow and services, such as community learning disability teams, are not adequately resourced to meet demand. Provider concerns investigations also divert resources away from other areas of work.

3.28. What made the experience "troubling" and "upsetting" in part was the lack of placement options and the effort it took to effect change.

Staff support – the need for "PPE for our minds"

3.29. It has become apparent during interviews and at the learning event how traumatic it was to have been involved in this provider concerns investigation, and how emotionally upsetting the experience continues to be. It involved "a huge amount of stress" but "peer support was amazing." It was

"a once in a lifetime experience." "I thought it was just me." The experience impacted, then and now, on their physical health, mental wellbeing and relationships. "How awful it was in the beginning." It has been suggested that there was no support for staff "from above." It was "hit and miss with managers." "I had to find my own networks." "There was only a vague awareness of what we went through." "It was really hard." Debriefing sessions did not appear to be the norm. However, some agencies did provide debriefing sessions for their staff.

> **Commentary:** there is clear learning here for the West Sussex Safeguarding Adults Board and for senior managers about recognising and responding with care to the lived experience of staff.

3.30. Some staff have reported feeling ostracised, experiencing challenging relationships with other services, and felt they were labelled as "bad people." "I was seen as a pain in the neck and not always invited to meetings." For many the experience was troubling, upsetting and traumatising, and continues to be so because "not all moved to better lives" and some residents died after they were moved[18]. Healthcare and safeguarding practitioners, and inspectors, went in twos when visiting the provider to avoid being misrepresented by the provider and to check out their observations and conclusions with colleagues. Some practitioners who visited took extensive notes and photographs at the time, not least to avoid subsequent disputes and because the provider appeared resistant to any kind of observations. However, for many, they have been left questioning "what did I not see? What was I not told?"

3.31. What has been emphasised was the "bravery and courage" of key individuals, and the "professional tenacity" required of those involved in raising concerns with the provider and to other services, and the subsequent investigation. It required them to avoid becoming scared of the provider and of families when they were vocal in opposition. It was "incredibly stressful." Some staff who were closely involved in the police investigation were given welfare packs.

3.32. Safeguarding practitioners in health and social care have talked about "having to become our own experts" as no training or specialist advice seemed available.

[18] A few examples were given, however, about the positive changes that occurred for some individuals after they were moved away from the provider. For example, a practitioner reported the following: "*he talks now because they [new provider staff] talk to him*."

3.33. Families also, as reported earlier, had grappled then and were grappling now with what the right thing to do was for their relative – to move to safeguard them or to continue with the placement where they had friends – practitioners also struggled then and now with what might have been the best approach. A sense of feeling "powerless" was present at times at the learning event and in interviews.

> **Commentary:** when faced with such dilemmas, perhaps it is easier to base decision-making not on seeking the right answer but on what might be, when all the evidence is weighed in the balance, the least wrong answer. Senior leaders across all services should reflect on how they support staff who are having to manage complex and challenging situations. *West Sussex Safeguarding Adults Board should request assurance reports annually about staff support.*

Law and legal literacy

3.34. The learning here partly revolves around such questions as: who has a power of entry and who has a power to seize what health and care records? CQC does have a power of entry and a power to seize records[19] but it does not have, it appears, an explicit power to search. Sussex Police have observed that in law (Police and Criminal Evidence Act 1984), their search and seize powers were contested and unclear. ICB and Adult Social Care practitioners have observed that West Sussex health and social care practitioners did not have a right of entry unless for the purposes of assessment and review of a resident for whom they had funding responsibility[20]. The local authority had "limited leverage" when it was not the commissioner.

> **Commentary:** however, providers must ensure that residents receive appropriate treatment (Regulation 9) and that assessments are carried out by practitioners with required knowledge and skills, following national guidance (Regulation 14)[21].

[19] Sections 62 and 63 Health and Social Care Act 2008. It is a criminal offence to obstruct CQC's work.
[20] Section 115 Mental Health Act 1983 enables an Approved Mental Health Professional to gain access if they have reasonable reason to believe that a mentally disordered person is not under proper care. The Mental Health Act 2007 defines mental disorder as any disorder or disability of mind. This provision does not appear to have been considered.
[21] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

3.35. The learning that has emerged from reflecting back on the police investigation also invites questioning of whether existing law is sufficiently robust, for example when checking staff competence, training and continuing professional development, or when access is denied by a provider to residents and/or particular places. There was no mechanism through which West Sussex local authority could stop commissioners from elsewhere placing people with the provider when safeguarding concerns had emerged and were being investigated, something also observed in the West Sussex Safeguarding Adults Board SAR Matthew and Gary. *Agencies involved in this review have recommended review of the legal rules surrounding power of entry and seizure of medical records of individuals who have died and strengthening of checks of training records and people's competence to work in the care sector.*

3.36. Those involved in the police investigation have talked about the challenges in proving corporate manslaughter[22] and wilful neglect[23], and have questioned whether the two offences are sufficiently distinct. They have also questioned whether, in the case of wilful neglect, it was appropriate to "lay everything on single practitioners" in a context of organisational abuse. A frequent misconception was also observed of what is deliberate neglect to cause harm versus poor practice and inadequate training.

> **Commentary:** to some degree this reinforces a finding from the aforementioned second national analysis of SARs, namely that current definitions in the statutory guidance of neglect/acts of omission and of organisational abuse should be reviewed. This is the second time that DHSC have been advised to reconsider the definitions of these types of abuse/neglect.

3.37. Building on the previous paragraph, Sussex Police have commented on the CPS rationale not to pursue prosecutions. One important thread is to establish "mens rea", namely intention, malice and deliberateness behind poor care. This is an extremely high threshold for a criminal prosecution. There was no doubt that the police investigation found evidence of poor care. However, fundamental culpability for poor care fell short of the legislative threshold that currently exists. Furthermore, CQC have observed that the police did pass over cases that they had decided not to progress. However, the threshold for CQC criminal enforcement action and

[22] Corporate Manslaughter and Corporate Homicide Act 2007.
[23] Criminal Justice and Courts Act 2015

prosecutions is also "high", a serious breach on the part of a registered manager or registered provider.

> **Commentary:** these paragraphs suggest the fundamental importance of reviewing how the law defines criminality if nationally there is serious intent to safeguard adults at risk from organisational abuse and from neglect/acts of omission. West Sussex Safeguarding Adults Board's SAR Kingswood and SAR Orchid View also highlighted that the criminal threshold had not been reached. *DHSC and the Home Office should lead on a review of the definitions of, and thresholds for offences that were designed to safeguard against and to prosecute organisational abuse.*

3.38. A successful prosecution depends on achieving best evidence. At the time there was variable understanding across partners of who could and should be contributing to achieving best evidence, and the roles and responsibilities of the different agencies involved. It is clearly a detective function to determine what evidence is needed to meet a legislative threshold. It has been suggested that there was a lack of consistency in thresholds and tolerances across the services involved. Sussex Police have also observed that early engagement with CQC on search warrants was a lesson learned to ensure understanding of the records to seize. Another lesson learned was early engagement with coroners in relation to their power to obtain medical records[24].

3.39. Alongside knowledge of the legal rules, of powers and duties, was the challenge of implementation. It has been suggested that enforcing statutory powers and regulations proved difficult when challenge from the provider was expected. A challenge for CQC was the threshold for taking provider-level enforcement action (as opposed to action at each individual location); this was the first time CQC had done so. A subsequent Tribunal hearing was "traumatising" for CQC staff, with challenges "made very personal" and "battering".

3.40. Occasionally in interviews, misunderstanding of the Mental Capacity Act 2005 has been mentioned. The independent reviewer is also aware that the Court of Protection was involved in some instances.

[24] Schedule 5, Coroners and Justice Act 2009.

Procedures and parallel processes

3.41. Initially there was no framework for agencies to follow to work together to investigate provider concerns and provider failure of this magnitude. Consequently, initial responses were "very separate" and it took time to establish joint working, between agencies within West Sussex and with CQC, and between the police and CPS, when earlier collaboration had been needed. Once processes had been established and agreed, collaboration was stronger. "When we had a whole team, things moved." "Integration of police, local authority and CQC worked well." The subsequent police search has been described as "methodical", guided by a generic list of what to look for. There was specialist clinical input and advice to guide the investigation in terms of what should be expected from a specialist provider.

3.42. Such a framework might also have provided guidance on how police and CQC powers to undertake criminal investigations could be combined into one joint investigation. As it transpired, the police understandably assumed primacy for the criminal investigation. Owing to the initially unforeseen time that this investigation took, because of the number of individual cases involved, the time within which CQC could pursue their own criminal investigation had expired. Nonetheless, CQC took enforcement action that reflected the volume and seriousness of the concerns. This included enforcement action that removed the provider's ability to operate from specific locations, restricted admissions and care provision to people with specific needs, required regular reporting on specific areas and deployment of specific professionals, and ultimately cancelled provider registration. Fixed penalty notices were also issued. *One recommendation to emerge involves the promotion of joint CQC/police investigations and the removal of any time limit on CQC with regards to criminal investigations and prosecutions.*

3.43. Closer involvement with the Health and Care Professions Council (HCPC), General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) would also have been helpful to strengthen the oversight of the standards of on-site provision and contracted in services from GPs. Nor at the time did there appear to be a clear interface, at least initially, between adult safeguarding (section 42 Care Act 2014) and provider concern procedures.

> **Commentary:** it might be useful to think of the "team around me", namely all those agencies, including regulators and Healthwatch, with a potential contribution to make to safeguarding individuals living in residential and nursing care settings.

3.44. A further challenge was securing the collaboration of other local authorities in whose area the provider was operating or who had commissioned placements. For example, a local authority was reported to have responded differently when information about concerns was fed through, leading those involved to believe that this was seen as a "West Sussex problem." Other local authorities where the provider was operating were kept informed and updated but feedback from their staff, CQC and partner agencies was that they were not seeing the same issues. Indeed there was a home in West Sussex County Council where these issues had not been found.

> **Commentary:** a consistent message throughout this review process has been the absence of a whole system response to concerns about a provider, whole system here meaning across and between local authorities and clinical commissioning groups (now ICBs). West Sussex Safeguarding Adults Board's SAR Matthew and Gary also found that another local authority did not attend safeguarding meetings.

> **Commentary:** based on their experience, agencies were very clear about the importance of holding very early multi-agency meetings at which powers, duties, roles and responsibilities are outlined, for example to ensure understanding of CQC's remit and powers. Subsequently, there should be regular review meetings[25]. At times during the police investigation there were daily meetings to share concerns, findings and updates. Holding a very early multi-agency meeting could have included a focus, for example, on "a better seize and sift plan."

3.45. *Another recommendation is that each Safeguarding Adults Board should have a procedure for investigation of a whole service provider concern.*

Family involvement

3.46. Written submissions and interviews have highlighted the challenge of responding to family anxieties. Those involved with investigating and responding to provider concerns were not always clear what could be said to families, with an additional complication being the interaction between the provider and families, leading some families to conclude that "West Sussex was being difficult." Some practitioners were specifically told not to

[25] Section 4.26 below indicates that policies and procedures have embedded this learning.

talk to families by legal advisers, which did not sit comfortably with their values.

3.47. During the police investigation, meetings were held with the thirteen families whose relatives had been included in it. A coroner supported these meetings, alongside health, social care and the police. There was a consistent media plan that enabled a quick response to enquiries. Nonetheless, those involved have acknowledged that it was very emotional and disquieting for families when CQC registration was withdrawn and/or residents were moved. Some families voiced their anger and frustration, which compounded the stress being experienced by those involved with the investigation. "CQC was lambasted when they closed a home by the media and by families." Some families appeared reluctant to contemplate change and it was "bizarre" to experience such reluctance even when the risks of no change were explained.

> **Commentary:** families have spoken about their experiences of the investigation and of the meetings that were convened at the time (see section 2 above). Clearly it was an emotional, challenging, stressful and distressing time for everyone involved.

3.48. West Sussex Safeguarding Adults Board's SAR Kingswood also highlighted the same complicating factor, namely that some families were positive about the provision. That report questions whether families feared the consequences of complaining and whether they were sufficiently aware of standards and quality requirements.

> **Commentary:** how families responded underlines the importance of practitioners being trauma-aware and being enabled to work in a trauma-informed way.

4. KLOE: what has been learned and what measures are now in place to minimise risk and support a partnership response?

4.1. "West Sussex is now in a really different place." "Absolutely loads has been done, huge improvements." "We would go more strategic more quickly." "We have all learned the value of coming together and working together." The written submissions, interviews and feedback at the learning event have all emphasised what is now in place in West Sussex to prevent organisational abuse and to respond effectively if provider concerns of the magnitude investigated by the police investigation were to happen again.

Model of care

4.2. CQC have published statutory guidance. "Registering the Right Support" was first published in 2017. It was revised and retitled "Right Support, Right Care, Right Culture in 2020. It continues to be statutory guidance under section 23 of the Health and Social Care Act 2008. CQC have clearly stated that provision along the lines of this provider would not now be approved. CQC have also prioritised the identification, prevention and investigation of organisational abuse through the creation of a programme of work which is supported by a newly formed safeguarding and closed cultures team. This team will work to provide advice and support on cases and refer for legal advice when appropriate. "We are in a different place now."

Quality assurance

4.3. CQC have published (2022) guidance on how it identifies and responds to closed cultures. E-learning resources are also available. CQC have also published an emerging concerns protocol (2024). During interviews and at the learning event, there were references to other resources[26] that enable practitioners, commissioners and managers to identify signs of organisational abuse and closed cultures.

> **Commentary:** an expert reference group established by Partners in Care and Health (Local Government Association and ADASS) and CQC has developed a pack of resources on organisational abuse. *Safeguarding Adults Boards should disseminate this resource pack widely to raise awareness.*

4.4. Some services have introduced learning from Pan-Sussex SARs, with cross-referencing against evidence of service delivery. Some services, such as the ICB, have provided training on organisational abuse.

4.5. Monitoring of provider concerns has been strengthened, with closer working with CQC. Systems are now in place that facilitate the identification of patterns. Specifically, QASIG[27] (2019) has been established and is very well attended, with membership that includes CQC and Healthwatch. Its focus includes information-sharing, prevention and risk mitigation. It maintains oversight of the quality and safety of the care market, and ensures clarity of response when concerns arise. Low and high incident reporting providers are monitored. Providers are supported with guidance and signposting. A quality pathway enables information to be shared with contract managers.

4.6. In addition to QASIG, some agencies, such as the ICB, have introduced internal meetings, with an information flow to and from QASIG. This has made it easier to identify services where care quality has dropped and/or where there are safeguarding concerns.

4.7. In written submissions, interviews and at the learning event, the creation of QASIG and the operational framework for managing provider concerns (2022) under West Sussex Safeguarding Adults Board auspices was believed to have resulted in better alignment in processes, improved sharing of

[26] Marsland, D., Oakes, P. and White, C. (2012) Early Indicators of Concern in Residential Support Services for People with learning Disabilities. University of Hull; Age UK (2023) Safeguarding Older people from Abuse and Neglect.
[27] Quality Assurance and Safeguarding Information Group.

intelligence and greater understanding of where improvement in care quality is needed.

4.8. The police have advised that there is generally a good understanding across partner agencies of achieving best evidence, namely where relevant evidence is to be captured and preserved. Many practitioners have talked about keeping better records of what they have observed.

4.9. An organogram has been developed that charts the interface between safeguarding and provider concerns procedures, and the two-way exchange of information between them. The organogram contains a reference to advocacy.

> **Commentary:** ongoing monitoring of the effectiveness of this interface would be advisable.

4.10. West Sussex Safeguarding Adults Board have also published (2024) a Strategic Provider Concerns Group Protocol. This group provides strategic direction and support regarding organisational abuse/neglect by a provider. Representation is multi-agency at a senior level. It provides oversight of the approach to risk mitigation and the outcomes of improvement plans.

4.11. Commissioners in West Sussex have talked positively about the introduction of the quality pathway, including the sharing of themes, trends and "soft intelligence." With 600 providers in West Sussex, a new risk-based approach to contract management is being introduced in collaboration with partner organisations. Market provision statements have been developed to inform current and potential providers what is needed in line with demographic and strategic needs. A suspension protocol has been published after consultation with legal services. Finally, information is shared within the ADASS South East commissioning network.

4.12. In terms of the quality assurance response to provider concerns, the process needs more power to act if the provider refuses to engage. Those involved in this review have concluded that the new processes work very well with providers who are willing to engage, and some excellent results have been achieved. However, there is concern that when the provider is resistive, defensive and litigious, there are fewer measures with which to move the process forward.

Safeguarding

4.13. Contributions have identified improvements in safeguarding, for example improved listening to specialist clinical input and advice, and strengthened partnership working between adult safeguarding in the local authority and health practitioners. “We have given ourselves permission to look around the corners.” Within individual services and through the local authority’s safeguarding hub, there is more proactive use of safeguarding data and better records of (the pattern of) concerns and incident reporting. This has been supported by a Sussex-wide threshold document, and escalation and resolution process. Safeguarding practitioners in the local authority have commented on how much they have learned about the healthcare needs of residents, for example the risks of aspiration pneumonia, hopefully leading to a greater understanding about how referred healthcare concerns meet the criteria outlined in section 42(1) Care Act 2014. Practitioners are contacting safeguarding leads and CQC earlier than previously, with a greater recognition of the importance of escalation, for example if access is hindered or denied, or appointments missed. The wide experience convened in the safeguarding hub, it has been suggested, has enabled a more robust response. All safeguarding referrals come through the hub, with improvements in monitoring, recording and feedback. There is an advice line attached to the hub for concerned practitioners to “sense-check.”

4.14. South East Coast Ambulance Service have advised that, whilst previously there was no mechanism to receive feedback on referrals of adult safeguarding concerns, a system is now in place. Significant concerns about a care facility would now also be escalated to a newly established Safeguarding on Call Service. Two such major incidents have resulted in early information-sharing with a local authority and ICB. Their training emphasises the importance of professional curiosity and timely escalation of concerns. Their training also uses learning from SARs.

4.15. The police have advised that they have reviewed and renewed their adult safeguarding policy and added detail about power of entry and search/seizure of medical records. Healthcare practitioners have talked about noticing residents who are not referred. Safeguarding practitioners have talked positively about closer working with healthcare practitioners, including joint adult safeguarding enquiries, for example involving eating, drinking and nutrition concerns, although it can prove challenging to maintain this level of input and resourcing.

4.16. The quality team within the ICB monitors and tracks actions following Regulation 28 notices issued by coroners. CQC will also assess information received regarding Regulation 28 notices.

4.17. The West Sussex Safeguarding Adults Board Quality and Performance subgroup monitors the implementation and impact of SAR recommendations by conducting and reviewing periodic assurance surveys, audits and self-assessments. This enables learning to be tracked. The West Sussex Safeguarding Adults Board Learning and Policy subgroup produces learning resources such as briefings and podcasts as examples for dissemination of learning. The West Sussex Safeguarding Adults Board bi-annual self-assessment and challenge process also checks on how learning has been embedded from SARs. West Sussex Safeguarding Adults Board's SAR subgroup monitors the action tracker arising from review recommendations. This learning informs West Sussex Safeguarding Adults Board's annual meeting where priorities are reset. SAR learning is also shared regionally and nationally through networks of Safeguarding Adults Board business managers and independent chairs.

4.18. Since the police investigation there has been a significant fall in safeguarding concerns. CQC have advised that joint investigations with the police are now more common as a result of learning from this experience and from other situations.

4.19. Learning from experience, several systems have been implemented within West Sussex to assist with early identification of patterns of concerns, their escalation and the application of a multi-agency response without delay. Examples are the development and implementation of the provider concerns framework, and the introduction of QASIG. "QASIG has been really critical."

Resources

4.20. Sussex Community NHS Foundation Trust have increased staffing and established an Enhanced Care in Care Home Matron Service. This service provides advice and can escalate concerns to the ICB and local authority. The service covers individuals with highly complex needs and co-existing long-term conditions. Sussex Partnership NHS Foundation Trust have invested in the Trust's safeguarding service since 2020. The service now has a full-time Head of Safeguarding Adults and a Named Professional for Safeguarding Adults, with support from three deputies. This has enabled the

Trust to improve the amount and quality of safeguarding training as well as to provide increased safeguarding support to operational staff, especially when encountering challenging situations. This level of safeguarding service had not been available to Trust staff between 2016 and 2020.

Staff support

4.21. At the learning event, especially, the importance of staff support and wellbeing was emphasised. Some services have introduced internal processes for staff support, including debriefing sessions, which have been utilised.

Law and legal literacy

4.22. South East Coast Ambulance Service have helpfully highlighted a legal provision, namely that if paramedics are denied access, they would utilise the Emergency Worker Obstruction Act 2006 and liaise with the police to gain access where there was reasonable reason to believe a person was experiencing serious harm or illness, or had died.

4.23. CQC have clarified that it has a power of entry and that it is a criminal offence to obstruct the work of the regulator[28]. CQC staff have access to legal advice and are "well versed" in enforcement.

Procedures

4.24. New guidance has been developed by the West Sussex Safeguarding Adults Board and its Sussex Safeguarding Adults Board partners. There is now a Sussex Escalation and Resolution Protocol (2021). The Operational Framework for Managing Provider Concerns offers an improved provider concern framework. It outlines the roles of placing and host authorities, the sharing of information with CQC, the stages within the framework and the importance of liaison with ICBs and local authorities beyond West Sussex.

[28] Sections 62 and 63, Health and Social Care Act 2008.

> **Commentary:** where the framework refers to significant safeguarding concerns, it would be helpful to define what is meant by significant. The interface between this framework and the section 42 Care Act 2014 duty to enquire could also be further developed. It would be useful to clarify how this framework is meant to dovetail with criminal investigations by CQC and/or the police.

4.25. An Adult Death Protocol has also been introduced. This acknowledges shortcomings in earlier inter-agency systems, and aims to ensure that services are equipped to respond in a timely and collaborative manner. The role of an initial joint agency meeting is outlined, with the aim to ensure an effective multi-agency response from the beginning. *It would be advisable for West Sussex Safeguarding Adults Board to receive assurance reports on the effectiveness of the policies, procedures and protocols that have been introduced.*

4.26. Early multi-agency meetings are now in place via the Adult Death Protocol (2020), Operational Framework for Managing Provider Concerns (2022) and Quality Assurance Safeguarding Information Group (2019).

> **Commentary:** it has been suggested that multidisciplinary team meetings and professional meetings are now happening more frequently in relation to learning disabled people. However, not every service shares this perspective, such that West Sussex Safeguarding Adults Board should consider receiving assurance reports on this particular component of the aforementioned policies and protocols.

4.27. Multi-agency working is a priority for 2024-25 and has led to the creation of *a new multi-agency working section of the Sussex Safeguarding Policies and Procedures, a learning briefing and podcast, and a scheduled survey.* The survey aims to identify issues, barriers and positive factors of multi-agency working. Following this, an action plan will be implemented to take forward any identified improvements.

4.28. However, not everyone has expressed confidence that risk has been minimised and some have warned that complacency would be dangerous. Not everyone appears confident that recently introduced processes (planning, commissioning, and collaborative information-sharing) would prevent a large campus style service from being built and opened. At the learning event it was suggested that closer liaison is required with district councils and planning officers. This theme, essentially of next steps, will be explored further in the next section.

4.29. Considering the developments recorded in this section regarding safeguarding, quality assurance, commissioning and market management, procedures and resources, it is clear that these are positive responses to learning from previously completed reviews and from the investigation into this provider.

5. KLOE: What else could be achieved to support the partnership to best respond to any future provider concerns of this scale?

5.1. Some interviewees have suggested that both the West Sussex Safeguarding Adults Board and the local authority experienced conflicts of interest as the provider sought to expand its provision.

> **Commentary:** this was also highlighted in West Sussex Safeguarding Adults Board's SAR Matthew and Gary as a concern of the families involved. West Sussex Safeguarding Adults Board now has in place an escalation and resolution protocol. There is also a Board membership pack. Meetings of the Board and its subgroups begin with recording any conflicts of interest. *It would be advisable for West Sussex Safeguarding Adults Board to review the effectiveness of the processes it has in place to identify and manage conflicts of interest.*

5.2. It has also been suggested that West Sussex Safeguarding Adults Board itself had insufficient powers. Also mentioned was a period of time that predated the police investigation when there was tension between partners that required mediation, and frequent changes in representation from some agencies.

> **Commentary:** Safeguarding Adults Boards cannot command or instruct; rather, their effectiveness depends on relationship building and trust. A Safeguarding Adults Board's mandate is to seek assurance about the effectiveness of adult safeguarding and, through audits, training, reviews and policy development, to drive improvements where these are indicated as necessary. *All Safeguarding Adults Boards should consider how they would respond when there are tensions between partners that undermine the Board's effectiveness.*

Out of area placements

5.3. Information was shared with placing authorities but subsequent collaboration was variable and often poor. Funding authorities are not consistently informing the host authority where they are placing people about the care needs which are being transferred into their area. It was recognised at the learning event that this should happen, but it does not. Current guidance is not strong enough. Along the same lines, services in West Sussex were often unclear whether or not residents placed in their area were subject to deprivation of liberty safeguards.

> **Commentary:** repetitive findings regarding out of area placements was identified as a service improvement priority in the aforementioned second national analysis of SARs and has been escalated to DHSC for action. *A strong recommendation is for primary legislation to set out roles and responsibilities relating to out of area placements. Additionally, NHS England and ADASS should review the compliance by ICBs and local authorities with statutory and advisory guidance on roles and responsibilities when placing individuals out of area.*

5.4. *Another strong recommendation from the learning event was that the statutory right to advocacy should be extended, and always put in place for people who are resident as an out of county placement.* Advocacy was identified in one SAR[29] as an illusion. Advocacy is an important safeguard, especially when it is "long-term, person-led and holistic" rather than focused

[29] Durham SAB (2023) SAR Whorlton Hall.

just on specific tasks or decisions[30]. *All Safeguarding Adults Boards should ensure that an advocacy provider is a member of the Board.*

Model of care

5.5. Some concern was expressed that a new provider had emerged on the same site with some of the same management and staff. QASIG has monitored this provision. There remains placement shortage, with evidence in West Sussex and elsewhere of placements not matching people's needs. General concerns were articulated about large homes for older people and some large providers of learning disability services. There was also recognition, however, that size is no guarantee of a quality non-institutional model. What these concerns highlight is doubt about whether care for people with complex needs has actually been transformed. As the Durham SAB (2023) SAR Whorlton Hall also articulated clearly, there remains no clear national approach to achieve alternative models of care. "There is a need, nationally, to plan and invest in local services." *DHSC should be invited to reaffirm its commitment to transforming care for people with complex needs.*

5.6. *A recommendation from this review is that whenever specialist services are being commissioned, relevant specialist clinicians should be involved in that process.*

5.7. A reflection at the learning event questioned whether, for care staff living on site, especially but not just those recruited from overseas, stronger legal protections were needed for those who blow the whistle and share concerns about quality of care.

[30] See, Mercer, K. and Petty, G (2023) A Review of Advocacy for People with a Learning Disability and Autistic People who are Inpatients in Mental Health, Learning Disability and Autism Specialist Hospitals. NDTi.

Quality assurance

> **Commentary:** a recent research report[31] has found that 98% of homes closed by CQC between 2011 and 2023 were operated by private companies. This finding further underscores the realisation that this SAR is the latest in a long line of reviews and enquiries that have focused on organisational abuse. In that context, contributors to this review have identified how quality assurance could be further strengthened both locally and nationally.

5.8. Locally, contributors have suggested that information available to QASIG members should be disseminated widely. A database shared across partners would also be helpful, or at least shared access to records. Technology has not developed to facilitate information-sharing between services but the problem is not insurmountable. One suggestion was that agencies could potentially make better use of SharePoint (an NHS system which allows information to be shared securely between services).

5.9. Contributors have suggested that the new quality pathway needs to be better publicised. It is the avenue through which concerns that fall below the safeguarding threshold can be monitored. Health agencies should be considered for joint monitoring visits to providers, for example when CQC conduct inspections. This would help to ensure the presence of a clinical voice. Work could be undertaken to ensure more effective engagement and involvement with primary care.

5.10. Locally also, contributors have suggested a need for awareness raising on how to achieve best evidence, linked to knowledge about recognition of closed cultures and of "what good looks like" in residential and nursing care settings. More support also needs to be given to agencies, for example to support staff with giving witness statements. *West Sussex Safeguarding Adults Board should consider possible next steps on quality assurance, for example through the provision of training and briefings about closed cultures, standards for residential and nursing care provision, and giving evidence.*

5.11. It was suggested that the same approach to quality assurance needs to extend to domiciliary care and supported living.

[31] Bach-Mortensen, A., Goodair, B., Degli Esposti, M., Corlet Walker, C. and Barlow, J. (2024) Evidencing the Outsourcing of Social Care in England. University of Oxford.

5.12. Nationally, two strands have emerged from contributors' reflections. The first relates to a need for better protections for people, particularly older people, who are self-funders. Currently there is no oversight.

5.13. The second strand focuses on having a better registration system that can track provider directors and corporate companies and hold them accountable for harmful care. A new organisation followed the provider owned, managed and staffed by some of the same people.

> **Commentary:** this is not a new concern. The need for law reform of the existing rules of corporate governance has been identified by other SARs[32] and enquiries[33], to strengthen and enforce accountability and counter the evasion of responsibility for organisational abuse. *West Sussex Safeguarding Adults Board should request that the National Network for Safeguarding Adult Board Chairs should escalate the lack of law reform on accountability and care standards to DHSC.*

Safeguarding

5.14. Work is underway to further develop safeguarding practice to strengthen clinical health input in safeguarding decision-making. The ICB offer clinical advice and support to the safeguarding hub. Safeguarding surgeries are being planned. Decision-making on referrals of adult safeguarding concerns is being kept under review to ensure that the criteria in section 42(1) are being appropriately applied and are in line with the Pan-Sussex thresholds protocol.

5.15. In keeping with suggestions regarding awareness-raising, *West Sussex Safeguarding Adults Board should seek assurance that all agencies in West Sussex are clear on procedures for safeguarding and provider concerns operationally and strategically*. *West Sussex Safeguarding Adults Board should also monitor the use of the escalation and resolution process, especially as it appears not to be well known*. Statutory guidance[34] outlines the principles to follow, along with roles and responsibilities in responding to abuse in care settings. *West Sussex Safeguarding Adults Board should seek*

[32] For example, South Gloucestershire SAB (2012) SAR Winterbourne View.
[33] Flynn, M. (2011) In Search of Accountability. A Review of the Neglect of Older People Living in Care Homes Investigated by Operation Jasmine. Welsh Government. See also Flynn, M., Griffiths, A., Keywood, K. and Pritchard-Jones, L. (2022) Law Commission 14th Programme of Reform Proposal: Safeguarding Adults and the Need for Legal Reform in which the authors call for enhanced regulation to drive up care standards.
[34] DHSC (2024) Care and Support Statutory Guidance, section 14.68 onwards.

assurance of compliance by commissioners, providers and services with this guidance.

5.16. Two referrals to the Nursing and Midwifery Council (NMC) were made but other referrals to NMC, the Health and Care Professions Council (HCPC) and the General Medical Council (GMC) might have been appropriate. *All Safeguarding Adults Boards should consider liaison with bodies responsible for professional registration and training as part of their development of procedures relating to organisational abuse.*

Resources

5.17. Reference has already been made to Healthwatch and the need to enable it to contribute to safeguarding and quality assurance through its powers for enter and view. Currently, Healthwatch "rarely if ever cover care homes." However, Healthwatch is a member of QASIG and is scheduled to outline to this West Sussex Safeguarding Adults Board subgroup its powers and availability for enter and view visits in West Sussex, and its schedule for forthcoming activity.

5.18. There are now systems in place to monitor the provider market and to guide the collective response to provider concerns. Some uncertainty has been expressed regarding whether agencies would have the staff and other resources needed to respond, should another similar situation happen again.

> **Commentary:** vigilance needs to be as close to 24/7 as possible. "What happens when no-one is looking?[35]" The frequency of CQC inspections and Healthwatch enter and view visits should ideally be dovetailed with intelligence from contract management and quality assurance. The agencies involved with QASIG, including CQC, draw on data, intelligence and insight from a wide variety of sources, including commissioners and local authorities, to inform monitoring and assessment of registered and commissioned services.

[35] Hayley Moore, CQC, during a presentation for a webinar on organisational abuse, October 2024.

Staff support

5.19. There is more to be done around support for all staff involved in investigations of organisational abuse. Anticipating having to give evidence in criminal proceedings was "a vulnerable place to be in." Both an individual and team perspective needs to be taken. Past trauma, it has been suggested, might make practitioners more wary of raising concerns.

> **Commentary:** this highlights again the importance of focusing on staff wellbeing, including provision of training in court craft and on closed cultures.

Law and legal literacy

5.20. It has been suggested in individual interviews and at the learning event that knowledge of law is variable, legal literacy in relation to the powers and duties of all the agencies potentially involved in investigating organizational abuse. *West Sussex Safeguarding Adults Board should consider collating the powers available to different services to ensure care quality and to safeguard people from abuse/neglect. This could be disseminated more widely once developed as a useful resource.*

5.21. Concern was expressed in individual interviews and at the learning event that the thresholds for criminality are too high to ever be achievable. *The thresholds for corporate manslaughter and wilful neglect should be re-considered. They are not serving the function for which they were created.*

5.22. Sussex Police were challenged by the provider regarding the legality of their search warrant, with a suggestion that a production order should have been used instead. This would be a matter for the courts to decide. However, the issue of police powers to seize health records, including in criminal cases of deceased persons, is opaque and requires further attention by legislators. This was raised in a Law Commission report (2020) on search warrants.

5.23. As a result of experiences within the police investigation, Sussex Police contributed to a Law Commission's review[36] that concluded that "law and procedure which governs search warrants is unnecessarily complex, inconsistent, outdated and inefficient." In December 2020 the then Home Secretary wrote to Sussex Police regarding the Law Commission's report and the challenges that the police experienced with respect to document seizure.

[36] Law Commission (2020) Search Warrants.

She acknowledged the need for reform of "complex legislation governing search warrants." She pointed to the Law Commissions recommendation 42, namely to balance the prevention and investigation of serious crime with the protection of the individual's health and counselling records.

> **Commentary:** the independent reviewer is not aware of any reform to current law on seizure of health records by the police (Police and Criminal Evidence Act 1984). CQC, as already stated in this report, can seize records but only for the purpose of CQC's regulatory remit under the Health and Social Care Act 2008. *DHSC and the Home Office should be asked to review and reform the law relating to police powers of search and seizure in order to strengthen the protection of individuals from organisational abuse.*

5.24. This report has already signalled its endorsement of previous calls for legislative change to require placing authorities to engage when concerns are raised (to strengthen this aspect of the duty to cooperate in the Care Act), the development of minimum standards for staff employed in care settings, and reform of corporate governance.

Procedures and parallel processes

5.25. The independent reviewer understands that there was a memorandum of understanding between the police and CQC for the police investigation. The police had primacy regarding the investigation of deaths, which had needed longer than initially envisaged, with the result that CQC was unable to then progress any criminal investigation owing to the time that had elapsed. CQC did have primacy in all other cases and regarding the general running of the care homes and took enforcement action.

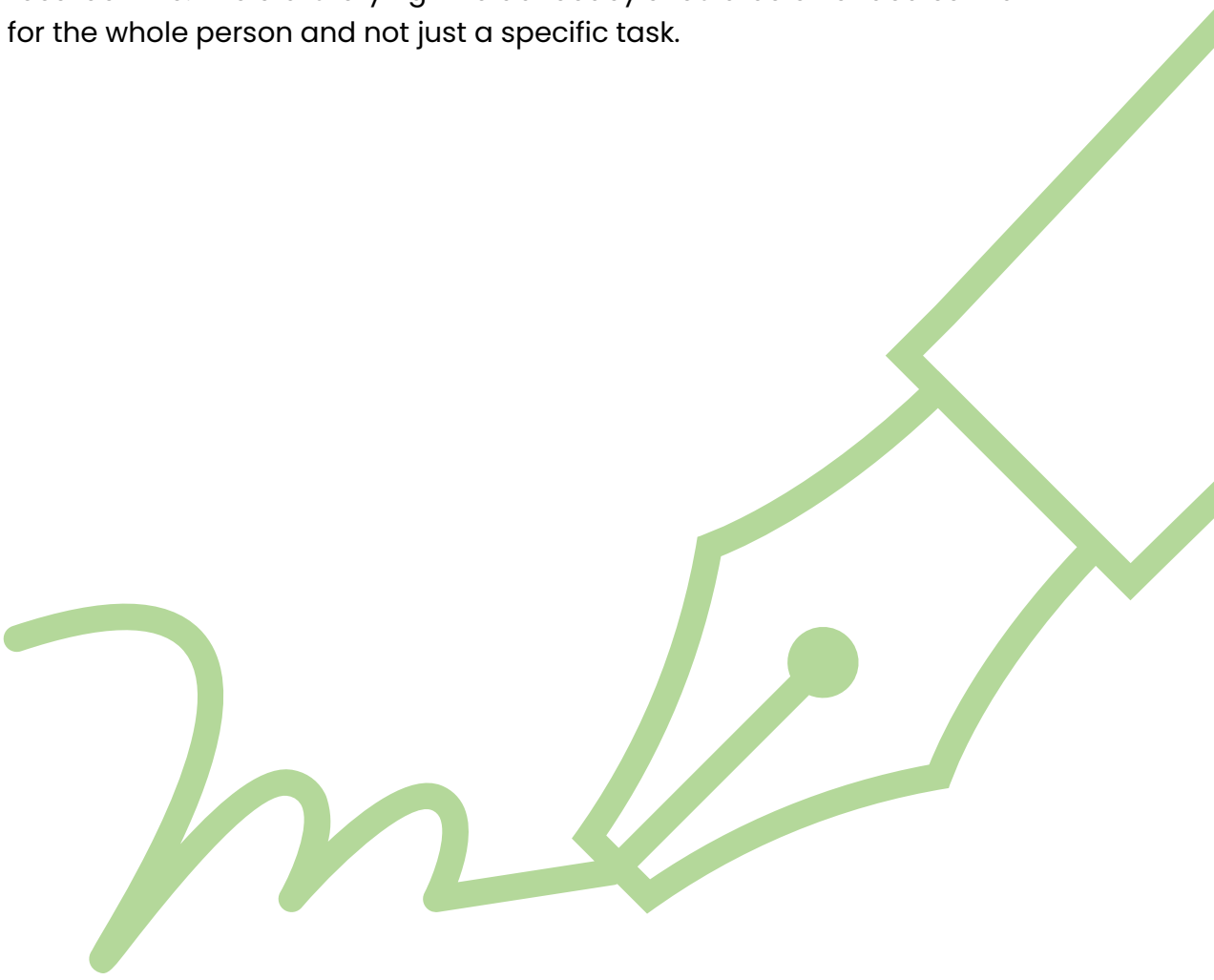
5.26. Two next steps have been suggested. A memorandum, of understanding between CQC and the National Police Chiefs Council (NPCC) already exists and covers how information is shared and powers used between the two organisations to ensure that both meet their safeguarding responsibilities. *In light of learning from this review, consideration should be given by CQC and NPCC to whether any revisions to the memorandum of understanding are required and whether there is sufficient awareness of it.* Secondly, law reform to relax or remove the time restriction within which CQC can conduct a criminal investigation. Those involved in the review have suggested that, as a minimum, CQC should be able to apply for an extension in their ability

to prosecute, or a stoppage on their time zone until police investigations conclude.

Family involvement

5.27. More work needs to be done on engaging with families and thinking about the guilt they might feel knowing that their loved one might be in a situation of abuse or neglect. How can practitioners work with and reassure families more effectively? One suggestion was that information could be produced for families on what good care looks like, drawing for example on the Age UK Homes Checklist.

5.28. Advocacy was covered earlier in this section under out of area placements. It is worth reiterating that those involved in this review concluded that more should be done to look at advocacy support for people and their families when they are transitioning from children's to adult services, and that support should be put in place to help families understand what good services look like. The statutory right to advocacy should be extended so that it is for the whole person and not just a specific task.



6. Concluding discussion

6.1. There was discussion that health inequalities for people with learning disabilities are still huge. This is a risk that still exists nationally and there were questions over the availability of services. Over the years preceding the police investigation there were some deaths that occurred that practitioners felt were potentially "written off" because the people who died had learning disabilities.

6.2. People with multiple and complex needs (including but not limited to those who have a profound learning disability) alongside their complex physical disabilities often have unstable health conditions that interact with one another. Many of this group are younger adults who have their lives ahead of them to live well in community. In addition to services that can support people's health and physical disabilities, they also need to be able to support people emotionally and socially to live their best lives in community . Additional commissioning of specialist community learning disability capacity needs to reflect this. Work currently being done by commissioners and public health services to map demographic needs and to engage with providers in market development is therefore important. Funding and resource constraint continue, however, to be barriers to creative commissioning and transforming care.

Pan-Sussex observations

6.3. It was suggested at the learning event that procedural development in West Sussex is not mirrored in the neighbouring authorities of Brighton and Hove, and East Sussex. Partners have fed back that the different systems across Sussex make reporting and responding to provider concerns more challenging. They would prefer as many Pan-Sussex procedures as possible.

6.4. There was recognition expressed at the learning event that in terms of provider concerns, the new West Sussex system is strong. Both the QASIG and provider concerns framework were praised for being robust. There was frustration expressed, however, that East Sussex and Brighton and Hove have not developed similar approaches. *West Sussex Safeguarding Adults Board should share this review with East Sussex and Brighton and Hove*

Safeguarding Adults Boards and explore again the potential for a Pan-Sussex approach to provider concerns and quality assurance.

Regional and national observation

6.5. Some providers operate regionally and/or nationally. The National Quality Board has published national guidance[37] for how quality concerns and risks should be managed within integrated care systems and in collaboration with NHS England and other partners. The guidance identifies what should happen when quality concerns justify escalation to a regional or national response, for example when there are multiple commissioners and when concerns might require regulatory action and service closures.

> **Commentary:** the independent reviewer understands that this guidance will be updated shortly. In any update, NHS England, CQC and ADASS should review the outcomes and effectiveness of this national guidance on management of quality concerns and risks.

6.6. During the police investigation, staff across all the organisations involved often worked "out of hours." They worked flexibly, often late into evenings. This led at the learning event to a question whether the current health and social care model is outdated. Working 9 – 5 Monday to Friday might not be the best fit for customers, especially given that vigilance needs to approximate as closely as possible to 24/7. This is a national rather than a local issue but current funding would render this difficult to manage long term.

> **Commentary:** the independent reviewer has been assured that the out of hours service is responsive when their involvement is required.

[37] National Quality Board (2022) National Guidance on Quality Risk Response and Escalation in Integrated Care Systems. This guidance replaces 2017 national guidance on risk summits.

7. Local, regional and national recommendations

Local

7.1. West Sussex Safeguarding Adults Board should request assurance reports annually about staff support (section 3.33).

7.2. West Sussex Safeguarding Adults Board should receive assurance reports at least annually on the effectiveness of the policies, procedures and protocols that have been introduced (section 4.25).

7.3. West Sussex Safeguarding Adults Board should consider reviewing the effectiveness of the processes it has in place to identify and manage conflicts of interest (section 5.1).

7.4. West Sussex Safeguarding Adults Board should recommend to commissioners that, whenever specialist services are being commissioned, relevant specialist clinicians should be involved in that process (section 5.6).

7.5. West Sussex Safeguarding Adults Board should consider possible next steps on quality assurance, for example through the provision of training and briefings about closed cultures, standards for residential and nursing care provision, and giving evidence (sections 5.10 and 5.19).

7.6. West Sussex Safeguarding Adults Board should seek assurance that all agencies in West Sussex are clear on procedures for safeguarding and provider concerns operationally and strategically. West Sussex Safeguarding Adults Board should also monitor the use of the escalation and resolution process, especially as it appears not to be well known. West Sussex Safeguarding Adults Board should seek assurance of compliance by commissioners, providers and services with statutory guidance (section 5.15).

7.7. West Sussex Safeguarding Adults Board should consider collating the powers available to different services to ensure care quality and to safeguard people from abuse/neglect. This could be disseminated more widely once developed as a useful resource (section 5.20).

Pan-Sussex

7.8. West Sussex Safeguarding Adults Board should share this review with East Sussex and Brighton and Hove Safeguarding Adults Boards and explore again the potential for a Pan-Sussex approach to provider concerns and quality assurance (section 6.4).

National

7.9. West Sussex Safeguarding Adults Board should use the National Network for SAB Chairs' escalation protocol, agreed with the Department of Health and Social Care (DHSC), to recommend to DHSC that:

7.9.1. National guidance should require that, when placements are commissioned, individuals and their families are given details about how to raise concerns and to submit complaints (section 2.9).

7.9.2. There should be a legal requirement on placing health and social care commissioners to notify the host authority and/or ICB. Primary legislation rather than statutory guidance should delineate the duties on placing commissioners and host agencies, for example regarding placement reviews and maintaining a dynamic support register of people placed out of area that can then be the focus of assurance reports to Safeguarding Adults Boards (section 3.3).

7.9.3. Statutory entitlement to advocacy should be extended to embrace those individuals in placements where there is no other circle of support (section 3.4). The statutory right to advocacy should be extended to always include people who are resident as an out of county/area placement (section 5.4).

7.9.4. The legal rules should be reviewed, jointly with the Home Office, surrounding power of entry and seizure of medical records of individuals who have died and the strengthening of checks of training records and people's competence to work in the care sector (sections 3.35 and 5.23).

7.9.5. DHSC and the Home Office should lead on a review of the definitions of, and thresholds for offences that were designed to safeguard against and to prosecute organisational abuse (section 3.37). The thresholds for corporate manslaughter and wilful neglect should be re-considered. They are not serving the function for which they were created (section 5.21).

7.9.6. Primary legislation should set out roles and responsibilities relating to out of area placements. Additionally, NHS England and ADASS should review the compliance by ICBs and local authorities with current statutory and advisory guidance on roles and responsibilities when placing individuals out of area (section 5.3).

7.9.7. DHSC should be invited to reaffirm its commitment to transforming care for people with complex needs (section 5.5).

7.9.8. DHSC should remove the time limit on CQC with regards to criminal investigations and prosecutions (sections 3.42 and 5.26).

7.9.9. The lack of law reform on corporate governance, accountability and care standards (section 5.13).

7.10. West Sussex Safeguarding Adults Board should recommend that:

7.10.1. CQC and the National Police Chiefs Council (NPCC) promote joint investigations of organizational abuse (section 3.42).

7.10.2. Consideration should be given by CQC and NPCC to whether any revisions to the memorandum of understanding are required and whether there is sufficient awareness of it (section 5.26).

7.10.3. In any update, NHS England, CQC and ADASS should review the outcomes and effectiveness of this national guidance on management of quality concerns and risks. (section 6.5).

7.11. West Sussex Safeguarding Adults Board should recommend to the National Network for SAB Chairs that:

7.11.1. It advises all Safeguarding Adults Boards to have a procedure for investigation of a whole service provider concern (section 3.45).

7.11.2. Safeguarding Adults Boards should disseminate this resource pack (developed by an expert reference group led by Partners in Care and Health and CQC) widely to raise awareness (section 4.3).

7.11.3. It advises all Safeguarding Adults Boards to consider how they would respond when there are tensions between partners that undermine the Board's effectiveness (section 5.2).

7.11.4. All Safeguarding Adults Boards should ensure that an advocacy provider is a member of the Board (section 5.4).

7.11.5. All Safeguarding Adults Boards should consider liaison with bodies responsible for professional registration and training as part of their development of procedures relating to organisational abuse (section 5.16).

Report completed January 2025