SOLAR CENTRE SERIOUS CASE REVIEW – EXECUTIVE SUMMARY

Gill Poole Independent Author

JULY 2014

ON BEHALF OF DONCASTER SAFEGUARDING ADULT PARTNERSHIP BOARD

Executive Summary

1. Circumstances which led to the Serious Case Review being conducted in relation to the abuse which occurred at the Solar Centre

1.1 The Solar Centre is a day service provided by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) for vulnerable individuals with profound and multiple disabilities.

1.2 Since an initial safeguarding referral in March 2007, safeguarding adult, Police and disciplinary investigations have been undertaken. Evidence has been submitted to the Crown Prosecution Service on three occasions, reports have been submitted to the Doncaster Safeguarding Adults Partnership Board (DSAPB) and a Lessons Learned Review was commissioned by the DSAPB and undertaken in 2011.

1.3 Two alleged perpetrators were found guilty of abuse, and were imprisoned.

2. The review process

In July 2013, following the completion of the court case in May 2013, and the conviction of two perpetrators, the DSAPB revisited the circumstances surrounding the abuse at the Solar Centre and decided to commission a Serious Case Review.

3. Terms of Reference

This Serious Case Review pursued the identification of actions and developments which organisations agreed following the safeguarding, police and disciplinary investigations. Assurance and evidence has been sought that actions have been undertaken and resulted in changes in practice; this is to mitigate against a repeat of the circumstances, which led to the abuse at the Solar Centre. It is not a reinvestigation process.

A summary of the terms of reference for this Serious Case Review are:

1. To establish the lessons to be learned
2. To review the effectiveness of procedures
3. To inform and improve local inter-agency practice
4. To improve practice by acting on learning (developing best practice)

4. Agencies involved in the Serious Case Review

The following were asked to contribute to the review:
Care Quality Commission (CQC)
Crown Prosecution Service (CPS)
Doncaster Advocacy Service
Doncaster Safeguarding Adults Partnership Board (DSAPB)
NHS England
Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
South Yorkshire Police

5. The Independent Author

The independent author for this review is Gill Poole who has a background in nursing, health visiting and senior management within the NHS. Gill is the Independent Chair of a Safeguarding Adults Board and has worked as a self-employed independent public sector management consultant for over 7 years.

6. Families of patients abused at the Solar Centre

Families of the abused were contacted by letter, initially by the DSAPB to inform them of the decision to undertake the review; and then by the independent author. Three families were interviewed and their views are included in the review overview report.

7. Summary of the abuse at the Solar Centre

The investigations into the abuse at the Solar Centre found that there were at least 24 allegations related to 18 individual service users who attended the Day Service. The abuse occurred over a period of at least 16 months (November 2005 – March 2007).

8. Lessons to be learned and conclusions

Since the initial allegations of abuse were made in March 2007, there have been significant developments in legislation and national safeguarding policy.

The Serious Case Review has identified lessons, which have been learned and acted upon. There is evidence of good practice, embedding of the lessons learned and subsequent changes in the organisations involved in relation to processes, policies, awareness raising and training.

The investigation reports and action plans, from the organisations involved, focus on organisational changes and do not relate to the impact of the abuse on the victims. There is little evidence of a person centred approach or culture in the safeguarding process.

The investigations into the abuse at the Solar Centre took too long, and the independent author found that agencies did not effectively engage the victims or their families. The combined investigation and criminal processes, involving a range of organisations, took over 6 years.

The Serious Case Review process has highlighted the importance of recognising the impact that abuse has on individuals and their families, the need to effectively support victims, and ensure they do not get lost in the process, particularly in large scale investigations.

9. Recommendations

Recommendation 1
The DSAPB should express its regret, to the individuals and families who suffered as a result of the abuse at the Solar Centre. The apology should relate to the length of time the various processes have taken, including the commissioning of a Serious Case Review; and also address their feelings of not being heard, involved or in control of the various safeguarding investigations.

Recommendation 2
The DSAPB write to the Department of Health, copying in CQC, highlighting the gap in regulation and inspection of day services.

Recommendation 3
The DSAPB should seek assurance from the CPS that practice has changed nationally as a result of the learning from this and similar cases.

Recommendation 4
The DSAPB needs to seek assurance from the commissioners of advocacy services that there are specific contracts with clearly expressed outcomes when commissioning advocacy services.

Recommendation 5
The DSAPB should assure itself that the systems and processes now in place, including the current Serious Case Review Policy, reflect the lessons learned through this SCR. This should include the personalisation of safeguarding processes and the timeliness of decisions to take SCRs.

Recommendation 6
The DSAPB should ensure that effective communication is embedded in safeguarding processes, through implementing 'Making Safeguarding Personal'; and that they are responsive to the needs of victims and their families, particularly in relation to frequency.

Recommendation 7
The DSAPB should gain assurance from commissioners that any relevant support services are made available, for all individual victims and their families who are affected by abuse, including those involved in the Solar Centre.

Recommendation 8
The DSAPB write to the Department of Health, Home Office and ADASS network to seek clarity in relation to the supremacy of police investigations and the interface with all other investigations.

Recommendation 9
South Yorkshire Police should assure the DSAPB that training in relation to the Mental Capacity Act 2005 and Safeguarding Adults policies have made a difference to practice and improved outcomes for victims.