SOLAR CENTRE

SERIOUS CASE REVIEW REPORT

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JULY 2014

ON BEHALF OF DONCASTER SAFEGUARDING ADULTS PARTNERSHIP BOARD

Contents

SERIOUS CASE REVIEW OVERVIEW REPORT OF SOLAR CENTRE

1. Introduction

This report details the circumstances surrounding allegations of abuse made in March 2007, in relation to the Solar Centre and describes the actions and learning undertaken up to the present time.

It includes an evaluation of action plans, evidence of learning and recommendations to the Safeguarding Adults Partnership Board (DSAPB) for further assurance.

This Serious Case Review relates to the abuse by staff employed at the Solar Centre of 19 vulnerable people within their care. Convictions were secured relating to 12 of the 19 victims.

A number of investigations have been undertaken in relation to the abuse at the Solar Centre, these include:

A Safeguarding Adults Investigation

A Police Investigation

A Serious Untoward Incident Investigation

This Serious Case Review has been commissioned by Doncaster Safeguarding Adults Partnership Board (DSAPB) and is intended to provide an overview of actions taken by all agencies relating to 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; and a Lessons Learned Review was commissioned and undertaken in 2011.

1.3 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).

1.4 There were no clear guidelines about the ‘supremacy of investigations’, and an understanding and belief that the police investigation had priority. This resulted in the disciplinary and safeguarding investigations being stopped during the police investigation.

1.5 A Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change, which will help to improve the safeguarding and wellbeing of vulnerable adults in the future.

1.6 This Serious Case Review has been undertaken in line with the Serious Case Review policy guidance of the Doncaster Safeguarding Adults Partnership Board, and South Yorkshire's Adult Protection Procedures.

Since 2007, it is important to note that there have been many changes in organisations, personnel, policies and procedures, locally, regionally and nationally; as per the chronology in Section 5.

2. Terms of reference

2.1 The Doncaster Safeguarding Adults Partnership Board agreed to commission the Serious Case Review in late July 2013; the first meeting with the independent author was on the 8th August 2013.

2.2 The Safeguarding Adults South Yorkshire Policy does not include any timescales in relation to the completion of a Serious Case Review. The initial allegations of abuse at the Solar Centre were in March 2007, the Police and disciplinary investigations did not conclude until May 2013.

The terms of reference for this Serious Case Review are:

1. To establish the lessons to be learned from the circumstances at the Solar Centre in relation to the way in which local professionals and agencies worked together to safeguard vulnerable adults
2. To review the effectiveness of procedures (both multi-agency and those of individual organisations)
3. To inform and improve local inter-agency practice
4. to improve practice by acting on learning (developing best practice)
5. To prepare an overview report which will bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action (ADASS, 2010)
6. The purpose of this review is not to reinvestigate, but to identify evidence that action plans of the agencies involved have been implemented. The Serious Case Review will bring a collective reflection and assurance of the different interventions undertaken by organisations and formally note the lessons learned and that the learning is embedded within each organisation involved.
7. The overview report brings together, and draws overall conclusions from, the information and analysis contained in the individual management reviews, reports commissioned from relevant parties; and meetings with relevant agencies and organisations.

Summary
This Serious Case Review pursues 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; to mitigate against a repeat of the circumstances, which led to the abuse at the Solar Centre. It is not a reinvestigation process.

3. Process of the Serious Case Review

3.1 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.

3.2 The methodology for the Serious Case Review has been to:

- Request investigation reports and action plans from agencies involved
- Identify the learning by agency
- Analyse action plans
- Seek evidence that changes have occurred in practice

4. Contributions to the Serious Case Review

There were a wide range of contributors to this review; all of whom were helpful and cooperative in their dealings with the independent author.

The following agencies were asked to contribute to the independent review:

Families of patients abused at the Solar Centre
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

4.1 The Families

In order to identify the individuals and families affected by the abuse the independent author received contact details from RDaSH which were ratified through meetings with the Police.

In early September 2013, an initial explanatory letter about the Serious Case Review was sent from the DSAPB to 22 families who had relatives involved in the abuse allegations at the Solar Centre.

The independent author sent an introductory letter in late September 2013, which outlined the process, acknowledged the sensitivity of the situation and stated that no further contact would be made, if they did not respond.

No response was received from 18 families; and as stated, no further letters were sent to those who did not respond.

A family member contacted the independent author requesting no further contact. Three families responded that they were happy to be interviewed either face to face or on the telephone. Those families were asked for their opinions on what learning they would wish to be gained from the review process. A series of five questions about the safeguarding process were asked of the parents and families:

1. What worked, or went well?
2. What did not work, or did not go well?
3. What support did you receive, and was this effective?
4. Was there support that you would have liked which was not available and who might have supplied that support?
5. What blockages were there in achieving a satisfactory conclusion?

4.2 The Care Quality Commission prepared an overview report relating to its inspection activity, information and engagement relating to RDaSH since April 2010 when it registered with CQC. (Appendix 1)

4.3 The Crown Prosecution Service for Yorkshire and Humberside – the Deputy Chief Crown Prosecutor along with the lead solicitor met with the independent author, discussed key issues and shared written information relating to the investigations and prosecution processes involving the alleged perpetrators of abuse at the Solar Centre. A letter to the Senior Policy Manager at the Department of Health, was shared with the independent author, which summarises the CPS's involvement. (Appendix 2)

4.4 The Doncaster Advocacy Service submitted a report of its involvement with the Solar Centre investigations, prepared by the Chief Executive. (Appendix 3)

4.5 The Doncaster Carer Support was recorded as attendees at initial safeguarding strategy meetings, but has no record of involvement with the investigations. It was therefore not required to provide a report.

4.6 The Doncaster Safeguarding Adults Unit provided support, information, a central point of contact, including secure email address and evidence of safeguarding referrals, strategy meetings, case conferences and annual work plans. A chronology was also produced, which is attached as Appendix 4.

4.7 Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) submitted a comprehensive Individual Management Review (Appendix 5). There was one member of staff who worked at the Solar Centre and was implicated in the abuse, who was employed by Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT). Shortly after the allegations were made, this member of staff resigned. This occurred before RDaSH's investigation commenced and as a consequence, a formal interview did not take place with this individual.

4.8 The South Yorkshire Police personnel provided detailed information on the Police investigations into the allegations of abuse at the Solar Centre. South Yorkshire Police Public Protection Unit provided copies of revised policies relating to public protection and abuse that occurred within the settings of Hospitals, Care Homes and other care facilities. An Individual Management Review of the Police involvement was provided (Appendix 6).

4.9 NHS England provided a report which sets out the commissioning arrangements for NHS services from 2007 to date (Appendix 7).

5. Chronology - including agency actions, legislation, policy and guidance

This chronology includes relevant legislation, policy and guidance to give context to the timeline from March 2007, when allegations were first made, to the commissioning of this Serious Case Review process in 2013.

2000 'No Secrets' was published by the Department of Health. 'No Secrets' provides guidance on the development and implementation of multi-agency policies and procedures to protect adults "at risk" from abuse.

No Secrets defines a 'vulnerable adult' as a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; **and** who is or maybe unable to take care of him-or herself, or unable to protect him-or herself against significant harm or exploitation' (DoH 2000)

2004 Doncaster Safeguarding Adult Protection Policy was developed and implemented.

2006 The Safeguarding Vulnerable Groups Act 2006 (c 47) is an Act of the Parliament. It was created following the UK Government acceptance of recommendation 19 of the inquiry headed by Sir Michael Bichard, which was set up in the wake of the Soham Murders.

The Act establishes the legal basis for the Independent Safeguarding Authority to manage two lists of people barred from working with children and/or vulnerable adults replacing the current barred lists (List 99, the Protection of Children Act 1999 (PoCA), the scheme relating to the Protection of Vulnerable Adults (PoVA) and Disqualification Orders). The Act also places a statutory duty on all those working with vulnerable groups to register and undergo an advanced vetting process with criminal sanctions for non-compliance

2007 - In 2007 there were 152 Primary Care Trusts (PCT) which reported to 10 Strategic Health Authorities (SHA's). The PCT were commissioning organisations but they were also responsible for the provision of some services. The SHA covered the geographical area of Yorkshire and Humber and in turn was responsible at that time to the Department of Health. In 2007, it was Doncaster Primary Care Trust which was responsible for commissioning services from RDaSH, including the day services at the Solar Centre.

8th March 2007 Allegations of abuse at the Solar Centre, were made to an RDaSH officer by a member of staff who was asking for a transfer from the centre. On being

asked why she wanted a transfer from the facility, she stated that some staff ill-treated patients and intimidated staff and managers. The alleged perpetrators were suspended from work.

9th March 2007 A referral under the Safeguarding Adults South Yorkshire Procedures was made by Day Service Manager following allegations made by a member of staff following a request by them to be transferred. A report was also made to the Police, with a Police investigation, commencing on the same day.

29th March 2007 An Adult Protection multi agency strategy meeting was held and it was determined that the Police investigation was on going.

A safeguarding strategy meeting/discussion must recognise the priority afforded to Police/criminal investigations. Criminal investigations by the Police take priority over all other investigations.

This halted the safeguarding investigation. During the initial Police investigation RDaSH continued with an Incident Management Group process and including implementation of an action plan.

15th May 2007 An Adult Protection multi agency strategy meeting determined that the Police investigation was still on going.

2007 The Mental Capacity Act 2005 (MCA) came into force in October 2007; within the Act Independent Mental Capacity Advocates (IMCAs) were introduced. The role of Independent Mental Capacity Advocates (IMCAs) is to support and represent a person who lacks capacity in making a specific decision, and who has no-one (other than paid carers) to support them. The Mental Capacity Act states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. This is one of the principles of the MCA.

The abuse at the Solar Centre occurred before the Mental Capacity Act 2005 came into force in October 2007.

November 2007 South Yorkshire Safeguarding Adults Policy was introduced alongside Doncaster specific practice guidance. This replaced the Doncaster multi-agency procedure introduced in 2004.

December 2007 A file of evidence was submitted by the police to the Crime Prosecution Service (CPS) for charging advice, the evidence was almost entirely derived from eyewitness statements.

29th December 2007 The Police informed RDaSH that CPS had advised that proceedings could not be brought because the allegations were of common assault and were either more than 6 months old, or the date could not be determined. RDaSH immediately instigated a Serious Untoward Investigation (SUI[1])

[1] Until 2010 a range of terms - Serious Incident, Critical Event, Significant Event, Serious Untoward Incident - were used to describe occurrences in health care where harm or the risk of harm to patients had occurred. In 2010, the National Patient Safety Agency (NPSA) developed a national framework for the notification, management and learning from **serious incidents** in the NHS.

5th June 2008 RDaSH concluded the SUI; an action plan was developed and implemented to reduce the risk of reoccurrence.

The SUI conducted by RDaSH substantiated the abuse on the balance of probability. Three employees were subject to disciplinary proceedings; of these two were dismissed and one was disciplined. This was a catalyst for South Yorkshire Police to revisit the case.

October 2008 – January 2009 The Department of Health, the Home Office and the Ministry of Justice launched the national consultation on the review of the No Secrets guidance in October 2008 and this concluded in January 2009.

The consultation involved 12,000 participants, including 3,000 members of the public, many of whom were adults to whom this guidance applied, or their carers. The remaining 9,000 participants were professionals working in the field. Nearly 500 long and detailed written responses were received.

The key messages from the consultation were:

A. Safeguarding requires empowerment/the 'victim's' voice.
B. Empowerment is everybody's business; but safeguarding decisions are not.
C. Safeguarding Adults is not like Child Protection.
D. The participation/representation of people who lack capacity is also important.

In relation to the victims of the abuse at the Solar Centre, the families interviewed as part of the Serious Case Review, agreed and related to A, B and D. Empowerment and participation were not evident in the investigations into the abuse at the Solar Centre.

2009 Primary Care Trusts separated into commissioning and provider arms.

10th February 2009 The Safeguarding Adults investigation resumed and Doncaster Advocacy Service began a series of unannounced visits to Solar Centre. The focus of their visits was to check that the action plan, developed and agreed by RDaSH, was being implemented.

1st April 2009 New procedural safeguards, known as 'Deprivation of Liberty Safeguards' (or DOLS) were introduced to protect individuals from the unlawful deprivation of their liberty. The new procedures were an amendment to the original Mental Capacity Act 2005.

March 2010 Doncaster Metropolitan Borough Council (DMBC) and NHS Doncaster published Being Valuable, Being Valued, A strategy for people with learning disabilities in Doncaster 2010 – 2013. This was Doncaster's strategy for people with learning disabilities for 2010 – 2013, was written in conjunction with Doncaster Learning Disability Partnership Board, and the Choice for All in Doncaster (ChAD) Group.

Early 2010 Doncaster Director of Adult Services commissioned an independent review of adult safeguarding processes. The outcome of the review was to

implement a central recording system. During the period between 2007 and 2010 there was recognition at a national and local level of the need for a review of Safeguarding Adults processes.

20th September and 29th November 2010 Two meetings chaired by RDaSH Chief Executive took place involving relatives and their legal representatives.

December 2010 South Yorkshire Police approached the CPS to ask for a review of the case on the basis of charges under Section 127 of the Mental Health Act 1983.

2011 Community Health Services were split off from PCT's.

5th January 2011 A third meeting chaired by RDaSH Chief Executive was held involving relatives, their legal representatives and South Yorkshire Police.

February 2011 A further file of evidence was submitted by the Police to the CPS. Additional information was then requested from the Police up to June 2011.

May 2011 A Lessons Learned Review was commissioned by the DSAPB. This was undertaken on behalf of the Board by an officer from Doncaster PCT, which was the NHS commissioning body at that time. The review explored three main issues relating to the Solar Centre investigation process and outcomes these were:

- Investigation processes and information sharing;
- Ability to report incidents: Multi-agency service provision and training standards.

The Lessons Learned Review concluded that abuse had occurred at the Solar Centre; that the organisations involved including the DSAPB had made significant changes; and that the culture and processes surrounding safeguarding adults had evolved.

Some issues were identified which required consideration by DSAPB and these were embedded in the DSAPB work plan for the year 2011 / 2012. Evidence of this was provided to the independent author.

May 2011 The Department of Health (DH) published a 'Statement of Government Policy on Adult Safeguarding'. This document sets out the government's policy on safeguarding vulnerable adults. It includes a statement of principles for use by local authority social services and housing, health, the police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements.

September 2011 The CPS gave the police advice and stated that 'eye witnesses' could not be relied on because they had witnessed the incidents and had done nothing. They therefore became secondary parties to the act, or were potentially guilty of wilful neglect. Without their evidence there could be no proceedings. Although no action could be undertaken, continuing sympathy was expressed for what a number of service users had clearly experienced.

This advice provoked representations from the families of those abused and brought the case to the attention of the Chief Crown Prosecutor for the CPS Yorkshire and Humberside. The case was then referred to the CPS Yorkshire and Humberside Complex Casework Unit for a review of both the decisions and the evidence.

2012 The Clinical Commissioning Board and Clinical Commissioning Groups were established. There was a reorganisation of PCT's into clusters and Strategic Health Authorities grouped into sub-national organisations.

July 2012 following the submission of further material, the reviewing lawyer advised the Police that the defendants could be charged under the Mental Health Act 1983.

12 October 2012 A meeting was held with the families affected by the abuse at the Solar Centre at a Police station in Doncaster. The Chief Crown Prosecutor, and the lawyer in the case attended along with representatives of South Yorkshire Police.

December 2012 The Department of Health published Winterbourne View Review: good practice examples. This document pulls together a number of good practice examples sent in by stakeholders and people who use services across England as part of the Department of Health review into the abuse of vulnerable adults which occurred at Winterbourne View

2013 Strategic Health Authorities and Primary Care Trusts were abolished and NHS England established.

March 2013 Doncaster Safeguarding Adults Partnership Board ratified its policy Guidance on the Coordination of Safeguarding Investigations (with other Investigations).

10th May 2013 A review of the Department of Health's 'Statement of Government Policy on Adult Safeguarding' was published. The policy states that safeguarding adults is everybody's business; and the objective continues to be to prevent and reduce the risk of significant harm; whilst supporting individuals to maintain control of their lives and to make informed choices without coercion.

The Policy is based on a set of Safeguarding Adults Principles, which are:

Empowerment – presumption of person-led decisions and informed consent
Prevention – it is better to take action before harm occurs
Proportionality – proportionate and least intrusive response appropriate to the risk presented
Protection- support and representation for those in greatest need
Partnership – local solutions through services working with their communities, communities have a part to play in preventing, detecting and reporting neglect and abuse
Accountability – accountability and transparency in delivering safeguarding

17th May 2013 Following court proceedings one defendant was found guilty of 15 out of 20 charges, and a second was found guilty of 10 out of 19 charges. They were subsequently sentenced to 2 years and 9 months imprisonment. Two other defendants were acquitted of all charges. In a press statement, on the day of the

sentencing, the Chief Crown Prosecutor acknowledged the convictions had taken some time to secure and paid tribute to the fortitude of the victims and their families.

6. Findings and actions undertaken as a result of investigations

The safeguarding process took from March 2007 until May 2013 and this is too long.

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.

6.1 Care Quality Commission and Health Care Commission

The Care Quality Commission is the regulator of health and adult social care in England. It is their role is to ensure that the care people receive meets essential standards of quality and safety. It is important to note that the Solar Centre is a Day Service and according to the Registration under the Health and Social Care Act 2008 is not deemed to be a 'regulated activity'. A day service is defined as:

> *'Where a person is receiving personal care but it is not being provided in the place where they are living (for example day services), then the service is not required to register' (CQC, 2013).*

The Healthcare Commission took over the role of the Commission for Health Improvement (CHI) on the 1 April 2004 and also assumed some of the responsibilities of the National Care Standards Commission (NCSC) and the Audit Commission, as well as a number of additional functions. The Healthcare Commission was a non-departmental public body sponsored by the Department of Health of the United Kingdom. It was set up to promote and drive improvement in the quality of health care and public health in England and Wales. It aimed to achieve this by being an authoritative and trusted source of information and by ensuring that this information was used to drive improvement. The Commission was abolished on **31 March 2009** and its responsibilities in England broadly subsumed by the Care Quality Commission (CQC). The CQC from this point in time became the independent regulator of health and adult social care.

In 2007, the Solar Centre Day Services would have been commissioned by the Doncaster Primary Care Trust, as part of the services provided by RDaSH. RDaSH is registered with CQC, as are all providers of health and adult social care. There is a requirement for it to meet essential standards of quality and safety; including a standard on safeguarding.

The Care Quality Commission and the Healthcare Commission, which were the performance assessors at the time had no involvement in the investigations

associated with the Solar Centre. It is not within their remit. CQC was made aware of the allegations and subsequent events; RDaSH supplied CQC with the Serious Untoward Incident Report and the consequent action plans.

The CQC are currently reviewing their approach to inspections and regulation of providers following the 'Winterbourne View' abuse scandal. However 'Day Services' are still not defined as a regulated service.

Recommendation 2

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

6.2 Crown Prosecution Service

The independent author met with the Deputy Chief Crown Prosecutor for Yorkshire and Humberside CPS and the lead solicitor for the Solar Centre case. They were clear that there had been issues with the way the evidence for the Solar Centre case had been reviewed in 2007 and 2011. The case had been referred to the CPS Yorkshire and Humberside Complex Casework Unit (CCU) for a review of both the decisions and evidence.

The review by a CCU lawyer found that in 2007, neither the Police nor the CPS reviewing lawyer appear to have considered the availability of alternative charges. There were potential alternative offences, which could have been considered. The CCU lawyer also disagreed with the conclusion of the review in September 2011, that evidence from the eyewitnesses could not be used. He felt that far from being passive participants, there was evidence that they were not willingly acquiescing to the ill treatment; rather they were afraid to speak out due to the culture of intimidation which existed at the Solar Centre.

In July 2012, following the submission of further material, the CPS advised the police that the defendants should be charged under the Mental Health Act 1983; and this formed the basis of the trial in April 2013.

Since May 2013, CPS has significantly raised the awareness of prosecutors in relation to the issues presented by cases involving offences against vulnerable people. It has published guidance on the prosecution of offences against older people and in relation to disability hate crime. This is to ensure a consistent approach, and that prosecutors are aware of the options available.

The guidance states, "It is important to make a distinction between a disability hate crime and a crime committed against a disabled person because of perceived vulnerability. A disability hate crime is any crime committed in any of the circumstances explained in section 146 Criminal Justice Act 2003[2]. Where there is evidence available to prove that an offence is aggravated by hostility

[2] Those circumstances are—
(a) That, at the time of committing the offence, or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on—
(i) the sexual orientation (or presumed sexual orientation) of the victim, or (ii) a disability (or presumed disability) of the victim, or
(b) that the offence is motivated (wholly or partly)—(i) by hostility towards persons who are of a particular sexual orientation, or
(ii) by hostility towards persons who have a disability or a particular disability.

based on the victim's disability we will do our utmost to ensure that that evidence is put before the court for sentencing purposes" (CPS, 2007).

In May 2013, the Chief Crown Prosecutor acknowledged that the convictions had taken some time to secure; and paid tribute to the fortitude of the victims and their families.

The CPS assured the independent author that changes in practice have been introduced in the years since the abuse at the Solar Centre including development of new policy, publishing national guidance and raising awareness of prosecutors to crimes involving vulnerable people. These changes were already in progress independent of the Solar Centre abuse, and are summarised in a letter to a Senior Policy Manager in Adult Safeguarding at the Department of Health (Appendix 2). That policy has now been implemented, nationally and locally.

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.

6.3 Advocacy Services

RDaSH contacted the Doncaster Advocacy Service, in March 2007 with a view to the organisation supporting those service users who were alleged to have been subject to abuse and who were without family members or friends who could represent them in relevant meetings. Doncaster Advocacy is an independent voluntary organisation, and it was felt that the involvement of an independent advocate, experienced in working with adults with learning disabilities would be beneficial to the service users concerned.

The report submitted for this Serious Case Review states that the desired outcomes from their involvement were to ensure that the issues that had arisen had been dealt with satisfactorily, and that measures had been put in place to prevent, as far as possible, reoccurrence.

After the initial contact made in March 2007, by RDaSH, and attendance of Doncaster Advocacy Service at the strategy meetings on 29th March 2007 and 15th May 2007; there was no further involvement of the service until February 2009. The report provided by Doncaster Advocacy Service states that "due to the Police investigation having supremacy, RDaSH was asked not to take any follow up action of its own, as this could have compromised the Police investigation". This resulted in a further delay in investigations.

Following the contact from RDaSH in February 2009, it was not until October 2009 that Doncaster Advocacy reviewed the files of 8 service users and met them and the staff at the Centre. It was agreed that Doncaster Advocacy would, in effect, 'take a "watching brief"; to ensure that there was some independent input into the review of the service users individual situations. The independent

author found a lack of clarity in relation to the outcomes expected from the work of the advocacy service and no specific formal contract between Doncaster Advocacy Service and RDaSH relating to the Solar Centre.

Doncaster Advocacy did not have a close working knowledge of any of the patients who had been abused and therefore the role for advocacy was limited.

The action plan identified in the RDaSH SUI report (see 6.5), and subsequent actions to improve and develop the services at the Solar centre were checked by Doncaster Advocacy in 9 unannounced visits between November 2009 and September 2010.

The conclusions of the report developed for this SCR by the Chief Executive was that the actions undertaken "had all contributed to an improved service, and hence an improved experience for service users who attend the Solar Centre. Hopefully they will also ensure that similar issues to those that revealed in 2007 will not happen again."

During the initial period following the allegations made in March 2007, it appears there was some advocacy available to the families of the abused through the Doncaster Partnership for Carers and South Yorkshire Centre for Inclusive Living. There was attendance by representatives from both these organisations at the Adult Protection strategy meeting in May 2007. The independent author could not find evidence that the organisations have records or details of their involvement.

The Doncaster Advocacy Service was involved in Adult Protection strategy meetings from March 2007 and February 2009, but only for those patients with no family member to represent them. No evidence was submitted to the Serious Case Review independent author of a contract, specifically relating to the Solar Centre, for the advocates involved after the allegations were made in March 2007.

Within the record of a multi-agency strategy meeting held on the 15th May 2007, there was representation from Doncaster Partnership for Carers. They stated that families felt as though they were being 'kept in the dark'. One family was asking that their details be shared with other families so that they could get in touch and provide support to each other; this process was not facilitated by agencies.

In reviewing the information supplied there is a question about whether IMCAs should have been involved given that regulations under the Mental Capacity Act gave local authorities and NHS bodies powers to involve IMCAs in other decisions concerning:

- A care review
- Change of accommodation
- Adult protection procedures (even in situations where there may be family or friends to consult).

The IMCA service is commissioned by DMBC and provided by Sheffield Mental Health Advocacy Service, working in partnership with Cloverleaf Advocacy. This service has been commissioned by Sheffield, Doncaster and Rotherham councils under a joint agreement.

The Serious Case Review found evidence of involvement from advocacy services during the investigations undertaken by RDaSH and a role in ensuring the SUI action plan had been implemented. However, there was no clear definition of the remit of Doncaster Advocacy Service in relation to the victims of abuse, or their families.

The appointment of IMCAs was not evident. There was no clear contract in relation to advocacy or specific outcomes of the involvement evident to the independent author. In addition there was no additional funding for Doncaster Advocacy Service, the input was to be delivered within the existing contract.

There should be flexibility in the provision of advocacy, when commissioned in relation to adult safeguarding, to ensure appropriate, timely and effective support. This should apply whether it is commissioned by individuals or by large organisations.

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.

6.4 Doncaster Safeguarding Adults Partnership Board

Doncaster Safeguarding Adult Partnership Board (DSAPB) commissioned this Serious Case Review which was initiated in August 2013.

The DSAPB (previously known as the 'Doncaster Adult Protection Partnership') Adult Protection Policy, was implemented in November 2004. It included an example of good practice in that it laid out the process for multi-agency safeguarding and it made reference to Serious Case Reviews.

The 2004 procedures identified the first priority as ensuring the safety and protection of vulnerable adults.

In 2007, at the time of the allegations being made at the Solar Centre, the South Yorkshire Adult Protection Procedures were in development and launched in November 2007. Serious Case Reviews (SCR) are discussed in detail in these procedures and three events which might lead to a SCR are suggested. These include where "Serious abuse takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale, and may require more time." There is an acknowledgement here that such a case would take some time to review.

There is no written evidence that the DSAPB considered a Serious Case Review earlier than 2013, although the abuse at the Solar Centre was of multiple victims by multiple perpetrators. In the view of the independent author, the victimisation and abuse of the patients who attended the Solar Centre meets the criteria for a Serious Case Review, and one should have been commissioned sooner.

In 2011 Doncaster Safeguarding Adults Partnership Board undertook a Lessons Learned Review. The report of the Lessons Learned Review (LLR) was reported to the DSAPB late in 2011. It highlighted the lack of clear guidelines regarding the primacy of investigation processes; and what actions must not be undertaken and what can continue. In relation to the Solar Centre there was a Police investigation, SUI process, disciplinary process and safeguarding investigation. A briefing was developed and presented to Board in response to the issues in the LLR and a strategic work plan was developed based on this. The work plan included the development of an SCR / LLR policy which was submitted for the DSAPB approval on the 7th Dec 2011; and alignment of the Serious Incidents and Safeguarding processes which was included within the Chairs report to the DSAPB in October 2011.

As a direct action from the Lessons Learned Review the DSAPB developed Guidance on the Coordination of Safeguarding Investigations (with other Investigations), which was implemented in 2013. The 'Guidance on Coordinating Safeguarding Investigations with other investigations' was developed and presented to Board 8th March 2013, this includes Serious Incident investigations.

In July 2013, following the completion of the court case in May 2013, the DSAPB revisited the circumstances surrounding the abuse at the Solar Centre and agreed to commission an independent review on how agencies involved, had embedded the learning within their organisations.

Given the context of the review, the proposed scope developed for the review and the public interest in this case the Board revisited its decision and decided that a Serious Case Review was appropriate.

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.

6.5 Families

The independent author met with relatives of 2 patients of the Solar Centre and spoke to one on the telephone.

The main themes were that the families did not feel that they were part of the investigations or the outcomes and have continuing concerns about the welfare of their relatives.

The Serious Case Review found little evidence from the 3 families who were interviewed, that lessons had been learned or actions taken relating to the concerns raised by families in meetings in late 2010 and early 2011. Similar issues were raised with the independent author, these concerns were around:

- The quality of communication with relatives when the allegations were first made;
- The level of support provided to service users following the reported allegations;
- The involvement of advocacy to support service users and their families in the investigations;
- Information sharing between affected families;
- Clarification about current and updated safeguarding processes in the trust;
- The length of time it took to complete the investigations.

The families interviewed do not feel that the impact of the substantiated abuse on their family members or themselves has ever been acknowledged by agencies.

The independent author asked the relatives a series of five questions relating to the abuse and subsequent investigations:

1. What had worked well?

There was little positive to report.

2. What did not work well?

Communication was generally felt to have been poor. Relatives were often left for long periods of time with no contact. Even to have been told there was nothing to report would have been helpful.

Some relatives felt that the issue of confidentiality was used in a negative way "to hide things". For example, families were told that they could not be told certain things because of the need for confidentiality or the Data Protection Act.

3. What support did they receive, and was this effective?

The relatives felt they had received no support; at a time when they were devastated by knowledge that their loved ones had been abused.

4. What support would you have liked?

Consistently the relatives cited regular communication, and that it should be to suit the individuals. Some wanted frequent communication (weekly) others were happy for it to be monthly or as agreed with them.

The wish to 'be listened to' was really important to relatives, and that staff at all levels in organisations 'try to walk in my shoes'; and understand how it feels living 'this nightmare'.

Relatives wished to be involved in care planning and reviews; and to feel like staff really care and know their relative.

Relatives strongly expressed the wish for the abuse to be acknowledged by agencies.

5. What blockages could they identify in the processes?

Relatives felt that training was required for staff including the Police in how to communicate with vulnerable people, those with learning disabilities and who are non-verbal.

Relatives want honesty, accountability and transparency, not delay and denial, which is what they feel they received from most of the contact with agencies and organisations involved.

The feelings and perceptions of the families interviewed in the SCR correlate to some of the findings of the No Secrets consultation. The common features which are felt by people who have been through safeguarding processes include:

1. People involved in adult safeguarding processes can sometimes feel: they have little control; that they are rushed to make decisions; are not involved in discussions about them; and have little say over outcomes.

2. There is a need to develop more effective means of empowering people, including people who may be being coerced by the person or people who are harming or abusing them, to work through what can be very difficult decisions about their lives.

3. The most commonly reported categories of outputs in safeguarding plans seem to be “increased services” or “increased care management monitoring”.

4. There is a view that people have insufficient access to criminal or restorative justice. (Klee, 2009)

The perceptions of the families interviewed as part of this Serious Case Review concur with the issues in 1, 2 and 4 above.

6.6 Rotherham Doncaster and South Humber (RDaSH)

RDaSH implemented a comprehensive improvement plan following the Serious Untoward Incident investigations undertaken during 2007 and 2008. There were 13 recommendations for action, made by the investigation team:

1. Deploy increased senior management supervision to the staff within the Solar Centre
2. Initiate changes to the physical environment by introducing vision panels to doors and changing the lock systems
3. Ensure qualified nursing staff led activity groups
4. Ensure community homes staff who transported patients to the Solar Centre, remain with them whilst they are there
5. Initiate a plan to rotate staff
6. Increase the frequency of Director’s visits and ensured on going visits.
7. Introduce unannounced visits by Assistant Director and Deputy Nurse Director
8. Ensure all staff are able to access care plans and patient records
9. Complete an audit of IR1’s (incident reports)
10. Undertake a review of supervision records and performance development reviews of all staff
11. Review sickness and absence records of all staff
12. Review other SUIs in Learning Disability Services
13. A Safeguarding Practice Development Bulletin was introduced across the Trust from June 2008

The safeguarding adults’ allegations were referred on the same day as they were raised; this was consistent with the policy at the time and good practice. The Doncaster Adult Protection Partnership Adult Protection Policy (2004) stated that it was the responsibility of all staff to act on any suspicion or evidence of abuse or neglect and to pass on concerns. Clearly this did not happen in a timely fashion at the Solar Centre. This was said to be due to staff feeling intimidated by the perpetrators.

RDaSH state in the report submitted for the Serious Case Review that key members of the senior management of the Trust maintained contact with the families throughout the investigation. This is not the view of the 3 families who agreed to be interviewed by the independent author, who feel there was insufficient communication.

Relatives were invited to meetings chaired by RDaSH Chief Executive (September and November 2010 and January 2011) involving legal representatives and South Yorkshire Police where a number of issues were raised. The concerns included the quality of communication with relatives when the allegations were first made; the level of support provided to service users following the reported allegations; the involvement of advocacy to support service users and their families in the investigations; information sharing between affected families; clarification about current and updated safeguarding procedures in the Trust and the length of time it took to complete the investigations.

In 2007, the Solar Centre provided a service, which was aimed at giving a 'change of scenery' for social interaction and activities. Service users were not afforded a choice about their attendance, and whilst some consideration was given regarding the activities offered to individuals, there was little monitoring of engagement and satisfaction.

The Individual Management Review, provided to the independent author, by RDaSH provided some evidence of personalisation through a timeline of personalisation from 2007 to the present time. The evidence includes the use of communication passports, peer advocacy and the implementation of 'My Plan' for all service users.

There are also descriptions of how service provision and documentation have been personalised to better "represent individual's specific needs, choice and support requirements". This has been actioned through the Solar Developing Excellence Plan, and involvement in the Peer Advocacy Pilot Project.

The Serious Case Review found evidence that lessons have been learned, by RDaSH and a comprehensive range of interventions have been undertaken. There is evidence of changes and actions within reports, guidance, revised policies and through observations by Doncaster Advocacy Service.

RDaSH apologised to the victims and their families, and this is evidenced within the Individual Management Review produced for this SCR. There was a statement read in May 2013, at court by an RDaSH officer: "We fully apologised to service users and their families at the time of the incidents and we apologise again today for the actions of the individuals that have been found guilty".

RDaSH staff complied with the safeguarding adults procedures that were in use at the time of the abuse. The safeguarding investigation and process undertaken in 2007 predates the implementation of the Mental Capacity Act 2005.

There has been no analysis of the impact of the abuse on the individuals and their families. All individuals and families should be approached by DSAPB, on behalf of the partnership, and asked if there are any ongoing needs which could be addressed. The impact for the victims and families of the abuse at the Solar Centre may have been exacerbated by the length of time it took to for the various investigations to conclude.

The chronology (Appendix 4) was provided by Doncaster Safeguarding Adults Unit, other information was provided to the independent author including copies of reports from safeguarding referrals, strategy meetings, convenor reports and case conferences.

Recommendation 7

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

6.7 South Yorkshire Police

South Yorkshire Police gathered the evidence relating to the allegations of abuse at the Solar Centre and submitted the files to the CPS. Knowledge of legislation was an issue, for both the Police and reviewing solicitors in CPS. 'No Secrets' guidance (DH and HO, 2000) states that agencies and practitioners should know about the law and use it appropriately. At the very least, this would seem to involve the following considerations.

Different legal options: there is a lot of potentially relevant legislation; there may be more than one option that can be used to safeguard an adult at risk of harm. So if one option is not legally possible (because it does not apply to the situation that has arisen) or will not result in a good outcome for the person at risk, then another may be available.

South Yorkshire Police have developed a policy with particular reference to Care Home Settings; this has been reviewed and revised as a result of the Solar Centre experience. This means that the Detective Inspector in charge of the Public Protection Unit will be responsible for:

- Identifying and suitably resourcing all complex investigations in relation to safeguarding adults, in particular in relation to abuse that has occurred within the settings of Hospitals, Care Homes and other care facilities.
- Quality assuring all vulnerable adult abuse investigations.
- Maintaining and developing multi agency relationships.
- Ensuring effective recording of all Vulnerable Adult abuse investigations and concerns. Developing and promoting vulnerable adult abuse investigative practices throughout their District.

South Yorkshire Police have provided evidence to the Serious Case Review of lessons learned and taking appropriate action where required through a report (Appendix 6).

There were clearly lessons to be learned in relation to knowledge of legislation, and along with the CPS, this has been recognised and action taken.

Recommendation 8

The DSAPB writes 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.

7. Analysis and Conclusions

The independent author considers that it was correct and important that the DSAPB commissioned a Serious Case Review at this time. Since the initial allegations of abuse were made in March 2007, there have been significant developments in legislation and national safeguarding policy.

The context of this Serious Case Review is significant, in that it is not a reinvestigation of the abuse which happened to the patients who attended the Solar Centre.

The terms of reference focus on the learning and evaluation of the implementation of learning across the multi-agency partnership.

The recommendations focus on issues where the independent author considers there has been insufficient learning, implementation of learning or evidence of sustainability and embedding of learning in practice.

The DSAPB and the partner agencies involved in this Serious Case review have examined the ways they worked together and as single agencies, they have identified areas where there is a need to improve Safeguarding Adults practice.

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 DSAPB should work with its partners to gain support and commitment to embed the principles of Making Safeguarding Personal in safeguarding adults practice. This would be evidenced by an outcomes focussed and person centred practice. (LGA, 2014) and would include:

Improved engagement with people; and evidence that safeguarding adult procedures involve people at the beginning, during and at the end of the safeguarding process.

Improvements in enabling people to express what they want from safeguarding activity and evidence of achieving outcomes from safeguarding processes that were articulated by the individuals involved.

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 response of agencies and organisations was to review and revise management, policy and processes.

The organisations and the processes seem to have lost sight of the 19 individuals who were abused; and the impact that the abuse and subsequent investigations have had on the victims and their families.

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.

8. 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 writes 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 individuals 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.

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Appendix 2 Crown Prosecution Service

Appendix 3 Doncaster Advocacy Service

Appendix 4 Doncaster Safeguarding Adults Safeguarding Board

Appendix 5 RDaSH Individual Management Review

Appendix 6 South Yorkshire Police Individual Management Review

Appendix 7 NHS England

References

ADASS (2005) Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work. London. The Association of Directors of Social Services

CPS (2007) Guidance on prosecuting cases of disability hate crime, London: CPS.

CQC (2012) Learning disability services inspection programme: National overview – June 2012;

CQC (2013) Registration under the Health and Social Care Act 2008: The scope of registration. Newcastle. Care Quality Commission.

Department of Health (2013) Statement of Government Policy on Adult Safeguarding. Published to www.gov.uk/dh

DH (2012) Winterbourne View review: good practice examples. London. The Stationery Office

DH and Home Office (2000) No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, London: The Stationery Office.

Doncaster Adult Protection Partnership (2004) Doncaster Adult Protection Policy. Doncaster Adult Protection Multi-agency Steering group.

DMBC and NHS Doncaster (2010) Being Valuable, Being Valued; A strategy for people with learning disabilities. Doncaster Metropolitan Borough Council and NHS Doncaster.

DSAPB (2013) Guidance on the Coordination of Safeguarding Investigations (with other Investigations)

Human Rights Act (1998) HMSO

Klee, D. (2009). A review of literature on safeguarding adults: Supporting 'vulnerable' people who have experienced abuse with difficult decision making. Local Government Association. www.lga.gov.uk/lga/aio/7818348 .

LGA (2014) Making Safeguarding Personal Guide. London, Local Government Association,

Office for the Public Guardian (2007) OPG606 Making decisions. The Independent Mental Capacity Advocate (IMCA) service (10.07)

Appendix 1

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24 April 2014

CQC report for Doncaster Safeguarding Adults Board SCR of the Solar Centre

We have been requested to prepare and submit a report to DSAB for a SCR that has been commissioned in respect of the Solar Centre. The terms of reference provided by the independent reviewer for this Serious Case Review are:

- To establish the lessons to be learnt from the circumstances at the Solar Centre in relation to the way in which local professionals and agencies worked together to safeguard vulnerable adults
- To review the effectiveness of procedures (Both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To prepare an overview report which will bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action (ADASS, 2010)

Trust background:

Rotherham Doncaster and South Humber NHS FT was registered with CQC in June 2010 under the Health and Social Care Act 2008 and is registered to provide the following regulated activities;

- Accommodation for persons who require nursing or personal care (5 locations);
- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (6 locations);

- Diagnostic and screening procedures (8 locations);
- Family planning (1 location);
- Personal care (2 locations);
- Transport services, triage and medical advice provided remotely (5 locations);
- Treatment of disease, disorder or injury (7 locations).

The Trust has 10 registered locations and provides services for people in Doncaster, Rotherham, North Lincolnshire, North East Lincolnshire and Manchester;

- Trust Headquarters, Doncaster
- Swallownest Court
- Great Oaks
- Emerald Lodge
- New Beginnings - Doncaster
- Learning Disability Assessment and Treatment Unit
- St. John's Hospice
- 88 Travis Gardens
- 10a-10b Station Road
- Danescourt

The services include adult mental health, older people's mental health, child and adolescent mental health (CAMHS), learning disabilities, psychological therapy services, and early intervention.

The Solar Centre

The Solar Centre is a day care centre for people with learning disabilities. The Solar Centre is not a registered location with CQC. The regulations do not require day care services to be registered with the CQC

Historical context

As an NHS Trust, services provided by Rotherham Doncaster and South Humber NHS FT were not regulated by the predecessor organisations, The Healthcare Commission or the Commission for Social Care Inspection prior to 2009.

The Healthcare Commission registered and regulated independent sector health care providers under the Care Standards Act 2000, modified by the Health and Social Care Act 2003 but this did not include registration and regulation of NHS organisations.

The role of the Healthcare Commission in relation to the NHS was to assess the performance of NHS organisations. The first function consisted of an annual assessment of performance (the Annual Health Check) which for PCT's included an assessment of its performance at commissioning as well as provision of services.

The Care Quality Commission was created by the merger of the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection, and came into being as a statutory body on 1 April 2009.

The Care Quality Commission was created, in line with the Health and Social Care Act 2008.

All locations of Rotherham Doncaster and South Humber NHS FT providing Learning Disabilities services have been inspected since the Trust was registered under the Health and Social Care Act 2008 in June 2010 however, there is no specific reference to the Solar Centre within the reports as this service was outside the scope of regulation. In 2007 and prior to the formation of the CQC a national Learning Disabilities review was carried out by the Healthcare Commission which included services provided by Rotherham Doncaster and South Humber NHS. A further review was carried out in 2008 however due to the length of time and the change of the organisation these reports are no longer available.

The CQC was not involved in the review at the Solar Centre as the CQC was not in existence and the predecessor organisation although aware of the events that took place, had no regulatory remit.

Latest inspection of Rotherham Doncaster and South Humber NHS FT

CQC last inspected Rotherham Doncaster and South Humber NHS FT on 21 and 22 October 2013 which included an inspection of Trust Headquarters location, Doncaster. Although the Solar Centre is a day care facility that does not fall within the regulatory remit of CQC we spoke to three members of staff who work in the centre as part of our overall assessment across the Trust of staff understanding about training, induction, supervision and safeguarding of people who are made vulnerable.

These staff told us: "there were very clear policies and procedures in place for staff. They said they had received good quality training in safeguarding and also had regular updates via e-learning. They were very clear of their role and confident about the action they should take if they suspected, saw or heard about anything that concerned them. They said safeguarding was a part of their regular supervision."

They said they worked well as a team and supported each other. They told us they had regular supervision sessions organised by a manager whom they found supportive.
They also told us they had received their mandatory training in subjects such as health and safety, moving and handling, and infection control. They also told us they received more specialised training, relevant to the needs of the people who used the service. This included epilepsy and Makaton training. Makaton is a way of using signs and symbols to help people communicate."

The CQC learning and changes to our regulatory model for mental health and learning disability inspections

Following the expose on Winterbourne View in 2011, we carried out a themed inspection of learning disability services across England. This involved 150 unannounced inspections and most of the failings we found were as a direct result of care not being centred on the individual, or tailored to meet their needs. We made a

number of recommendations for service providers, commissioners and the CQC to change the way they work.

Alongside this the CQC are signatories to the DH concordat for transformation of learning disability services. We have reviewed and strengthened the registration products and process for all new applicants of learning disability services raising the bar on the requirements to register. We are also implementing new inspection methods for all mental health and learning disability hospital services in England.

The regulatory model of inspection has been reviewed and strengthened and new regulations coming into force in October 2014 will further enhance our inspection process. By April 2016 all health and social care services will be rated so that people who use the service, their families, carers, and members of the public have clear information about each service and how well it provides those services.

We have clear systems in place to respond to whistleblowing with a dedicated team to monitor and follow each alert through to what action has been taken and conclusion of the alert.

We have strengthened our relationships with our strategic partners such as the Adults Safeguarding Teams to share information of concern and work collaboratively driving improvements in services and targeting areas of risk. When we receive allegations of abuse we respond swiftly and work closely with our strategic partners, sharing information and working together. This ensures the most effective action is taken in a timely manner and everyone is clear of what action is being taken by each organisation to protect people who use services.

Summary

The unacceptable events, behaviours and abuse at the Solar Centre took place between 2005 and 2007; some years before the establishment of the CQC and before any established regulatory framework for the National Health Service. The CQC has regulated the provider within the scope of the regulatory powers we have had since 2009. We can only provide the data and information we hold since 2009 to a serious case review dealing with matters from some nine years ago. CQC is a key partner in the system transformation for people with a learning disability and their families. Our current approach to registration, inspection and enforcement are a reflection of the seriousness and responsibility we place on our duties to protect those individuals made most vulnerable by the health and care system.

Appendix 2

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CPS

Claire Crawley
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Department of Health
[redacted]

9 August 2013

Dear Ms Crawley

R v JAMES HINDS and SUSAN MURPHY, SHEFFIELD CROWN COURT

Thank you for your e-mails of 26 and 31 July 2013 regarding concerns about the handling of the above-named case by the Crown Prosecution Service (CPS). Your e-mail has been passed to me for response as Head of the Criminal Law and Procedure Unit in the CPS Strategy and Policy Directorate. I have now received a report on this case from the CPS Yorkshire and Humberside Complex Casework Unit.

As you will be aware, this case involved the prosecution of members of staff at a care facility in Doncaster for people with a mental disorder. James Hinds and Susan Murphy had both worked for some time as care assistants at the Solar Centre which was a day care facility at St Catherine's Hospital offering care to service users, some of whom had considerable disabilities.

In March 2007 another member of staff at the centre sought a move from the unit. When she was asked why, she told managers that some of the staff ill-treated service users and intimidated staff and management. Other staff supported what had been reported and the Rotherham, Doncaster and South Humber Trust (RDaSH) which ran the hospital reported the matter to the South Yorkshire Police.

<u>The first CPS advice</u>

A police investigation followed and a file of evidence was submitted to the then South Yorkshire CPS in December 2007 for charging advice in respect of James Hinds, Susan Murphy and Julie

Burge, another member of staff at the centre together with Michael Barnard, a physiotherapist who was on secondment from another health authority. The file was submitted on the basis that the evidence, which was almost entirely eye witness evidence from staff members, showed that service users had been assaulted.

The reviewing lawyer reviewed the case on the same basis and advised that although there were clearly concerns about the treatment that a number of service users had received and that there was a need for them to be properly protected, proceedings could not be brought because the complaints amounted to common assault and the incidents were either more than six months old, or the date of the allegations could not be determined. There was also an allegation of false imprisonment, but there was a lack of corroboration and the lawyer felt that the evidence, without more, was insufficient to provide a basis for a prosecution. The lawyer additionally expressed some concerns about the form of the statements, which appeared to have been taken from recorded interviews. The police accepted the advice. Neither the police nor the reviewing lawyer appear to have considered at that stage the availability of alternative charges.

The second CPS advice

Following the CPS advice, RDaSH carried out an internal investigation, resulting in a report in September 2008 which found that there was evidence that service users had been ill-treated. The three employees of the Trust were the subject of internal disciplinary proceedings as result of which, in 2011, Hinds and Murphy were dismissed and Burge was disciplined. It is understood that the RDaSH action was the catalyst for South Yorkshire Police to re-visit the case which culminated in an approach to CPS around Christmas 2010 to ask if the case could be further reviewed and consideration given to a prosecution on the basis of charges under section 127 of the Mental Health Act 1983.

A file was submitted to the CPS in February 2011 and a lawyer in South Yorkshire CPS undertook the review. Additional material was requested from the police and provided up to June 2011 and in August an 'initial advice' was given. This became the final advice given in September 2011 which was that the eye witnesses could not be relied on because they had witnessed the incidents and done nothing and in so doing became secondary parties to the act or were themselves potentially guilty of wilful neglect. The advice was that, without their evidence, there could not be proceedings and that therefore the advice was for no further action to be taken notwithstanding our continuing sympathy for what a number of service users had clearly experienced.

The third CPS advice

The advice in September 2011 generated representations from the families, a response from the police and was the subject of media coverage, which brought the case to the attention of the Chief Crown Prosecutor (CCP) for CPS Yorkshire and Humberside who undertook to look into the case with the then Deputy Chief Crown Prosecutor (DCCP) for South Yorkshire. The DCCP took the view that the decision not to proceed had been premature and that there were some issues which had not been resolved. As a result the CCP referred the case to the Yorkshire and Humberside Complex Casework Unit (CCU) for a review of the both the decisions in the case and the evidence.

It was the view of the CCU lawyer that whilst the decision in December 2007 was correct as far as it went, there had been potential alternative offences which, regrettably, had not been considered. He disagreed with the conclusion of the review in September 2011 that the eye witnesses could not be used. Far from being passive participants, there was evidence that they were not willingly acquiescing to the ill treatment, rather they were afraid to speak out because of the atmosphere of intimidation which existed in the Solar Centre. The lawyer agreed with the police that section 127 of the Mental Health Act 1983 was appropriate legislation under which the four suspects could be charged and duly advised on further steps for the police to take to enable a full review of the case.

Following the submission of further material, in July 2012 the reviewing lawyer advised the police that the defendants should be charged with a number of charges under the Mental Health Act 1983 and it was these charges which formed the basis of the counts on the indictment upon which the defendants were tried in April 2013.

On 17 May 2013, Susan Murphy was found guilty of 15 out of 20 charges relating to the ill-treatment of patients, and James Hinds was found guilty of 10 out of 19 charges. They were subsequently sentenced to two years and nine months' imprisonment. Julie Burge and Michael Barnard were acquitted of all charges.

In a press statement issued on 17 May 2013, Martin Goldman, Chief Crown Prosecutor, CPS Yorkshire and Humberside acknowledged that the convictions had taken some time to secure and paid tribute to the fortitude of the victims and their families.

In the time since these matters were first referred by the police, steps that the CPS has independently being taking have significantly raised the awareness of prosecutors in relation to the issues presented by cases involving offences against people with disability and older people. It has published guidance on the prosecution of offences against older people and in relation to disability hate crime to ensure a consistent approach and that prosecutors are aware of what options for action are available to them.

I hope this letter is of assistance in explaining how this case came to be handled.

Yours sincerely

Arwel Jones
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Appendix 3

Doncaster Advocacy – Involvement in Solar Centre investigations (2007 – 2009)

Prepared by [redacted], Independent Advocate, Doncaster Advocacy

At the time that the allegations of abuse within the day to day activities of the Solar Centre were made in March 2007, Doncaster Advocacy was contacted with a view to the organisation being involved in respect of those service users who were alleged to have been subject to abuse and who had no family members or friends to represent them. We are an independent voluntary organisation, and it was felt that the involvement of an independent advocate, experienced in working with adults with learning disabilities would be beneficial to the service users concerned.

The desired outcomes from our involvement were to ensure that the issues that had arisen had been dealt with satisfactorily in respect of the service users concerned, and that measures had been put in place to mitigate as far as possible against them reocurring.

In practice, after initial contact had been made with us by the professionals at RDaSH, very little happened at that time. We attended multi disciplinary meetings in respect of Safeguarding on 29th March 2007 and 15th May 2007; after that we had no contact regarding this matter until February 2009. I understand that this is because a police investigation was being carried out during this time, and that RDaSH was asked not to take any follow up action of its own, as this could have compromised the police investigation.

In February 2009 [redacted], Adult Safeguarding Lead, RDaSH, contacted me to say that the police investigation had been completed and that she, as Adult Safeguarding Lead for RDaSH, now had responsibility for the work that RDaSH would be doing in relation to their own internal investigations into the matter.

I met with [redacted] on 6th July 2009 and on 18 September 2009 to discuss Doncaster Advocacy's role in the RDaSH investigation and reporting. At this meeting [redacted] gave me the names of the eight people about whom she would like some input from Doncaster Advocacy: [redacted]

We did not have a close working knowledge of any of those concerned, and had not been involved with most of them at all before, but we agreed that in their cases there ought to be someone involved for them, to ensure that an attempt was made to have input on their behalf.

Getting to know all those people in order to fully represent them would simply not be possible in the timescales involved, and bearing in mind that the situation happened

some time ago and that this would be the "final stage" of wrapping things up (as corrective action had been taken in respect of the situation), I decided that we have to take a very pragmatic view on how to become involved meaningfully but in a way that would be manageable to us time-wise as an organisation.

It was therefore agreed with [redacted], Assistant Director, Community LD Services, RDASH, that Doncaster Advocacy would, in effect, take a "watching brief" role in respect of those individuals concerned, to ensure that they had some independent input into the review of their individual situations but that this was undertaken in a realistic way.

I visited [redacted] office at 11 Fulwood Drive on 20th October 2009 and reviewed the files of the eight service users concerned. I noted that in seven of the eight cases involved, the staff members accused of abuse had been dismissed. In the eighth case it was not clear about the exact nature of allegations made, or against which staff members the allegations had been made, although notes on the file appeared to state that there were various allegations.

I noted the measures that had been put in place to ensure that the situation did not recur and have checked that these had been actioned eg:

- All Solar Centre staff had attended Safeguarding Practice Development training
- All Solar Centre staff were receiving monthly one-to-one sessions
- Direct management was now in place on-site at the Solar Centre
- Clear management structure and lines of responsibility within the unit with easy access to management for staff had been introduced.
- Total review of the utilisation of the premises and resources had been undertaken, to ensure maximum openness and transparency whilst maintaining service user safety
- Promotion of open access to Solar Centre for management, family members and other visitors
- Revision of timetabling within the Solar Centre to allow for optimum use of resources
- Rotation of staff roles within the unit
- Process in place to guard against personal relationships between staff members affecting the operation of the Solar Centre
- Increased partnership working with other agencies, home support staff and family carers

I visited Solar Centre with [redacted], Assistant Director, Community LD Services, RDASH, on 23rd October 2009 to witness the current operation of the Centre and meet the staff and service users prior to my implementing a series of unannounced visits to the Centre to maintain the watching brief role.

I found staff to be friendly and welcoming, keen to make the changes, and supportive of the new working methods. Service users all appeared to be happy and relaxed, to have good relationships with staff and to be involved in activities they were enjoying.

Over the next year I made unannounced visits to the Solar Centre on the following dates:
02/11/09
08/12/09
16/02/10
21/04/10
21/05/10
23/06/10
16/07/10
05/08/10
10/09/10
On each visit, I was welcomed into the Centre, visited service users in several different rooms each time, was able to do so without being accompanied by staff (as they recognised me as a fellow professional; obviously staff were with service users at all times and I was not left alone with any service user on any occasion). I was able to sit and join in with activities service users were undertaking; was offered drinks and biscuits if I called at tea break time; was able to communicate one to one with service users, and generally felt that there was a happy and settled atmosphere for staff and for service users.

Lessons learned; I think that these are reflected in the measures that had been put in place to ensure that the situation did not recur, as noted above.

Having direct management on site; ensuring that all staff received relevant and updated training; changes to working practices in terms of staff rotas and timetabling; the development of a culture of openness and transparency, and more relaxed attitudes to attendance times for service users and to the welcome offered to visitors (whether expected or not) had all contributed to an improved service, and hence an improved experience for service users who attend the Solar Centre. Hopefully they will also ensure that similar issues to those that revealed in 2007 will not happen again.

Report prepared 13 January 2014 by [redacted] CMgr FCMI
Chief Executive
Doncaster Advocacy

Appendix 4

DSAPB Safeguarding Adults Unit Chronology – Solar Centre

Date From	Date To	Staff	Source of information	Event	Action	Comments
09/03/2007		Deputy Manager	Case files - email	Safeguarding Adult Referral form requested by RDASH	Emailed referral form and advised of	
15/03/2007		Deputy Manager	Case files – SA Referral	SAU received completed Referral from RDASH – dated 09/03/07	Deputy Manager, SAU requested Strategy meeting be arranged	Emails demonstrate Deputy Manager requesting families be contacted
19/03/2007			Case files - email	Email received by Head of Service from ENABLE Advocacy Service Co-ordinator requesting information on behalf of a family member	Email forwarded to RDASH for appropriate action	
21/03/2007		Deputy Manager	Case files - email	Advised RDASH in relation to strategy meeting and meeting with families		
22/03/2007		Deputy Manager	Case files - email	Assurance received from RDASH that meetings with families would be arranged		
29/03/2007		Deputy Manager	Case files – SA Strategy Meeting	Strategy meeting held	Police investigation ongoing RDASH to have face-to-face meetings with family and seek advocacy for those without family or support	
15/05/2007		Deputy Manager	Case files - SA Strategy Meeting	Additional strategy meeting held	Feedback to family and Police Investigation ongoing	

Date From	Date To	Staff	Source of information	Event	Action	Comments
08/01/2008		Deputy Manager	Case files - email	Email received from RDASH informing of Police investigation concluded – not being pursued by CPS	RDASH commenced investigation	
21/01/2008		Deputy Manager	Case Files - email	Safeguarding Unit sought clarity as to whether another strategy meeting was needed or proceed to case conference		Next email refers to Case Conference. No record of response
11/02/2008		Deputy Manager	Case Files - email	Advice given to RDASH re the consideration of feeding back to families through the case conference process		
04/09/2008		Head of Service	Case Files - email	Head of Service queried whether the report would be presented to the DSAPB		No response recorded
18/12/2008		Deputy Manager	Case Files - email	Deputy Manager offered RDASH support in developing convenors report		
30/01/2009		Head of Service and Deputy Manager	Case Files - email	Email received from RDASH informing of meeting arranged for 10th Feb 09		No record of this meeting on file
24/09/2010		SAU Admin Office	Case Files - email	Email received with completed Case Conference and Convenors reports for Solar Centre clients	Filed as appropriate and copied to Head of Service	No Safeguarding Investigation forms received by the SAU or on file

Date From	Date To	Staff	Source of information	Event	Action	Comments
23/02/2011		DSAPB Board	Board Minutes Confidential section	Board briefed on the Solar Centre case, investigations carried out and LLR process initiated.	Lessons Learned Report to be presented to Board when finalised	
04/05/2011		DSAPB Board	Board Minutes Confidential section	Lessons Learned Review presented to the Board	To anonymise and share locally to learn lessons. Board requested agencies check their whistleblowing policies are effective.	
07/07/2011		Head of Service	Case File	Sharing information meeting re whistle-blower	RDASH to advise and signpost whistle blower to CQC and RDASH complaints policy	
13/09/2012		DSAPB Board	Board Minutes Confidential section	Board briefed that in light of prosecutions RDASH was undertaking further work	RDASH to brief DSAPB at the next Board meeting	
06/11/2012		DSAPB Board	Board Minutes Confidential section	RDASH confirmed that criminal charges had been brought against the four members of staff involved, following a review by the Crown Prosecution Service.		
11/01/2013		DSAPB Board	Board Minutes Confidential section	RDASH briefed Board that the trial is to commence in April. Also RDASH have liaised with Police and urged them to support the alleged victims and their families.		

Date From	Date To	Staff	Source of information	Event	Action	Comments
04/07/2013		Safeguarding Adults Review Panel	SARP Minutes	Solar Centre case presented for consideration for Serious Case Review.	Outcome to audit agencies assurance of action plant, not to commission SCR	
04/07/2013		DSAPB Board	Board Minutes Confidential section	Decision presented to Board that actions will be considered and an independent person will be commissioned to validate these to ensure due process has been followed.	Independent author engaged to undertake external review of the Solar Centre case	
02/09/2013		Urgent ad-hoc SAR Panel meeting	SARP Minutes	Decision for Solar Centre SCR reconsidered and decision made to commission.	Inform agencies and independent author Update Board Develop Terms of reference	
05/09/2013		DSAPB Board	Board Minutes Confidential section	Presented decision to conduct a SCR for the Solar Centre in light of public interest.		
05/09/2013		DSAPB Board	Board Minutes	Board accepted decision made by SAR Panel to commission SCR for Solar Centre	Head of Service commenced commissioning process	
07/11/2013		DSAPB Board	Board Minutes	Update presented to Board re progression of SCR		

Appendix 5

Rotherham Doncaster and South Humber NHS Foundation Trust

Solar Centre

Individual Management Review

[redacted]
Deputy Director of Nursing and Standards

[redacted]
Deputy Chief Executive/Director Nursing & Partnerships

October 2013

Contents

Section 1 Introduction

This report has been compiled in response to Doncaster Safeguarding Adult Partnership Boards (DSAPB) decision to undertake a Serious Case Review (SCR) into the allegations of abuse at the Solar Centre, a service provided by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). The abuse took place between November 2005 and 8th March 2007, a period of 16 months. Following a comprehensive internal investigation the allegations of abuse were substantiated.

The report provides a background to the case, details a summary of the original investigation, including an outline of the allegations, investigation process and recommendations. Since the original investigation there has been a comprehensive approach to the recommendations made and improvement actions undertaken. These are set out in Section 4. Additionally, given the time between the original investigation and the current SCR there have been significant national changes to the profile of safeguarding, whistleblowing and the protection of vulnerable adults, and locally the Trust has developed and improved its approach to care delivery and these changes are detailed in Section 5. The report concludes with a summary.

Section 2 Background

The Solar Centre provides sessional day service support to adults with a learning disability and associated high health support needs. Following referral by a multidisciplinary team, patients[1] have the opportunity to access social activities and specialist recreational activities, and therapies, within this specialist accessible environment.

At the time of the abuse that occurred, the Solar Day Centre cared for patients who had profound learning disabilities and could present with challenging behaviour. There were a high number of patients with physical health problems, restricted mobility and behavioural traits including repetitive expression and/or vocalisation with sounds. The nature and degree of disabilities suffered by these patients was such that they lacked capacity to make many decisions and at times had difficulty in engaging in any meaningful activity.

On 8th March 2007 a nursing assistant approached the Day Services Manager for Learning Disabilities to request a job move and during this interview reported instances of alleged mistreatment of patients by four of [redacted] colleagues. The allegations referred to three RDaSH nursing assistants, and one physiotherapy assistant employed by Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT). In accordance with policy guidance the four accused staff were suspended from duty by both employers following the disclosure of the alleged abuse. In addition South Yorkshire Police and the Protection of Vulnerable Adults service (POVA) were informed.

South Yorkshire Police undertook an investigation and at their instruction RDaSH withdrew from its own internal investigation to allow the Police to complete theirs. Throughout the duration of the initial police investigation the Trust continued with an Incident Management Group process and instigated actions that are described in the next section.

[1] There are differing views on the terms patient, service user or client. Literature identifies that 'patient' is most commonly the preferred term. Therefore for the purpose of this report the term 'patient' is used throughout.

At the end of December 2007 the Trust received notification from the Police that they did not intend to pursue criminal proceedings. The Trust then commenced a full internal investigation in line with the Trust's Serious Untoward Incident policy.

Section 3 – Original Investigation

3.1 Outline

Following the allegations of patient mistreatment made to the Day Services Manager for Learning Disabilities on 8th March 2007, and in line with the Trust Serious Untoward Incident (SUI) Policy, an Incident Management Group was convened from the 9th March 2007. The Executive Director of Operations and the Executive Nurse Director immediately initiated the following actions:

- Deployed increased Senior Management supervision to the staff within Solar.
- Initiated changes to the physical environment by introducing vision panels to doors and changing the lock systems.
- Ensured qualified nursing staff led activity groups.
- Ensured community homes staff who transported patients to Solar, remain with them whilst they are there.
- Initiated a plan to rotate staff.
- Increased the frequency of Director's visits and ensured ongoing visits.
- Introduced unannounced visits by Assistant Director and Deputy Nurse Director.
- Ensured all staff were able to access care plans and patient records.
- Completed an audit of IR1's (incident reports).
- Undertook a review of Supervision Records and PDRs of all staff.
- Reviewed Sickness and Absence records of all staff.
- Reviewed other SUIs in Learning Disability Services
- A Safeguarding Practice Development Bulletin was introduced across the Trust from June 2008.

In addition the Incident Management Group, chaired by the Chief Executive or Executive Director of Operations, met initially weekly and regularly thereafter, other members of the group included representatives from Doncaster PCT and DMBC.

In line with the Trust Policy the matter was reported to the Police when the incident was disclosed. The Police undertook their own investigations and at the instruction of South Yorkshire Police, RDaSH did not progress its own internal investigation until the completion of the Police investigation. This caused a delay in the Trust being able to commence its own investigation into the allegations, this delay has also been a feature in other high profile cases, for example The Airedale Inquiry[2]

The concerns were also referred for further investigation under Protection of Vulnerable Adults (POVA) arrangements. Throughout the period of the Police investigation, the Trust continued with its Incident Management processes and implemented the actions described above.

An on-going Incident Management Brief provided a monthly update to the Board of Directors as part of the Trust's Serious Untoward Incident policy.

At the end of December 2007 the Trust received notification from the Police that they did not intend to pursue criminal proceedings. The Trust then commenced a full internal investigation in line with Trust policy. The terms of reference for the investigation team were:

- To establish facts surrounding the care leading up to disclosure of allegations involving abuse of patients at Solar Centre.
- To identify any potential care, system and/or service failures.
- To form recommendations and action plans
- To ensure any potential disciplinary or performance issues are flagged for separate investigation.

The investigation reported on 1st September 2008. The investigation team, having reviewed all available evidence related to the Solar Centre allegations concluded that, on the balance of probability, while only two alleged incidents had corroborated evidence, the abuse was likely to have taken place.

Although the investigation team's original terms of reference was to focus on the allegations of abuse, concerns were raised during the investigation about three of

[2] The 'Airedale Inquiry' was a report of an investigation presented to The Yorkshire and the Humber Strategic Health Authority on 8 June 2010. The investigation was into concerns regarding a member of nursing staff. Despite the concerns being highlighted in 2002 and reported to the police in 2003 the Trust investigation did not commence until 2009.

the managers and another of the staff nurses. These concerns were addressed within the recommendations arising from the investigation.

3.2 Findings

The investigation identified allegations of abuse made by nine nursing assistants against four members of staff, three of whom were employed by RDaSH as nursing assistants [redacted]. The fourth member of staff [redacted] was employed as a physiotherapy assistant by DBHFT. The four accused staff were suspended from duty following disclosure of alleged abuse on 8th March 2007 and denied the allegations.

Shortly after the allegations were made, the physiotherapy assistant tendered [redacted] resignation to [redacted] employers. This was accepted by DBHFT. This occurred before the Trust investigation team were able to commence their investigation and as a consequence, they were unable to conduct a formal interview with this individual.

One witness reported a specific incident that allegedly occurred in Summer 2001. This appeared to be the only incident that related to the period between October/November 2005 and March 2007, when the rest of the alleged incidents were reported to have occurred.

After extensive investigation the team concluded that despite indications of a specific incident occurring prior to November 2005, the remainder of the allegations of abuse related to the time period between November 2005 and the 8th March 2007. In essence there were 44 alleged incidents, which occurred between November 2005 and March 2007, a period of 16 months. These incidents were witnessed by a total of 9 staff but only 2 of the 44 incidents had been witnessed by two or more staff members.

The investigation team were aware that the events described in the witness statements did not occur in isolation and that understanding the circumstances in which these events occurred was vital. Following guidance provided by the National Patient Safety Agency (NPSA) the investigation team examined nine possible contributing factors to the abuse occurring, which may have been present in this case. The team concluded that eight of the nine NPSA contributory factors had, to some degree, featured in the investigation and analysis of these incidents.

In respect of the 44 allegations of abuse against patients perpetrated by the four members of staff, the incidents ranged from:

- A patient being locked in a store room and a chair put behind the door to prevent them from getting out
- A patient hit round the head and in the face
- A patient hit over the head with a microphone
- A patient slapped in the face and threatened

Of the incidents above the investigation team was made aware that there were only two instances where there was more than one independent witness present.

The allegations against the accused staff were as follows:

- [redacted] named in 25 allegations by witnesses.
- [redacted] named in 17 allegations by witnesses.
- [redacted] named in 2 allegations by witnesses
- There is also one incident where a witness has made a specific allegation that [redacted] and [redacted] jointly abused one patient.

The fourth accused [redacted], did not have specific allegations made separately against [redacted], but was party to three incidents where [redacted] was also present.

As a consequence of the police investigation and the length of time before the Trust was in a position to undertake its own investigation, the investigation team found it difficult to pinpoint specific dates and times for the alleged abuse.

The investigation team was made aware from interviews with witnesses that one of the accused staff [redacted] had told them that he had 'dealt' with a specific patient [redacted] who had challenging behaviour, shortly after starting work at the Solar Centre in 1997. During the course of the investigation the panel was unable to establish anyone who witnessed this. However it was reported that [redacted], over a prolonged period of time, had consistently boasted of having 'dealt' with this patient to unqualified staff. The investigation team could not prove or disprove that this event took place but included these allegations in the report as an indication to the character of [redacted].

At interview each of the witnesses was asked why they had not reported concerns at the time of the incidents taking place. The investigation team heard that the witnesses had felt unable to do so for the following reasons:

- Lack of confidence in the qualified staff whom they thought would side with the accused (because of the perceived relationships amongst the staff).
- Lack of appropriate response when previous concerns had been raised.
- General perception of being disempowered by the dominant group.
- Fear of retaliation from the accused staff, and in particular [redacted].

In concluding the investigation twelve recommendations were made by the investigating team, these are listed in the next section.

3.3 Recommendations

The investigation team made the following 12 recommendations:

1. The allegations made against the three accused staff working for the Trust warrant referral to formal disciplinary procedures.
2. Concerns raised about three managers and another staff nurse warrant further investigation to allow them to answer to the concerns in their own right (NMC Code of Professional Conduct[3]).
3. Review of day services as a whole should be progressed within the Learning Disability Directorate to address the alleged problems with working practices/culture within the Solar Centre. An external facilitator will lead this review.
4. A review should be undertaken of the training needs of the qualified staff with regards to clinical supervision to supplement the existing model of management supervision.
5. The Trust should explore alternative ways of providing clinical supervision. For example, supervision by professional staff working outside the Solar Centre would offer both independent support and an opportunity to raise concerns as soon as possible.
6. Managers and staff subject to investigation should not undertake the

[3] All nurses and midwives in England must abide by the NMC Professional Code of Conduct, that is the foundation of good nursing and midwifery practice, and is a key tool in safeguarding the health and wellbeing of the public

supervision of other staff members.

7. All staff throughout the Trust must be made aware of the Trust's policies on 'Personal Harassment' and 'Disclosure by Staff of Concerns on Healthcare Matters'.
8. The Trust must develop a clear policy in relation to staff forming personal relationships with work colleagues as guidance to all managers.
9. The Trust must identify, for specific patient groups in Learning Disabilities, clear staff/patient ratios that allow safe management of services and reflect the level of challenging behaviour displayed, and the degree of disability present.
10. A review must be undertaken of the administrative requirements of the Solar Centre to release the qualified staff to facilitate group sessions and provide clinical care to patients and support and supervision to non-qualified staff.
11. There must be adequate provision of administrative staff in the Solar Centre.
12. The programme of practice development days, introduced through the Trust's immediate action plan, to improve team working and positive therapeutic culture within the Learning Disability Directorate, should continue for the foreseeable future.

3.4 Safeguarding

Following the allegations of abuse on 8th March 2007, safeguarding referrals were made in respect of 18 patients on 9th March 2007. These 18 referrals were all fully investigated in line with the policy and procedures available at that time. The South Yorkshire Safeguarding Adults Procedures were launched in November 2007.

3.5 Family Engagement

Key members of the senior management of the Trust maintained contact with the families throughout the investigation. This contact was maintained for those families who wished to have contact as some families declined any further contact with the Trust in respect of these matters.

The families of the patients that wished to be involved were engaged throughout the safeguarding process and case conferences.

Subsequent to the completion of the Trusts internal investigation a number of meetings were held with the relatives of the patients to discuss the findings and to facilitate conversations with South Yorkshire Police. The Chief Executive of the Trust chaired three meetings, held on 20th September 2010 and 29th November 2010 (with relatives and family legal representatives) and also on 5th January 2011 (attended by family members, legal representatives and the Police).

At these meetings a number of issues were raised and responses provided during the meeting and subsequently in writing, covering a range of different concerns. The concerns raised included the quality of communication with relatives at the time of the incident; the use of psychological evidence and assessment by the police as part of their investigation; the level of support provided to service users following the allegations being reported; the involvement of advocacy to support service users and their families during the investigation; the process for making POVA referrals; information sharing between affected families; clarification about current and updated safeguarding procedures in the Trust and finally, how long it had taken to complete the investigations. All of these issues have subsequently been addressed as part of the improvement plan and refresh of Trust policies and procedures.

Section 4 – Improvement Actions

Immediately following the allegations being made on 8th March 2007 actions were undertaken in order to safeguard the patients involved and to address immediate concerns. These are detailed in section 3.1.

In addition a 'Developing Excellence Plan' was initiated in October 2009 to respond to the concerns raised by the Serious Incident Investigation report. This plan was generated to ensure that the lessons learnt process was taken forward. It was further developed to identify work streams to support an action plan that would improve practice and service delivery and also lead to valued outcomes for the users of the service.

4.1 Response to the Recommendations

A number of update reports and presentations were made within the Trust regarding progress against the original recommendations within the SI. The improvement actions are detailed below against each recommendation.

1. The allegations made against the three accused staff working for the Trust warrant referral to formal disciplinary procedures.

Formal disciplinary procedures were undertaken for the three members of staff who were employed by RDaSH. This process was completed at the end of November 2008 and the greater part of the allegations was proven. As a result of the Trust's investigation and disciplinary procedures, two members of staff were dismissed from the Trust. The remaining staff member did not return to work in the Solar Centre or in any of the Community Learning Disability Services. The fourth member of staff was employed by DBHFT and worked within RDaSH services under a local agreement. Following the conclusion of the initial police investigation that concluded in 2008, disciplinary procedures were commenced by DBHFT. Due to the staff member resigning [redacted] post this could not be concluded or resolved by DBHFT.

2. Concerns raised about three managers and another staff nurse warrant further investigation to allow them to answer to the concerns in their own right (NMC Code of Professional Conduct).

These concerns were fully investigated and actions were addressed with the staff concerned. One manager subsequently resigned their employment with the Trust and another manager returned to a clinical role elsewhere within the Learning Disability Services. The overall management of the Learning Disability Day Services was reorganised and brought under the management of the current Assistant Director for Learning Disability Services as part of a management restructure within the operational services. The service continues to be managed under this new arrangement, with the day services managed by the Lead Physiotherapist for Learning Disability Services.

3. Review of day services as a whole should be progressed within the Learning Disability Directorate to address the alleged problems with working practices/culture within the Solar Centre. An external facilitator will lead this review.

A new Assistant Director of service, previously external to the Solar Centre led a whole service review of all the Trust Learning Disability day services. This included the Solar Centre. Key areas of review were:

- Governance systems
- Effective management of key risks
- Patient safety
- Staff management
- Supervision
- Communication systems
- Clinical leadership

A full review and modernisation of the day services was undertaken. Specifically for the Solar Centre lessons learnt were taken forward with a development plan 'from lessons learnt to excellence'. This was monitored by a steering group that reports to the Learning Disabilities Governance Group.

4. A review should be undertaken of the training needs of the qualified staff with regards to clinical supervision to supplement the existing model of management supervision.

A review of the training needs for all qualified staff was undertaken. Staff participation in mandatory training were closely monitored. This was underpinned by a focus on their own supervision. All qualified staff now receive monthly clinical supervision, which includes a focus on the service philosophy, values, quality and safeguarding.

5. The Trust should explore alternative ways of providing clinical supervision. For example, supervision by professional staff working outside the Solar would offer both independent support and an opportunity to raise concerns as soon as possible.

A comprehensive review of the clinical management of the Solar Centre was undertaken. The Solar Centre is now lead by a new senior clinician who, at that time, was independent to the previous management arrangements for the Solar Centre. This senior clinician also led the developing excellence plan that was formulated to directly link to the investigations and recommendations. This work specifically included:

- Monthly supervision sessions for all staff
- New timetable that supported staff rotation
- Clinical management based in the centre to facilitate direct supervision and support decision making in complex situations
- Access to management within the building on a daily basis
- The provision of a mentoring and role model for staff
- Review of utilisation of the premises to ensure efficient use of resources, to ensure they are safe and well supervised without being overly restrictive or constrained
- Roles and responsibilities of staff were reviewed and refreshed
- Ensure staff are aware of the importance of reporting concerns immediately
- Staff encouraged to question practice and room utilisation

- Effective links established with MDT, local providers, other day services, students and invited visitors and open access encouraged
- Staff encouraged to share dilemmas and refer to home carers for advice

A key outcome of this work is recorded as staff being confident in the accountability framework and governance structure.

6. Managers and staff subject to investigation should not undertake the supervision of other staff members.

As a consequence of the review undertaken in response to recommendation 5, no managers or staff subject to investigation undertook the supervision of other staff members.

7. All staff throughout the Trust must be made aware of the Trust's policies on 'Personal Harassment' and 'Disclosure by Staff of Concerns on Healthcare Matters'.

This was achieved via a practice development bulletin and the practice development days that every single member of Learning Disability staff attended.

8. The Trust must develop a clear policy in relation to staff forming personal relationships with work colleagues as guidance to all managers.

The Trust reviewed its employment policies and considered this recommendation in the context of the policies in use at the time of the investigation. It was acknowledged that it was staff behaviours and actions that were the primary concern, whilst recognising that a relationship between employees could be a contributory factor. In analysing specific behaviours or actions of concern, managers and human resources officers may conclude that a personal relationship between two employees could be a contributory factor, along with many other possible contributory factors. It was deemed however, that the existing policies and guidelines provided sufficient scope and powers to deal with any behaviours or actions causing

concern, irrespective of the nature of any contributory factors. Although the current Trust policies do provide sufficient scope and powers to deal with personal relationships, the Trust is revising human resource policies and procedures and is developing a policy on personal relationships at work rather than being embedded in other policies and procedures.

9. The Trust must identify, for specific patient groups in Learning Disabilities, clear staff/patient ratios that allow safe management of services and reflect the level of challenging behaviour displayed, and the degree of disability present.

This recommendation was considered in detail. Through the lessons learned work it was identified that the issues within the Solar Centre related to the competency and attitude of staff and the availability of suitably skilled and knowledgeable staff rather than the specific numbers of staff available. This recommendation was therefore addressed through the development of staff and their skills, knowledge and attitude through the 'from lessons learnt to excellence' improvement plan.

10. A review must be undertaken of the administrative requirements of the Solar Centre to release the qualified staff to facilitate group sessions and provide clinical care to patients and support and supervision to non-qualified staff.

This recommendation was implemented and new staff nurse roles were developed accordingly. The issue was found not to be a requirement for additional administrative support, rather a review of clinical engagement with patients.

11. There must be adequate provision of administrative staff in the Solar Centre.

The required levels of support staff to all day service provision was undertaken within the day services review previously highlighted.

12. The programme of practice development days, introduced through the Trust's immediate action plan, to improve team working and positive therapeutic

culture within the Learning Disability Directorate, should continue for the foreseeable future.

A development plan to address the lessons learned was written. A summary of this is detailed in section 5 on page 20.

4.2 Update on the Developing Excellence Plan - April 2013

The original development plan was written in response to the findings and concerns raised by the investigation team looking at the abuse allegations at the Solar Centre in October 2009. This formed a starting point for action planning to improve practices and establish a positive culture.

The Day Service is registered with CQC and is required to meet and demonstrate compliance with the essential standards of care. The approach to monitoring and maintenance of the CQC essential standards is standardised across the whole Learning Disability Business Division. The Solar Centre is examined and scrutinised on the same quality and evidence standards as all services. Whilst the Solar Centre has not been subject to any direct CQC visits, other services within the Learning Disability Business Division have been inspected. Specifically this included an inpatient ward where the feedback was extremely positive from the CQC inspector, the carer and most significantly the expert by experience. Both this ward and the Solar Centre are under the same leadership structure. The modern Day Service is firmly embedded within the Trust portfolio of services, it has a positive established identity and all staff can demonstrate a clear commitment and accountability in respect of Trust Policies and Procedures.

All RDaSH Learning Disability Day Services are managed as one day service to ensure continuity of care for patients and transparency of provision.

The services on offer are valued by the patients and their carers. The Trust is operating an inclusive culture and utilising the Participation[4] ladder to evidence how we seek to achieve working in partnership with patients and their carers.

As part of the on-going determination to support staff to champion the rights and choices of services users the Solar Centre was a pilot site for the Doncaster Peer Advocacy Project. This was designed and rolled out by project workers from the independent advocacy service. Staff enthusiastically embraced the Dignity in Care Campaign and continue to demonstrate innovative ways to engage with patients who are hard to reach as a result of their complex health conditions.

All staff have been trained and are competent and knowledgeable to work in line with legislation and local guidance to deliver services which demonstrate that patients' rights, choices and wishes are at the centre of all decision making and service delivery. The training needs of all staff are established by a training needs analysis. This includes all mandatory training, in addition all staff received an annual Personal Development Review (PDR), this includes their individual training needs. Compliance with PDRs, Clinical Supervision and training and the on-going monitoring of this are included in section 5 on page 22.

Best Interest decision making and safeguarding training is delivered and is regularly revisited and reviewed in order to ensure staff have confidence and knowledge to continue to uphold values that underpin the quality and safety of the services provided.

The quality of the service provided today is linked to the Quality planning for the Trust and the specific Learning Disability Business Division quality markers. Quality plans operate on an annual basis to reinforce development priorities. Staff are clear on the Trust's priorities and their individual development plans, work plans and supervision is linked to the priorities. Staff are aware of the past and the historical

[4] Engagement can be considered on a spectrum that starts with informing and moves on to consulting, involving, collaborating and empowering. A ladder of participation was suggested by Hart (1992). Each of these different stages or levels implies a different 'promise' to patients, carers or the public on what to expect from the engagement activity.

factors which formed the lessons learned and shaped the modernisation agenda and take pride in service delivery that is open and responsive to patient and carer needs.

The Solar Centre was highly complimented by the Trust's infection prevention control team for the outstanding work done in promoting clean hand hygiene for staff and patients in innovative ways.

Staff are actively encouraged to complete incident reports and raise concerns in their own right. All incident reports are then responded to by Day Service management and expertise within the Trust is utilised to improve on existing practices and find new strategies to manage complex situations.

Partnership working with patients, their carers, family members and wider members of multi-disciplinary teams is crucial to promote inclusive safe working practices and person centred bespoke packages of care. Staff are actively networking to ensure that the best possible practice is being utilised and to source expertise and ideas to meet new challenges presented by individuals with profound multiple learning disabilities and complex health support needs.

Regular themed days and events are held and ad-hoc visits encouraged to ensure that the service is not run in isolation and that visitors are made welcome and encouraged to give feedback. Many patients access the Solar Centre resources supported by their own carers and family members. Annual care reviews are held on premises for all patients and their family carers. The Day Services operate an open door philosophy and are happy to accept visitors, students on placement and professionals at any time.

The unit works with the voluntary sector to provide structured work placements for registered volunteers, all of whom are subject to the necessary pre-placement checks and monitoring procedures.

In addition one of the Non-Executive Directors of the Trust undertook a visit to the Solar centre on 24th January 2013 as part of the programme of visits to all Trust services.

4.3 The Trust's Apology

The Trust is sincerely sorry for the abuse suffered by the service users at the Solar Centre.

Throughout the course of the investigation and subsequent review of services provided at the Solar Centre the Trust has apologised to the families of the service users who experienced the abuse. This has been completed both individually to the families and also publically through national media. Detail of the times and occurrences of the apologies are described below:

- Between the period of the abuse being reported in November 2007 and 2010, each family had an identified senior member of RDaSH management staff in order to receive updates regarding the investigation. During the meetings and conversations held through this time the management leads gave as much information as possible regarding the on-going case and provided verbal apologies for what the families were experiencing.
- A letter was sent to each family in May 2010 with a formal apology for both the actions of the Trust's staff and for the significant delays involved in concluding the investigation.
- A letter was sent to the victims' families in August 2010 with an apology for the abuse experienced by their relative.
- Letters were sent to the victims' families in August 2010 updating them on the police review and apologising for the on-going distress that may have been caused by the investigations
- Three meetings were held between the families of the victims and the Trust Chief Executive during 2010 and 2011; these are detailed on page 12 of this report. At each of these meetings the Trust Chief Executive apologised to the families for the abuse their relatives had experienced and the distress this had caused.
- Following the court case held on May 16, 2013 the statement below was read outside court to the media who attended the hearing. The statement was also read out on the same day to Trax FM; Doncaster Free Press and Radio Sheffield, as they were unable to attend the court hearing:

RDaSH statement regarding the 'Solar Centre' case

(Statement read at court by [redacted], Executive Medical Director for Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH))

"We fully apologised to service users and their families at the time of the incidents and we apologise again today for the actions of the individuals that have been found guilty.

"The Trust took immediate action as soon as we were made aware of the situation in 2007 and worked with South Yorkshire Police in their investigation into this matter.

"The Trust has implemented improvements to the learning disability service at this centre to minimise the risks of such incidents happening again.

"We will not tolerate staff mistreating service users and have reinforced our channels of communication to ensure that staff, service users and carers report suspected abuse so that we can take action."

"The jury has cleared two individuals of the allegations made against them but for legal reasons we cannot comment any further about them."

"We have a number of on-going civil claims, which are confidential, and so the Trust is not making any further comments."

Section 5 Changes Since 2007

5.1 National Developments

'No Secrets'[5] gave local Social Services authorities lead responsibility for coordinating local multiagency systems, policies and procedures to protect vulnerable adults from abuse. In October 2008, the Department of Health carried out a large national consultation on safeguarding adults from abuse and harm called 'Safeguarding Adults', the review of the No Secrets Guidance. The consultation set out to understand how far No Secrets had progressed across agencies. A key finding was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena.

5.2 Trust Developments

Against the backdrop of the national picture and the process of the investigation and findings from the allegations raised at the Solar Centre, significant developments have taken place across RDaSH.

In addition to the specific developments regarding the Solar Centre, broader Trust developments include:

5.2.1 Corporate Governance arrangements

In March 2007 the Trust Board critically appraised its governance systems, processes, skills and reporting mechanisms. This also supported the Trust's Foundation Trust status application.

Three Trust policy and planning groups were established. These policy and planning groups are sub-committees reporting to the Board of Directors and include Non-Executive Director and Senior Leadership Team members. These were:

[5] 'No Secrets' (DH 2000) sets out a code of practice for the protection of vulnerable adults. It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult patients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

- The Performance and Assurance Group, at which the Trust safeguarding activity was reported as a standing agenda item
- The Finance, Infrastructure and Business Development Group
- The Human Resource and Organisational Development Group

The Council of Governors for the Trust was also formed by April 2007. The User Carer Partnership Council, the Staff Council and the Professional Clinical Council were maintained. Operational management arrangements were fulfilled through the Directorate Management Team and operational groups.

As a consequence of a Board of Director Development Day a further review of the Trust Governance arrangements was undertaken in October 2011. This was undertaken to further strengthen the Trust Governance structures and included:

- The creation of the Clinical Governance Group, a fourth policy and planning group with Non-Executive Director and Senior Leadership Team members, at which safeguarding is a standing agenda item.
- The Terms of Reference for Performance & Assurance group were refocused
- The provision of a clear link for the Mental Health Legislation Committee to the Trust Governance Structure
- A review of Director involvement in policy and planning groups.

These arrangements continue to be the current Governance arrangements for the Trust and are represented diagrammatically in Figure 1:

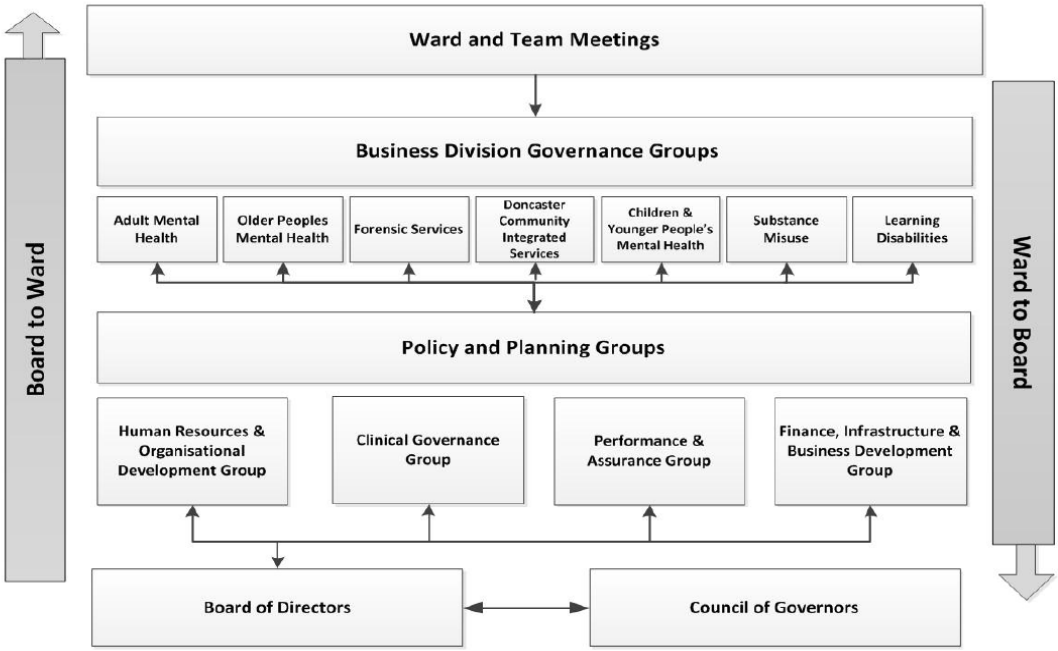

Fig 1: Trust Governance Structure

5.2.2 Safeguarding

- Adoption of the South Yorkshire Safeguarding Procedures in 2007
- Strengthening key responsibilities for safeguarding within the Trust. This included the Deputy Chief Executive / Director of Nursing and Partnerships as the Trust strategic lead and the Deputy Director of Nursing and Standards as operational lead.
- The initial appointment of a Safeguarding Adults lead for the Trust in 2009.
- Development of a Trust Safeguarding Adults Policy in 2006. This policy has been updated regularly in line with national and local developments in 2009 and 2010, it is currently undergoing a further review.
- Safeguarding activity is discussed through the Trust clinical governance structure detailed in Figure 2:
    - The bi-monthly safeguarding forum. All clinical services are represented. National developments and priorities are presented including key reports and investigations, in particular the Winterbourne review. The recommendations were reviewed in order to understand areas of learning for the Trust.

- As a monthly standing agenda item at the Clinical Governance Group. The minutes of the safeguarding forum are presented bi-monthly and key issues for discussion are presented monthly.
- A quarterly summary of safeguarding activity is presented in the Trust quarterly Quality Improvement Report and the quarterly Quality Governance Framework Declaration, which are also shared with the Trusts three main Commissioners through the Commissioners Quality Review Group.
- The Deputy Chief Executive/Director of Nursing and Partnerships monthly report to the Board of Directors includes safeguarding as a standard section. In addition confidential issues, including a quarterly professional update, are presented through the private section of the Board of Directors.

- The Clinical and Management Supervision Policy for Clinical Staff when updated in 2009 included vulnerable adults as a specific topic for supervision. This was further developed and the policy when reviewed in 2012 and 2013 now includes safeguarding vulnerable adults as a theme throughout.
- The safeguarding service in RDaSH was enhanced in 2011 and further safeguarding adults leads joined the Trust, resulting in the ability to provide an enhanced service to support clinical services in embedding safeguarding into their work. This included:
  - The development of a training matrix
  - Provision of Safeguarding Adults Training to all services
  - Collation of safeguarding training figures
  - Development of the safeguarding adults supervisors forum for all clinical services
  - Attendance at Safeguarding Adults Boards and sub groups in each of the Trust main localities
- Enhanced working relationships with the Local Authority safeguarding unit.
- Collation of safeguarding activity, including referrals and alerts, this includes an overview of activity and themes.

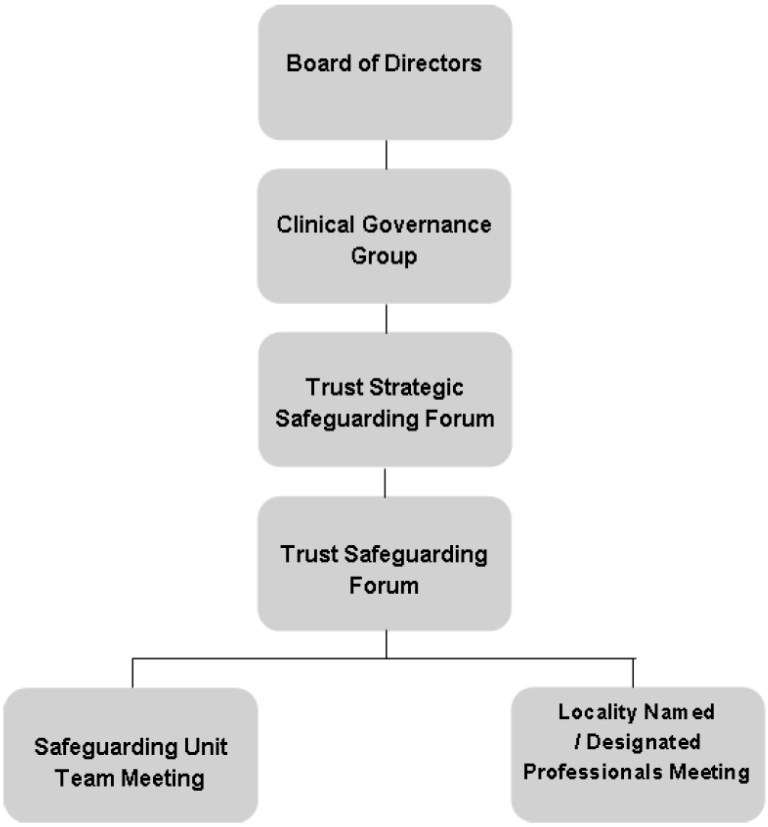

Figure 2: Trust Safeguarding Governance Structure

5.3 Developments within the Learning Disability Service

As previously indicated following the investigation a development plan was written to address the concerns highlighted. A thematic review of the actions undertaken is presented below:

5.3.1 Training, Supervision and Personal Development Review (PDR)

- Mandatory training records
  The Business Division maintains a database of all mandatory training required by each staff member, this is a live database that is monitored on an on-going basis. This specifically includes safeguarding training.
- Staff PDR Records
  A database is maintained for all staff annual PDR's and monthly supervision.
- In service training plans and records

In addition to the mandatory training, the Business Division additional training and practice development is held across the division by key staff both internal and external to the Trust. Specific examples include:

- Practice development days held across the Division by the Practice Development Lead.
- Externally facilitated training 'An introduction to Learning Disability and Mental Illness'
- Externally facilitated sessions 'Introduction to personalisation and care planning for people with a learning disability'
- Externally facilitated Autism training days for all staff
- Advanced Mental Capacity Act best interest assessors trained and based within the Business Division.
- Learning Disability Specific Approved Mental Health Professional (Mental Health Act 2007) in the division.

5.3.2 Leadership

A number of key leadership activities have been undertaken, including:

- In conjunction with the senior leadership changes previously described within this report a Lead Physiotherapist is now based within Solar Centre. This supports a leadership style of improved communication, visibility and engagement with all staff.
- There are additional mentoring opportunities for staff to embrace new ways of working and patient empowerment. This includes a positive role model for new and junior staff.
- The service philosophy has been reviewed and rewritten to capture best practice and a modern approach to the provision of day care.
- Frequent staff meetings are held and the minutes are available to all staff.
- A review of the documentation used was undertaken. This is now in line with the whole Business Division and Trust approaches.
- A review of working practices has been undertaken. This promotes inclusion, avoids segregation and endorses safe practice. The additional practice development days facilitated supports these approaches.
- As a result of the changes to the leadership of the Solar Centre there is an increased confidence of staff in the structure and accountability framework.

Unqualified staff have qualified staff and colleagues to consult during the course of their clinical work.

- Increased scrutiny and visibility of the services and care provided have been developed through the use of Trust volunteers and student placements.
- The activity timetable requires staff to rotate through the group structures every 12 weeks. This supports the mix of staff groups, development and maintenance of the enthusiasm and skills base of the staff.

5.3.3 Care delivery

The approach to care organisation and delivery has significantly developed both during and following the investigation. Key areas include:

- The manager of the Solar Centre is accessible and available to all staff and also included in the planning and delivery of activities.
- There is an improved approach to the planning of activities that is responsive to the needs of patients and individual care planning
- Patients all have individual communication profiles to help indicate/interpret their choice behaviours. This in turn supports them being given a choice regarding the nature and type of activities they undertake
- Planning sessions with staff to harness ideas and enthusiasm into structures that allow delivery in a safe, creative and suitably sympathetic manner
- All therapeutic and activity sessions are recorded. This supports activity evaluation and future session planning
- Following the Trust privacy and dignity project, there are now 27 registered dignity champions across the Business Division.

5.3.4 Physical environment

- The garden has been redesigned to ensure it is safe and accessible for patients.
- A review of the rooms and therapeutic spaces within the Solar Centre has been undertaken to ensure it is more effectively occupied on a daily basis.

5.3.5 Personalisation of Service Delivery

Since the concerns highlighted in 2007 all care provided within the whole Learning Disability Business Division, including the Solar Centre, has been progressively personalised to better represent individual's specific needs, choice and support requirements. This has been completed as part of the Trusts' Day Service modernisation programme and on-going service development. More latterly this has been completed in line with contemporary values and practices in 'Valuing People Now' and Doncaster Partnership Boards 3 year strategy "Being Valuable, Being Valued" (2010-2013).

The Day Service prior to 2007 was provided to individuals who in the main part had previously been long stay patients at St Catherines Hospital. This was provided on a half-day sessional basis. Day Service attendance was then aimed at providing a change of scenery for social interaction and activities. Service users were not always afforded a choice about their attendance, and whilst some consideration was given regarding activities to offer individuals, little was done to monitor actual engagement and satisfaction.

As part of the development of more personalised services work has been undertaken to ensure processes are in place for all stages of access to service via referral. Update of services and review of service packages offered is an MDT consultative process placing the service users and their carers at the centre of all decisions.

This allows individuals to be well supported and in receipt of tailored bespoke packages of care and this is represented in the service ethos of engagement and consultation.

Alongside practice improvements and maintaining the drive to develop services and maintain rapport with stakeholders to ensure they are pivotal in shaping the future the Trust quality improvement agenda was harnessed to target specific areas for further development and focussed scrutiny. The completion of an engagement and

participation ladder ensured that service design and direction are aligned to represent needs and priorities.

The Solar Centre also fully participated in the DMBC commissioned and Independent consultant facilitated Doncaster wide Day Service Review.

As part of this process the group of representatives (including service users and carers as well as professionals) and the lead consultant were able to review how bespoke packages of care were tailored for individuals to receive day services to extend their socialisation experiences, whilst receiving appropriate support for their complex health needs.

Acknowledgement was given to the challenges presented in trying to find purposeful, enjoyable leisure and recreation for individuals with complex disabilities, and high health support needs. This was given additional attention and focus by the Solar Centres participation in the Peer Advocacy Project with Doncaster Advocacy.

Working to harness the enthusiasm of the staff team, their expertise and experience and the wider multi-professional health team to tailor packages that are foremost safe, suitably flexible and represent a quality experience for service users is the continuing forward theme.

New service users joining us from transition are routinely being offered choice and the opportunity to purchase bespoke support packages from a range of providers and option of models via their personal budgets. This reflects that true choice is now available and gives further impetus to deliver quality packages of care, to assess and review needs and packages to satisfy the needs and wants of service users and their carers.

Section 6 Summary

Following the allegations of abuse made by a staff member on 8th March 2007 the Trust undertook a comprehensive approach to the investigation of the allegations.

Following instruction from the South Yorkshire Police the Trust did not to carry out its own internal investigation until their criminal investigation had been completed. Despite this delay the Trust undertook a series of immediate actions in response to the allegations and also, once in a position to, carried out a robust and timely investigation into the allegations.

At the conclusion of the initial South Yorkshire Police investigation a Serious Untoward Incident investigation was undertaken by the Trust. This identified that the abuse had taken place and made 12 recommendations.

The 12 recommendations have been addressed by the Trust both at the time of the incidents and also on a continual basis.

Throughout the investigation a serious incident group met, this consisted of senior staff within the Trust and partner agencies. Regular updates were provided on progress to the Trust Board of Directors. Family members were engaged throughout the process.

Formal disciplinary procedures were undertaken for three members of staff who were employed by RDaSH. Two members of staff were dismissed from the Trust. The remaining staff member did not return to work in the Solar Centre or in any of the Community Learning Disability Services. The fourth member of staff resigned [redacted] post and therefore disciplinary procedures could not be concluded or resolved by [redacted] employer, DBHFT.

A full review of the leadership and management of the Learning Disability day services was undertaken. This included new senior clinical staff working within the Solar Centre. Within the Solar Centre this was taken forward with a development plan 'from lessons learnt to excellence'.

Against a nationally developing picture of Safeguarding Vulnerable Adults, the Trust has undertaken significant developments. This includes the development of a team specifically to support staff to safeguard patients, to ensure that staff are suitably trained in safeguarding adults and to support staff who identify that vulnerable adults may be at risk in any setting.

Finally the main areas of concern from the original investigation findings and the implementation of the recommendations have proven to be firm foundations to redesign and focus the day service provision into the inclusive, positive service it is today.

Appendix 6

STRICTLY CONFIDENTIAL

Individual Management Review Report from South Yorkshire Police

SERIOUS CASE REVIEW: ESTABLISHMENT: SC 2007

Author: The author is independent from this case and has no managerial responsibility for any of the officers involved. PC [redacted] has been a police officer for 27 years and has worked in Child Protection, Domestic Violence and Adult Safeguarding since 2000.

Signed: [redacted]

Date: 14th May 2014

Countersigned: [redacted]

Date: [redacted]

Table of contents

Section

Section 1: Introduction

This individual management review report of South Yorkshire Police is produced in accordance with Doncaster Safeguarding Adults Partnership Board procedure for conducting a Serious Case Review.

It will form part of a multi-agency Serious Case Review overview report.

This report has been prepared following a review of the services provided to vulnerable adult victims of abuse and members of their family(ies).

Its purpose is to look openly and critically at individual and organisational practice to see whether the case indicates changes could and should be made, and if so, to identify how those changes will be brought about.

It is important to note in this case that the review undertaken covers the period of the initial police investigation only covering the period from March 2007 to December 2007.

Section 2: About South Yorkshire Police

South Yorkshire Police is responsible for the safeguarding of and investigation into the abuse of vulnerable adults.

In line with the above SYP has dedicated Public Protection Units (PPU) at each of the four policing districts across South Yorkshire.

Each PPU has a dedicated safeguarding adult officer and dedicated vulnerable adult abuse investigators.

PPU investigations into the abuse of vulnerable adults are overseen by the PPU Detective Inspector.

The above officers have the specialist knowledge, skills and experience required to deal with the safeguarding of and investigation into the abuse of vulnerable adults and work in line with:-

SYP Procedural instructions: Safeguarding Vulnerable Adults D51503

NPIA Guidance: Safeguarding Vulnerable Adults Minimum Standards of Investigation.

Safeguarding Adults South Yorkshire's Adult Protection Procedures.

Section 3: Reason for undertaking the IMR

SC is a day care unit for service users who have profound learning disabilities.
On 8th March 2007 a nursing assistant [redacted] approached the Day Services Manager [redacted] to report allegations of abuse of service users by four of her colleagues. [redacted].

On the 09.03.2007 the matter was reported to SYP.

A criminal investigation commenced which was allocated to and managed by Doncaster District CID.
It should be noted that at this time SYP did not have in place at each District a Public Protection Unit with officers who have specialist knowledge, skills and experience in dealing with vulnerable adult abuse investigations.

The criminal investigation looked into allegations of abuse reported to have occurred between January 2005 and March 2007.
As part of the evidence gathering process accounts were obtained from twelve members of staff [redacted], and [redacted]

From the accounts obtained seven members of staff [redacted] disclosed witnessing the abuse of twelve service users in their care [redacted] and [redacted].

The allegations of abuse are as outlined below:-
-Service user (SU) slapped and pulled to floor
-SU hit with microphone over the head
-SU locked in a cupboard and a chair put behind the door
-SU hit in the face
-SU hit in the face and around the head
-Wheelchair bound SU, hit or slapped for making noises
-SUs flinch when three staff members around them
-SU knelt on and hit
-SU wheeled out of one area and taken to [redacted] to be slapped
-SU pushed to floor and held by neck
-SU with hand print on face following being slapped
-SU pushed across the room and slapped round the head
-SU used as “target practice” throwing cushions at him
-SUs appeared frightened of four staff
-SU refuse and flinch near certain staff
-SUs scared of certain staff
-SU not changed or given drink
-SU dragged and slapped
-SU slapped in face when they would not wake up
-SU slapped in face and threatened
-Staff bragging about beating SU up on bus
-Staff saying they had thrown SU in Snoezelen and did you hear him squeal
-Staff offering to “sort people out”
-Staff saying “I’ll teach him not to do that” then pushing and rough handling

A locum consultant psychiatrist Dr [redacted] assessed the service users and provided evidence in the form of a letter for each that concluded they have "no capacity to consent to making a complaint or to investigations."

At the time of the matter being reported to SYP one of the service users [redacted] had a lump on his head and light grazing to one of his eyes.
None of the other services users had any visible injuries.

During the course of the criminal investigation the four suspects were interviewed about the allegations.
All four suspects denied the allegations.

On the 20.12.2007 an advice file was submitted to the Crown Prosecution Service.
At the time of submission offence options were limited to assault and false imprisonment by the officer in the case [redacted].
There is no evidence to suggest other offence options were explored.
At this point some of the assaults would have been statute barred due to the allegations reported taking place over a two year period from 2005 to 2007.

On the 20th December 2007 the Crown Prosecution Service decided that there was insufficient evidence on which to base a prosecution further stating that the allegations amount at best to "battery" and that on the evidence considered any such allegation is now statute barred from prosecution and the offences of false imprisonment were not corroborated.

In December 2007 SYP informed the Trust of the CPS decision.

Section 4: Chronology of involvement

Timeframe under Review

As referred to in the introduction the IMR covers the period March 2007 to December 2007 which relates to the initial police investigation only.

The following narrative seeks to make comment upon significant events, which are detailed within the accompanying chronology.

It should be noted that the original December 2007 file no longer exists in its original format. This is due to the fact that information from the file has been used to inform a subsequent review and further investigation into the allegations of abuse which resulted in a successful prosecution being secured in June 2013.

09.03.2007

Allegations reported to SYP.
ProCAD incident number 408 of 9/3/07 refers.
Attending officer PC [redacted] speaks with the day services manager [redacted] to obtain details.

13.03.2007

PC [redacted] completes report outlining allegations to the District Crime Management Unit for allocation.

On this report it is recorded “I have not crimed this incident as requested”.

A criticism of SYP is that they have failed to keep families updated in respect of this investigation and from reviewing the information available this criticism would appear valid.

However since 2007 changes in policy and procedure in respect of crime recording and victim contact have been implemented across SYP in respect of the reporting and recording of crimes and keeping victims of crime and if appropriate their family/ies updated.

These changes are in line in line with the National Crime Recording Standards and the Victims Code of Practice.

March 2007

Criminal investigation commenced which was allocated to and managed by District CID Acting Detective Sergeant [redacted].

It should be noted that at this time SYP did not have in place at each District a Public Protection Unit with officers who have specialist knowledge, skills and experience in dealing with vulnerable adult abuse investigations at all ranks.

As detailed in the section “About South Yorkshire Police” these units are now in place at each of the four policing districts and all vulnerable adult abuse investigations are overseen by the PPU detective Inspector.

20.03.2007

Witness account obtained from [redacted]

21.03.2007

Witness account obtained from [redacted]

22.03.2007

Witness account obtained from [redacted] and [redacted]

23.03.2007

Witness account obtained from [redacted]

25.03.2007

Witness account obtained from [redacted]

26.03.2007

Witness account obtained from [redacted]

27.03.2007
Witness account obtained from [redacted] and [redacted]

28.03.2007

Witness account obtained from [redacted]

04.04.2007

Witness account obtained from [redacted]

19.04.2007

Witness account obtained from [redacted]

12.06.2007

Tape recorded interview with [redacted]. A/P9/433/07/1 refers
Allegations denied on interview.

30.07.2007

Tape recorded interview with [redacted]. A/P12/7478/2007/1 refers
Allegations denied on interview

30.07.2007

Tape recorded interview with [redacted]. A/P12/7484/2007/1 refers
Allegations denied on interview

23.08.2007

Tape recorded interview with [redacted]. A/P9/574/07/1 refers
Allegations denied on interview

20.12.2007

Further tape recorded interview with [redacted]. A/P12/7484/07/2 refers
Allegations denied on interview

20.12.2007

Advice file submitted to the Crown Prosecution Service.

At the time of submission offence options were limited to assault and false imprisonment. From the information I have reviewed there is no evidence to suggest that other offence options were explored at this time.

At this point some of the assaults would have been statute barred due to the allegations reported taking place over a two year period from 2005 to 2007.

In 2007 dedicated PPUs with appropriately skilled VA abuse investigators were not in place across SYP.

Cases of this nature were allocated to District CID teams who had limited knowledge and experience in dealing with this type of investigation.

20.12.2007

Crown Prosecution Service reviewed the case and decided that there was insufficient evidence on which to base a prosecution further stating that the allegations amount at best to “battery” and that on the evidence considered any such allegation is now statute barred from prosecution and the offences of false imprisonment were not corroborated.

December 2007

SYP inform the Trust of the CPS decision.

Section 5: Conclusions

It is important to note in this case that the review undertaken covers the period of the initial police investigation only covering the period from March 2007 to December 2007.

Since this time SYP have changed their policy and procedures in relation to the safeguarding of and investigation into the abuse of vulnerable adults as detailed below.

South Yorkshire Police is responsible for the safeguarding of and investigation into the abuse of vulnerable adults and in 2007 dedicated PPUs with appropriately skilled VA abuse investigators were not in place across SYP.

Cases of this nature were allocated to District CID teams with limited knowledge and experience in dealing with this type of investigation. SYP now has dedicated Public Protection Units (PPU) at each of the four policing districts across South Yorkshire.

Each PPU has a dedicated safeguarding adult officer and dedicated vulnerable adult abuse investigators.

PPU investigations into the abuse of vulnerable adults are overseen by the PPU Detective Inspector.

The above officers have the specialist knowledge, skills and experience required to deal with the safeguarding of and investigation into the abuse of vulnerable adults and work in line with:-

SYP Procedural instructions: Safeguarding Vulnerable Adults D51503

NPIA Guidance: Safeguarding Vulnerable Adults Minimum Standards of Investigation.

Safeguarding Adults South Yorkshire's Adult Protection Procedures.

In line with this the consideration of offence options is more robust at the point of submission of an advice file to the Crown Prosecution Service due to officers having the required knowledge, skills and experience in managing this type of case.

Changes have been implemented across SYP in respect of the recording of crimes and the updating of victims of crime and in appropriate cases their family/ies. These changes are in line in line with the National Crime Recording Standards and the Victims Code of Practice,

Safeguarding Adults Training is now delivered to all officers across SYP as part of the Street Skills Programme and by way of NCALT Training Packages.

Section 6: Recommendations

Due to the timescales involved, March 2007 to December 2007, the points raised in sections 4 of this report have been acted upon by SYP as evidenced in Section 5.

Appendix 7

NHS England Response – SCR Solar Centre

NHS England has been asked to submit a response for inclusion in the Serious Case Review relating to the Solar Centre in Doncaster.

Whilst NHS England has not been directly involved in the commissioning of this service the author has requested a chronology of structural arrangements of commissioning from 2007 to the present date.

2007

In 2007 there were 152 Primary Care Trusts (PCT's) who reported to 10 Strategic Health Authorities (SHA's). The PCT's were commissioning organisations but they were also responsible for the provision of some services. The SHA covered the geographical area of Yorkshire and Humber and in turn was responsible at that time to the Department of Health.

2009

Primary Care Trusts separated themselves in to commissioning and provider arms.

2011

Community services are split off from PCT's.

2012

The Clinical Commissioning Board and Clinical Commissioning Groups were established. There was a reorganisation of PCT's in to clusters and Strategic Health Authorities grouped into sub-national organisations.

2013

Strategic Health Authorities and Primary Care Trusts are abolished and NHS England is established.

The above information sets out the commissioning arrangements for NHS services from 2007 to date.

Carole Lavelle
Assistant Director of Nursing
NHS England, South Yorkshire & Bassetlaw.