Teeswide Safeguarding Adults Board

Learning from Regional and National SAR Cases

Title of Review:	**Whorlton Hall**
Theme of Review:	Organisational Abuse
Local Authority:	Durham Safeguarding Adults Partnership
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Link to Full Report:	https://www.safeguardingdurhamadults.info/media/42270/Safeguarding-Adults-Review-Whorlton-Hall-May-2023/pdf/WhorltonHallReport-May2023.pdf?m=638205410398630000

Case Details

In May 2019 the BBC exposed concerns of allegations of physical and psychological abuse of patients residing at Whorlton Hall in a televised programme – Panorama.

Following the programme there were criminal investigations relating to nine suspects. An executive strategy process to investigate safeguarding concerns was initiated, led by Durham County Council (DCC). An incident coordination group was established, led by NHS England. An unannounced responsive inspection took place by CQC. Several staff at Whorlton Hall were suspended and Whorlton Hall closed in May 2019 once all patients had moved to alternative residences. The Safeguarding Adult Review (SAR) was published following the conclusion of criminal proceedings.

Whorlton Hall was an independent hospital registered with the Care Quality Commission (CQC) for two regulated activities: 1) Treatment of disease, disorder or injury; 2) Assessment or medical treatment of persons detained under the Mental Health Act 1983. The CQC inspected this service as a ward for people with learning disabilities and/or autism.

It was difficult for Durham Safeguarding Adults Partnership (DSAP) to engage with those who had lived at Whorlton Hall and their families for the purpose of the SAR, due to the parallel criminal investigations. DSAP intends to engage with everyone in a meaningful way now that the criminal process has concluded.

Key Findings

CQC visited Whorlton Hall in 2015 and rated it as 'requires improvement' but CQC decided at that time not to publish that report. On reflection, CQC felt this was a missed opportunity to record a poorly performing independent mental health institution. A CQC inspection in September 2017 rated the hospital as good. After whistleblowing concerns about bullying, cover up and disregard for the people living at Whorlton Hall in 2018, CQC visited unannounced. Following the inspection, requirement notices were issued specifying actions that Danshell (who owned Whorlton Hall at the time) must take. The issues raised were 24 hour shifts and overtime limits, agency staffing and training, supervision arrangements and overuse of restraint. The report was published in May 2018 and did not include a published rating.

What was missing in both the inspection and required actions was a rigorous investigation of the alleged 'alpha group', its members, relationships and behaviours. Six patients were spoken to as part of the inspection but there were several factors which influenced the effectiveness of this engagement; members of Whorlton Hall staff were present, the patients did not know the inspection staff and no identified communication training or aids were used. Staff were chosen at random to be interviewed to cover a cross-section of staff across the establishment, they did not appear to speak to those who had been named as part of the 'toxic clique'. The investigation did not take into account that staff may have been fearful of repercussions or consequences for speaking out. A series of closed questions were

asked which invited simple 'yes' or 'no' answers. CQC had not informed Durham County Council Adult and Health Services (DCCAHS) of the allegations. The Review found that collaboration between CQC's Adult Social Care directorate and Local Authority Safeguarding Teams is more routine and embedded. Communication between CQC's hospital directorate which oversee specialist facilities and mental health hospitals for people with learning disabilities and/or autistic people is less established.

A couple of months later concerns were raised to Durham Constabulary about an alleged assault on a patient by a care worker and that it was being covered up. The police focused on trying to gain evidence of the assault, but not the alleged cover up. No further action was taken by police due to no evidence. The allegations were passed to DCCAHS who allowed Danshell to conduct an internal investigation rather than conducting a Safeguarding Section 42 Enquiry under the Care Act 2014. When police decided no further action, this was wrongly taken by DCCAHS as evidence that there were no Safeguarding Concerns or need for protection.

DCCAHS later attempted to coordinate an organisational safeguarding response through Establishment Planning meetings, however Section 42 Enquiries were not completed for each of the four individuals who had been identified as the subjects of alleged abuse. This meant the focus was on one alleged assault and Danshell were asked to investigate the other allegations. CCG were informed, but DCCAHS did not take a coordinating role and there was no formal follow up. CQC were invited but did not regularly attend Establishment Planning Meetings. These meetings were stood down in February 2019, despite the issues around staffing levels and use of agency staff remaining.

During February 2018 and May 2019 there were 60 Safeguarding Concerns from Whorlton Hall to DCCAHS. However only 7 progressed as a Safeguarding Enquiry. A significant portion of the Concerns related to a small number of people who were known to often make allegations of abuse against staff, many of which were the reported to be untrue, often these patients would also retract their allegations. The fact that some patients made many complaints and regularly made allegations was probably a factor that resulted in some allegations being inadequately investigated.

A failure at the Concern stage to adequately assess the risk of harm to adults can potentially introduce bias into the remainder of the safeguarding process and response. An error in judgement not to proceed with a S42 Enquiry may leave a person being abused and closes the person's right to an independent advocate to support and represent an adult who is the subject of a Safeguarding Enquiry.

Clinical Commissioning Groups (CCGs)[1] from 10 different areas across the UK commissioned placements at Whorlton Hall. None were commissioned by Durham CCG. All 'placing' CCGs retained responsibility for undertaking their own commissioning quality assurance processes, including commissioner site visits. Statutory safeguarding responsibilities for placed individuals stay with County Durham Local Authority. The host Local Authority has no enforcement power in relation to a specialist hospital whose services they do not commission. This can lead to intermittent cycles of safeguarding activity and limited improvements with only deaths or high-profile exposure bringing about more substantive changes.

The Review found that even when the placing CCG provided good individual support for the patient in hospital, and oversight of their care, there were such limited community resources and such a significant demand that it was hard for good community services to be available to patients in a timely manner. A 'post code lottery' of service provision. This results in patients being placed for long periods of time in large hospitals that claim to be specialist, often at a distance from their family and this provides an opportunity for abuse to occur.

The absence of the voice of patients was apparent to the Independent Reviewers. Despite the hospital being in many ways a closed culture, there were in fact many people visiting patients at the hospital

[1] For this report the term 'CCG' is used as this was the structure in place at the time. From July 2022, CCGs became Integrated Care Systems/Boards (ICS/ICB)

regularly and some patients also attended groups outside of the hospital setting. Yet these contacts did not enable patients to report their abuse in a meaningful way. Many patients had communication difficulties, and some had previous experiences of abuse which would have made disclosure more difficult. None of the visiting professionals saw abusive behaviour, even though they spoke to patients and staff. It was evident from the documentary that some staff were able to manipulate visitors and 'pull the wool over their eyes'.

System Findings

1) **Lack of standards or expertise requirements for provider led investigations of culture –** Concerns relating to staff are in the first instance usually investigated by the provider organisations at the request of the Local Authority or CQC. This increases the chances of poor-quality investigations of allegations and makes it harder to expose toxic cultures.
2) **Centrality of a sustained relationship of trust with a professional to enable effective safeguarding responses for individuals in specialist hospital settings** – without an independent professional / advocate the Local Authority relies upon the provider as a key source of information about safeguarding concerns raised, creating potential conflict of interest.
3) **An illusion of advocacy provision for people with learning disabilities, and/or who are autistic, and who are inpatients or at risk of being admitted to specialist hospitals** – current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates are inadequate for people with learning disabilities and/or who are autistic and patients in specialist health hospitals.
4) **Need for closer working between the CQC and LAs to improve outcomes from organisational enquiries in specialist hospitals** - current guidance does not articulate adequately the necessary collaboration between CQC and host local authorities where there are quality issues that become organisational safeguarding concerns about specialist hospitals.
5) **Gaps in Guidance and funding responsibilities for emergency specialist hospital closures after organisational abuse or deregulation** – current national guidance is available but is not well known about. The Reviewers identified that there were also some gaps within the national guidance that should be addressed.
6) **No clear national approach to absorb learning, coordinate and resource action to transform care – there is currently no clear national approach or governance mechanism that pulls together the national strategy of NHS England's Building the Right Support Plan** – it risks the promise to 'transform care' continuing to lie beyond reach, at significant cost financially and an incalculable cost to the individuals whose lives are impacted.
7) **No evidence-base for what made a CCG effective at 'micro' commissioning and quality assurance of services for people with learning disabilities and/or who are autistic, to inform Integrated Care Systems (ICS')** – Before ICS there were a wide range of different structures for commissioning, managing and quality assuring individual placements. This resulted in variations of service provision. The establishment of ICS since 1 July 2022 provides an opportunity to learn about best practice form CCGs and through this enable the future development.

Key Findings Relevant to the Teeswide Safeguarding Adults Board

1) **Carrying out Investigations**

   Do CQC publish all inspection reports with ratings? If not, do CQC share any identified concerns with all relevant partners (including placing commissioners)?

   Where there are concerns regarding bullying or allegations against staff, those investigating should consider the most appropriate approach to encourage disclosures. E.g. not having staff present, considering advocacy, ensuring communication needs are met, avoiding asking closed questions etc.

   Where there are whistleblowing concerns, is there clear guidance on how best to gather/share intelligence, investigate and use the information that whistle blowers provide, particularly when it relates to toxic cliques and their closeted abusive behaviours?

2) Independent Scrutiny and Safeguarding

Where there are concerns or allegations relating to staff in institutional settings, it may not be appropriate to ask the organisation itself to carry out their own investigation. In these instances, it may be more appropriate that the Local Authority completes an independent investigation via a Section 42 Enquiry. A common pattern reportedly experienced by families is that they raise concerns with the Local Authority about abuse, who ask the provider to investigate, which invariably finds the concerns are not substantiated. It appears a common family view therefore that their reports of abuse are never accepted as true. TSAB's Causing Section 42 Enquiry Guidance states that it is not appropriate to cause an enquiry in relation to a concern of organisational abuse. If there are a series of concerns/significant concerns made about the same provider or staff this should trigger TSAB's Responding to and Addressing Serious Concerns Protocol.

For allegations linked to organisational abuse or multiple instances in the same setting, are Section 42 Enquiries completed for each individual?

Are Local Authorities able to report on location of abuse by care setting to spot any patterns that may indicate organisational abuse? Is this routinely monitored or flagged in any way?

3) Advocacy

The learning and assurance around advocacy can be picked up through an action identified from TSAB's Adult K SAR (refer to pages 46 - 53 of the SAR report). TSAB is also aware of work being undertaken by DSAP in relation to advocacy and will continue to link in with them.

TSAB can remind professionals about the different types of advocacy services and their role through the TSAB newsletter.

TSAB can reach out to advocacy services across Tees to encourage them to be safeguarding champions.

Many of the individuals at Whorlton Hall had communication needs and without support/communication aids this made it more difficult to convey their experiences. Through another SAR that TSAB are soon to publish, considering communication needs/aids and support will form part of the recommendations.

4) Multi-Agency Working between LAs (placing and hosting), CQC, CCG and Private Hospitals

There are two private mental health hospitals across Tees, rated as good (or better) by CQC. TSAB is aware that there are residents from other local authority areas placed in our local hospitals and also Tees residents who are placed in hospitals outside of the North East area.

TSAB is aware through previous discussions that communication has improved across Tees between CQC (adult social care directorate) and the Local Authority. How close are our links with the hospital directorate of CQC?

How do we make sure that out of area residents placed in our local private hospitals and Tees residents placed in hospitals out of area are not 'forgotten'? Are there close links between placing and hosting authorities/ICBs?

Between 2016 and 2018 the Department of Health and Social Care piloted a Named Social Worker programme. Through this initiative, people with learning disabilities, mental health conditions and who were autistic were assigned a 'named' social worker who could build a trusting relationship with them and advocate on their behalf. Hartlepool Borough Council have

recently introduced this for Care Providers, is this something that could be considered by other LA areas and include specialist hospital settings?

Are Local Authorities aware of the ADASS Out of Area Guidance and is this being used?

TSAB's Independent Chair has previously requested assurance from the ICB in relation to private mental health hospitals in Tees. The Board received an update in February 2022; Safe and Well visits alongside Care and Treatment Reviews were being undertaken for all patients placed within learning disability or mental health hospitals. Data was being fed in nationally and a thematic review is to be completed. TSAB's Independent Chair will be attending the Regional Safeguarding Adults Board Chairs meeting in December 2023, where ICB will be providing an update.

In January 2021 the Government published two sets of Guidance aimed at strengthening oversight and monitoring of the quality of care in learning disability units; Learning Disability and Autism - Host Commissioner Guidance and Learning Disability and Autism - Framework for Commissioner Oversight Visits to Inpatients. These two documents set out core requirements for CCGs (albeit that the Whorlton Hall SAR identified areas for improvement within both documents). There are also references within the guidance to Safeguarding Adults Boards as follows:

"All health professionals have a duty of care…and should they suspect a safeguarding concern, they should raise this via the relevant local authority in line with the Care Act 2014, as well as the host commissioner…the chair of the local safeguarding adults board should include the host commissioner as a partner when investigating any concerns that have been raised".

And a responsibility for service providers to…

"Ensure there is an interface with the local authority adult social care safeguarding service and also with the local Safeguarding Adults Board and with local partners so that any identified or potential safeguarding concerns are raised with the host local authority and dealt with as appropriate".

Were TSAB aware of this? The wording implies that this is at an individual/operational level, which may not be appropriate for SABs, however SABs should be aware of any strategic issues linked to concerns about private hospitals in their area. TSAB's Independent Chair could request that the ICB incorporates progress relating to implementation of these guidance documents as part of their Regional SAB Chairs update in December 2023.

5) Guidance for Closures

Are TSAB partners aware of the Joint Working Protocol: When a Hospital, Services or Facility Closes at Short Notice or do they have their own local process? The SAR recognised that guidance on the support that should be provided to families of patients involved in hospital closures was a gap. There is also no consideration of how the decision should be made to close. This can mean that if there are difficulties it becomes in the provider's interest to push for a rapid closure, even if this may not be in the best interests of the patients. Should TSAB raise awareness of the national guidance or is there a need for partners to develop something more localised across Tees?

6) Transforming Care

The SAR found that in most cases where the patient was younger or had not been in hospital there had always been attempts to place in the local ATU which were unsuccessful because there were no beds available. Some patients were older and had spent most of their life in hospital so had no real experience of living in the community making discharge planning even more complex. TSAB's Independent Chair can request an update from ICB regarding the local

position around the transforming care agenda and any national updates TSAB needs to be aware of. As part of the SAR DSAP have been asked to consider raising the transforming care issue via the SAR Escalation Protocol.

7) **Learning from Best Practice – ICBs**
This report will be shared with ICB Board members for consideration and wider dissemination across their networks. TSAB's Independent Chair continues to have discussions on a regional level with ICB representatives about safeguarding.

This report will be shared with Commissioning Leads (LA and ICB), CQC, Health Trusts, Provider Forums, Learning Disability and Autism Leads/Support Services, North East SAR Champions Network, Health & Wellbeing Boards, TSAB members (including the Independent Chair and Directors of Adult Social Services) for them to consider the learning from their organisation's perspective and share amongst their networks.

How can we share this report with private hospitals/owners?

TSAB are aware that DSAP will be addressing the learning and questions posed by the SAR and will link in with regional colleagues as appropriate.

TSAB will ask DSAP if they are able to share any learning or if they will be producing any guidance on how SARs can run parallel to high profile criminal investigations and the complexities that arise when a provider has closed, and the Reviewer is unable to engage with former staff for the purpose of the SAR.

Useful Resources

- Whorlton Hall Executive Summary
- Whorlton Hall SAR Report - Easy Read
- Associate Directors of Adult Social Services (ADASS) Out of Area Guidance
- Advice Note for Directors of Adult Social Services – also helpful for Commissioning Leads
- How CQC Identifies and Responds to Closed Cultures
- Joint Working Protocol: When a Hospital, Services or Facility Closes at Short Notice
- Mendip House - Somerset Safeguarding Adult Review
- Joanna, Jon and Ben - Cawston Park - Norfolk Safeguarding Adults Review
- TSAB Information and Resources on Organisational Abuse
- TSAB's Responding to and Addressing Serious Concerns
- TSAB's Causing Section 42 Enquiries Guidance