

**JOINT SAFEGUARDING REVIEW BY THE ADULT
SAFEGUARDING BOARDS OF LUTON AND BEDFORD AND
CENTRAL BEDFORDSHIRE**

**Joint Safeguarding Case Review
Independent Inquiry Overview report**

**In respect of :
Ward 17 at Luton and Dunstable Hospital**

Written by

Derek Law MBE

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Table of Contents

1. INTRODUCTION AND CONTEXT OF THE REPORT
2. REASONS FOR THE REVIEW
3. SCOPE AND PROCESS OF THE REVIEW
 - Terms of Reference
 - Time Period
 - Victims/Relatives
 - Independent Author
 - Membership of the Adult Safeguarding Boards Sub Group ('Task and Finish Group')
 - Evidence/reports/reviews/information/interviews requested from the following agencies
4. SUMMARY OF THE CASE AND AGENCY INVOLVEMENT
 - Summary of the case
 - First phase alert/investigation: 2009
 - Second phase alerts/investigation: 2011
5. AREAS OF INQUIRY
 - Was there a cover up in the hospital?
 - NHS relationship issues
 - 2009 Case – were the appropriate procedures followed?
 - 2009 Case – sound practice or not?
 - 2011 Cases – Practice and Procedural issues
 - Safeguarding 'alerts' – weaknesses in the system
 - Human Resource Management Issues at Luton and Dunstable Hospital NHS Foundation Trust
 - Could abuse have been prevented?
6. CHANGES IN PRACTICE/POLICY
 - Luton and Dunstable Hospital NHS Foundation Trust response
 - Working together on process, roles, responsibilities – particularly 'alerts'
7. LESSONS TO BE LEARNED
 - Embedding and Sustainability
 - Ensuring Human Resource best practice is embedded and closely monitored
 - Understanding potential perpetrators and assumptions

- Mending and building better relationships
- Assumptions about practice
- Review of Luton and Dunstable Hospital management of 'alerts'
- Clear escalation arrangements
- Leadership and sustainability
- Review of social work arrangements in Luton and Dunstable Hospital

8. RECOMMENDATIONS

1. INTRODUCTION AND CONTEXT OF THE REPORT

- 1.1 This independent review considers the circumstances surrounding the alleged sexual abuse/inappropriate behaviour toward 15 men on ward 17 of the Luton and Dunstable Hospital, (L & D Hospital), between October 2008 and January 2011. The alleged abuse took place on ward 17 which was, and remains at the time of writing, the adult stroke rehabilitation ward. It is therefore not difficult to conclude that all the victims could be defined as vulnerable adults.
- 1.2 It should be noted that the term 'alleged' abuse is used. That is because although a male Healthcare Assistant, who had worked at L & D Hospital and ward 17 since November 2006, was charged following a police investigation the matter never went to trial, on the date set, the 27th February 2012 because the 'alleged perpetrator', the AP, took his own life. The inconclusive nature of this was compounded by the fact that a letter was shown to the Coroner at the inquest of the AP's death in which the AP apparently said he was not taking his own life because he was guilty. It therefore has to be acknowledged that as the prosecution could not proceed, independent scrutiny and judgement could not be brought to bear on this case. This may, for some surviving victims and relatives/carers, mean it will be all the more difficult to achieve closure on this matter.

2. REASONS FOR THE REVIEW

- 2.1 The sub-group of the two Adult Safeguarding Boards of Luton and Bedford Borough and Central Bedfordshire determined the need to commission an Independent Inquiry rather than a Serious Case Review but it is clear that the terms of reference drew on Serious Case Review criteria and best practice. The purpose of any Serious Case Review is to establish what happened, whether information was fully shared by the professionals/agencies concerned and that procedures were appropriately followed, so that any deficiencies in services can be identified and lessons learned to minimise the risk for other vulnerable adults. This should also reassure the public and prevent the need or demand for further external inquiries.
- 2.2 This is an unusual case in that it concerns several individuals and Serious Case Reviews are ordinarily centred on one individual. It is also clear that as more victims became known in 2011 the Police naturally took the lead and were taking a prosecution forward when the AP committed suicide. This all contributed to the decision to commission an Independent Inquiry.
- 2.3 In drawing on Serious Case Review criteria it is true that serious sexual assault is one such criteria for commissioning a Serious Case Review where it is clear that the case gives rise to potential concerns about the way in which local agencies and professionals work together to safeguard adults at risk of significant harm. In this matter

serious sexual assault and abuse has been alleged by several of the victims and relatives and the case overall does indeed give rise to potential concerns about the way in which local agencies and professionals worked together to protect vulnerable adults.

The guiding principles which underpin a Serious Case Review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible
- **Impartiality** – those conducting the review should not have been directly involved with the adults concerned
- **Thoroughness** – all important factors should be considered
- **Openness** – there should be no suspicion of concealment
- **Confidentiality** – due regard should be given to the balance of individual rights and public interest
- **Cooperation** – the agreed Safeguarding procedures and practice guidance should be followed
- **Resolution** – action should be taken to implement any recommendations that arise

3. SCOPE AND PROCESS OF THE REVIEW

3.1 As already stated the Adult Safeguarding Boards of Luton and Bedford Borough and Central Bedfordshire decided early in 2012 to commission a Joint Safeguarding Case Review in the form of an Independent Inquiry. A sub-group of the two Adult Safeguarding Boards was established to agree terms of reference for the Case Review and then to commission and oversee the review.

Terms of Reference

3.2 The purpose of the Case Review is not to reinvestigate or to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result in order to inform and improve local inter-agency practice

- Review the effectiveness of relevant policies, procedures and systems in operation at the time
- Prepare an overview report which brings together and analyses the findings in order to make recommendations for future action

Time Period

- 3.3 It was agreed that the review should cover the period from November 2006 to early 2011 when the alleged perpetrator, AP, was working in the L & D Hospital on ward 17 as a Healthcare Assistant. The AP was employed on the 'staff bank' system from November 2006 until he acquired a substantive post from April 2008.

Victims/relatives

- 3.4 Proper consideration was given to the involvement and support that should be offered to surviving victims/relatives regarding this review. It was decided to offer independent expert support. To this end an experienced senior and highly qualified social worker was appointed to make contact with surviving victims and their relatives to explain this review, give them the opportunity to tell the review about and reflect on the impact the incident had on them; to share any views they might have that might have prevented the incident and how their concerns were handled once they had communicated them. Victims and relatives were also asked if they have had sufficient support and whether they needed further support be it counselling or other. Bedfordshire Police assisted with making contact with surviving victims and their key relatives having previously approached them to ask whether they would consent to the author of this report reading their police statements. At that time the police had also asked if victims/relatives would want contact with the 'review' team or not. A number did not want any further contact and apparently had stated to the police that they had had enough and now wanted to put what happened behind them.
- 3.5 The independent expert was given the details of 4 surviving victims and 3 daughters of fathers who had died and was eventually able to make contact with 6 people in total having not managed to contact 1 of the daughters, who, it was concluded, did not want further contact. The discussions varied considerably some people wanting to say a lot some very little. There was also a considerable difference in the impact that their experiences had on them with some still distressed with what had happened others wanting to forget it and put it behind them.
- 3.6 Although there was a comment about the rudeness of a ward staff member and therefore problems on the ward all 6 people interviewed either did not think the Hospital could have prevented what happened or did not know whether anything else could have been done. One person said "you could say that there should always be 2 members of

staff present when personal care is given but I think that's not easy". Another person thought there was nothing particularly in the layout or staffing of the ward that might have prevented the incidents from happening and said "I don't blame them for what happened to him, but they (the Hospital) should have communicated with Mum afterwards." Other quotes regarding this subject are as follows: "I don't think the hospital could have done much. They just let one slip through, you can only do so much," and "No I don't think the hospital could do anything. You have to pull the curtain around" and "We know that hospitals have done a lot on giving people privacy and dignity. This is needed but in this case it provided a shield for this horribleness to go on".

- 3.7 Communication following the reporting of the incidents was a common feature of the interviews and all 6 were complimentary about the police saying how supportive, patient and considerate they were. On the other hand 3 people were critical of L & D Hospital for having not communicated with victims or their relatives in any way whatsoever. In this regard one quote can be seen in the previous paragraph, others were: "I didn't hear anything from the hospital..." and "We didn't hear a word from the hospital, nothing. No apology or acknowledgement of what we had been through... They should not have swept it under the carpet so it was like we didn't exist." In response to a question as to whether it was too late now to hear from the hospital one person responded, "It would probably make me feel cross, but maybe...Maybe it would help some people. Maybe just an acknowledgement of how awful it is, just to say this dreadful thing should never have happened."
- 3.8 Of the 6 people interviewed, 2 said they wanted to see a copy of this report, 3 said they didn't want to see a copy and 1 did not say either way. None of the 6 said they wanted any further support. Consideration will now need to be given to how the findings, lessons to be learned and recommendations of this review are communicated to and shared with surviving victims and their relatives who wish to see a copy. In the same vein consideration should be given to sharing the contents of this report with the relatives of the late alleged perpetrator should they so wish.

Independent Author

- 3.9 The independent author of the overview report, Derek Law MBE is a qualified social worker and was until October 2011 the Corporate Director of Adult and Community Services with North Yorkshire County Council having been in that post for seven years. He was also the Chair of the North Yorkshire Adult Safeguarding Board. His appointment is in accordance with best practice, supported by The Association of Directors of Social Services and in "Working Together 2010" which states that: "The Overview Report should be

commissioned from a person who is independent of all agencies/professionals involved.”

3.10 Membership of the Joint Adults Safeguarding Board sub group:

Professor Michael Preston Shoot - Independent Chair, Luton Adult Safeguarding Board. Chair of sub group

Frank Toner – Director with responsibility for Adult Services, Bedford Borough Council

Pam Garraway - Director with responsibility for Adult Services, Luton Borough Council

Pauline Philip – Chief Executive, Luton and Dunstable Hospital NHS Foundation Trust

Pat Reid – Chief Nurse, Luton and Dunstable Hospital NHS Foundation Trust

Anne Murray – Director of Quality and Nursing, Luton and Bedfordshire Clinical Commissioning Groups

Julie Ogle – Director with responsibility for Adult Services, Central Bedfordshire Council and Chair of Bedford and Central Bedfordshire Adult Safeguarding Board

Detective Chief Inspector William Hawkes – Bedfordshire Police

Representative – East of England Strategic Health Authority
Initially Margaret Berry and subsequently report shared with Dr Ruth May, Nurse Director

3.11 Evidence /Reports /Reviews /Information /Interviews requested from the following Agencies:

Luton and Dunstable Hospital NHS Foundation Trust, referred to as Luton and Dunstable (L & D) Hospital throughout this report

Bedfordshire Police

Luton Borough Council, Adult Services

Luton Adult Safeguarding Board

Central Bedfordshire Council, Adult Services

Bedford and Central Bedfordshire Adult Safeguarding Board

NHS Luton

East of England Strategic Health Authority

It should be noted that the Inquiry has made all reasonable efforts to contact all relevant officers, professionals and other personnel based on the information provided by, and requested of, all the agencies and other relevant parties involved.

4. SUMMARY OF THE CASE AND AGENCY INVOLVEMENT

Summary of the Case

- 4.1 This review is about the alleged sexual abuse and/or inappropriate behaviour towards 15 men on ward 17, the stroke rehabilitation ward at Luton and Dunstable Hospital (L & D Hospital). The alleged abuse described by the alleged victims (the AV's) came to light through two investigations, one in 2009 (one AV) and another in 2011 (fourteen AV's). The alleged abuse of the 15 AV's took place between October 2008 and January 2011.

Summary of agency involvement

- 4.2 In order to manage the detail of the various agencies' involvement the author has divided the period into two phases/episodes.

First Phase Alert/Investigation: 2009

- 4.3 On the 30th November 2009 a patient on ward 17 became an AV making a complaint initially to his relatives that a member of the ward staff had sexually abused him whilst he was in the bathroom. Following disclosure to the ward sister an 'alert' (AP1) was raised by the ward sister and the staff member, who was the alleged perpetrator, the AP, was firstly suspended and then on 1st December 2009 asked to work on the day care unit of ward 17 until the investigation had concluded. The 'alert' was processed through to the relevant Luton Borough Council (LBC) social work team and faxed to Bedfordshire Police on that same day, the 30th November 2009. Following a risk assessment interview by the allocated social worker with the AV on the morning of the 1st December 2009 and a Police interview with the AV on the same day in the afternoon, a Strategy Meeting was held on 4th December 2009. Finally a Police interview with the AP was held on the 9th December 2009, when it was concluded, in particular by the Police, that there was no case to answer. At the strategy meeting it was stated by the Police that the patient's account of what happened was ambiguous and inconsistent and in terms of a criminal prosecution could not proceed. After the AP was interviewed by the Police on the 9th December 2009 it was decided, by the Police, to take no further action. On the same day the social worker attempted to contact the AV

to advise him of the outcome of the strategy meeting and the police decision after they had interviewed the AP. The daughter of the AV stated she would rather the social worker spoke to the AV's son so that he could feedback to the AV, his father. The son of the AV made contact and was told of the outcome. The son was not happy with the police decision and said he was going to follow up and get his father to consent to a further police interview with a solicitor present. The family were concerned as their father's account of what had happened on ward 17 had always been articulated in a consistent way to them, not confused or inconsistent. Further communication between the social worker and police indicates that no further contact was made to the police by the AV's family and a 'Closure Monitoring Form' was completed by the social worker on the 23rd December 2009, sent to all agencies concerned on 24th December 2009 and to the AV on the 29th December 2009 stating 'no further action required'.

- 4.4 Subsequently the AP was reinstated and carried on his duties on ward 17 receiving a letter from the General Manager – Emergency Services of the L & D Hospital on 16th December 2009 saying that the Police investigation had been completed with an outcome of no case to answer, that no further action would be taken and that he could return to his substantive role as Healthcare Assistant on ward 17. The same letter recognised that the experience would have been difficult for the AP and encouraged him to take advice and support from Occupational Health. As far as the L & D Hospital were concerned that was the end of the matter and no further action was taken. This was confirmed to the author by the Human Resources (HR) Manager who advised that the HR notes of that time were limited showing only that the AP was suspended for a very short time, (one day), and that not much else happened especially following the Police stating there was no case to answer.

Second Phase Alerts/Investigation: 2011

- 4.5 The second phase of alerts and subsequent investigation was triggered when an AV on the 11th January 2011 turned up at ward 17 asking to see the Ward Sister on duty, three days after his discharge, to say he had been sexually abused on the ward, in the Day Room, on the 7th January 2011 having been visited by the AP on 3 occasions. The Ward Sister, who was not the usual Sister in charge of the ward, gained the impression from the AV's information and description of the AP, that did not fit the description of any member of the ward staff, that it might have been an intruder into the hospital and security breached and so the hospital launched an internal investigation into security. It was suggested to the AV that he should contact the Police but he was not keen at this stage just wanting to ensure no other patients had his experience. The Ward Sister on duty left a report of the matter for the Ward Sister in charge of ward 17 and also spoke to her. The Sister in charge on the same day the 11th January 2011 completed and sent through a SOVA (safeguarding of vulnerable adults) referral (SV1) to

Central Bedfordshire Council, CBC, safeguarding adults' social work team. On the 12th January 2011 CBC contacted the Police Vulnerable Adults Investigation Unit, VAIU, suggesting it may be appropriate for the Police to investigate. The records show that the rationale for this was that the AV would receive victim support through this route and CBC wrote to the Police requesting they, the Police, contact CBC should they feel there was a role for social services. The Police replied on the 13th January 2011 to CBC suggesting that as the AV had made the initial complaint to the Hospital, lived back in the community and had capacity, that the hospital should inform the AV of the complaint findings (inconclusive at that stage as was thought to be a security breach) and allow/encourage the AV to make a decision or not to contact the police to make a complaint. On the 17th January 2011 the Ward Sister in charge of ward 17 contacted the AV again by telephone when the AV went into much more detail than he had done with the other Ward Sister revealing much clearer information; that the alleged abuse had taken place on the ward and had been initiated by a male staff member. The AV was again encouraged to inform the Police which he said he would consider and probably would. From this revised and much clearer description of the look, height, size and behaviour of the AP, and the event, the Ward Sister in charge eventually pieced things together, remembered the 2009 allegation, checked that the AP had actually worked in the Day Room of the ward on the 7th January 2011 and in her words 'put two and two together'. The Ward Sister in charge raised her concerns immediately with the Matron and with the Director of Quality of L & D Hospital who made immediate contact with the Police team within the hospital who advised stopping the internal investigation into security breach and to contact the Police VAIU Team. On the 20th January 2011 the Ward Sister in charge emailed the Director of Quality reiterating her concerns. The AP was off sick from work at this stage. The Director of Quality and Ward Sister in charge discussed the matter further and the former contacted the Police VAIU on 21st January 2011 to report the new information and to advise that the AV had again been encouraged to contact the Police. Further contact with the AV was attempted over the next few days and finally on the 25th January 2011 the Ward Sister in charge got through by telephone when the AV said he was willing to contact a named officer at the Police VAIU by telephone to report his allegations. The Director of Quality followed this up with an email to the named officer of the VAIU advising him of the AV's intentions.

- 4.6 By the 3rd February 2011 having not heard further from the Police the Director of Quality contacted the Police VAIU again in order to ascertain whether the AV had been in contact with the named officer in the unit. In the absence of the named officer the support staff at the VIAU advised they had no record of the AV making contact to that date. The Director of Quality and Ward Sister in charge were considering what steps to take should the AV continue not to contact the police when the situation took another turn on the 4th February 2011, a further alert being received from a Care Service Agency in the

Community. This latest AV, who by this date was back in his own home, had described the abuse he had suffered on ward 17 to a friend and with the AV's consent the friend had contacted the Care Service Agency to report the matter on his behalf. The Care Service Agency reported the matter to the police and also raised a safeguarding alert, completing an AP1 SOVA referral.

- 4.7 The Ward Sister and Director of Quality had been of the opinion that in terms of patient safety the suspected AP had been off sick (but according to the records only for 2 days on the 21st and 22nd January 2011) which gave the hospital time to check rotas and who had been on duty on ward 17. But when this second case on 4th February 2011 came to light the AP was immediately suspended to prevent him from returning to work.
- 4.8 When this last of the 3 separate independent allegations (from 2009 and 2011), by male patients, that they had been sexually assaulted on ward 17 was received on the 4th February 2011 it triggered an immediate, large scale and comprehensive Police investigation. In the period between the Police investigation commencing in February 2011 and the matter going before the Court it was not appropriate for other agencies involved, including L & D Hospital, to make contact with alleged victims and their relatives so as not to potentially undermine the case. The Police investigation led to the eventual identification of 15 victims, including the first 3 identified above, who had all been patients on the ward between September 2008 and January 2011. The investigation involved making contact with, and interviewing, existing and previous stroke patients who had been on ward 17 during the time period the AP had been working as a Healthcare Assistant on the ward.
- 4.9 The AP was officially charged on the 30th June 2011 with 17 counts of sexual abuse on 15 men going back from September 2008 to January 2011. The AP appeared at Crown Court on the 15th September 2011 when he pleaded not guilty to the charges. A date was set for a trial to take place on the 27th February 2012. As has already been mentioned, before the matter went to trial the AP committed suicide on the 25th September 25th 2011 the Coroner recording a verdict that the AP took his own life. In a letter shown to the Coroner at the inquest the AP is said to have written that he was not taking his own life because he was guilty.

5. AREAS OF INQUIRY

Was there a cover up in the Hospital?

- 5.1 One of the initial questions and therefore line of enquiry by the author of the Independent Review was the question of 'did staff on the ward or in the L & D Hospital have any knowledge or suspicions that the

alleged abuse was going on?’ Was there any form of cover up or protection of the AP? Could there be a conspiracy theory? What can be stated emphatically from the Independent Review is that there is no evidence whatsoever to suggest that any one staff member in the Hospital knew what was taking place. The detailed Police interviews that were held with staff during the investigation, the various internal and external reviews that have taken place in the Hospital and the author’s own interviews with staff and comprehensive review of evidence points to nothing that would give rise to that suspicion.

- 5.2 On the contrary the author found from the evidence and review of interviews and his own interviews with hospital staff that the AP had enjoyed a reputation for being a very good, caring Healthcare Assistant and was popular with staff and patients alike. There had been no complaints against the AP prior to the 2009 incident on ward 17 or any other ward or during the remainder of 2009 or 2010. Ward staff reported an exemplary record since employment started in 2006 and a number of compliments from patients and their relatives had been received about the AP during this time. There was indeed a sense of disbelief in the ward from staff who worked with the AP and to this day there are still some ward staff that do not believe the AP would have done what has been described.
- 5.3 The author concurs with the view that the AP may have operated in a clever way to ensure other staff would not be around at the time of the alleged offences and in areas of the ward where he would be less likely to be seen. It is a fact that the AP was able to spend reasonable amounts of time on his own with patients, operating either behind drawn curtains or in the bathroom and shower rooms. The AP allegedly would operate when staff he was working directly with went on their ‘break’ or would offer to work on his own when the ward was very busy. The fact is no one other than the AV’s saw what the AP was allegedly doing and staff told the author that because he was so popular and well respected in his work staff made it ‘easy for him’ accepting he was always working professionally. With hindsight staff told me that he must have worked in a devious way to ensure other staff were not going to be around when he saw patients on their own.
- 5.4 The author visited ward 17 and saw for himself the layout of the ward and the areas where the alleged abuse took place. The alleged offences were concentrated mainly in the male patient end of the ward in three 4 bed bays just to the right of an entrance into the ward. A smaller number of alleged offences took place in the Day Room Unit at the other end of the ward, adjacent to the three female 4 bed bays in the ward. Alleged offences also took place in the bathroom and shower room area which are located opposite the male and female bays and the ‘nursing station’ which is located between the male and female areas. The author was able to see for himself how easy it would be to operate alone, unseen and heard, with the curtains drawn around the bays, in the day room area and in the shower and bathroom. At times

there was a general sense of noise and activity that would be likely to drown out any peripheral sound coming from within curtained off bays or the bathroom/shower room. The visit to the ward served to reinforce the authors' tendency to concur with the view that the AP may have operated in a clever and manipulative way that would have assisted in the avoidance of detection.

NHS relationship issues

- 5.5 Although the author saw and heard evidence of strained and defensive relationships between NHS Luton and L & D Hospital he formed the view during his review of all the evidence that the relationship issues did not have a major bearing or influence on the incidents that took place on ward 17. That is not to say that this could not become a more corrosive element and cause system and other failures if they are not addressed. What's more the L & D Hospital needs to ensure it develops and sustains positive and enduring relationships with the soon to be fully operational Clinical Commissioning Groups for Luton and Bedfordshire replacing NHS Luton and NHS Bedfordshire. This is picked up in the lessons learned section of this report.

2009 Case – were the appropriate procedures followed?

- 5.6 Was the procedure, in place at that time, appropriately followed by L & D Hospital staff for the reported sexual abuse incident on 30th November 2009? The answer is 'yes it was'. Although looking back, and closer examination of the procedures, staff guidelines and processes has shown they were not adequate (which have all since been revised in line with Care Quality Commission, CQC, requirements,); there is clear documented evidence in the form of reports and paper trails that shows that the required steps of the safeguarding adults process were followed by L & D Hospital staff in response to the 30th November 2009 alert.
- 5.7 To elaborate, following disclosure on the 30th November 2009, the ward 17 sister immediately raised a safeguarding alert, and as required by the procedures in place at the time, she completed the required AP1 form and because the AV was a Luton resident forwarded it directly to Luton Borough Council (LBC) social work team. The AP was suspended with immediate effect and was asked to leave the site but on the next day, the 1st December 2009, was then asked to work on the day care unit of ward 17 until the investigation had concluded. A risk assessment interview with the AV was undertaken by a social worker of the LBC adult social care team on the morning of the 1st December 2009 and the Police interviewed the AV, in the presence of the LBC social worker, on the afternoon of the same day, the 1st December 2009. Four days after the 'alert' on the 4th December 2009 the required strategy meeting was held when the single

recommendation from the 'Protection Plan' was that the AP should be interviewed by the Police by the 9th December 2009. In fact the 'Protection Plan', signed off by LBC, Bedfordshire Police and the L & D Hospital was woefully short of detail, the only sections completed being the personal details of the AV and the recommended action to interview the AP by the 9th December 2009. On the 9th December 2009, (nine days after the 'alert') the AP was interviewed by the Police, in the presence of his legal representative, when it was determined that no further action was required and that the investigation was concluded.

- 5.8 In line with L & D Hospital policy the AP was then sent a letter on the 16th December 2009, from the General Manager in the hospital, stating that the Police investigation was now concluded and that there was no case to answer and that no further action would be taken. The AP was told he could return to work as a Healthcare Assistant on ward 17 and he was also encouraged to take advantage of advice and support from Occupational Health.

2009 Case – sound practice or not?

- 5.9 Although it is clear that the procedures in place in 2009 had been followed in this case it is also clear that best practice was not followed as has been acknowledged by the L & D Hospital Trust. That is the 2009 case shows that the matter was not escalated to other senior staff within the Hospital. So that none of the 'alert', cause for concern, strategy meeting or conclusions reached were communicated to the then Director of Nursing who had responsibility for adult safeguarding at the time. It could be argued that escalation may have spotted other issues and resulted in a more robust approach. It was not a written requirement within policy and procedures to escalate and it was not the practice in 2009 for all safeguarding alerts to be copied to the Deputy Director of Nursing as is now the case. Neither is there any evidence that the matter was reported to the PCT or any regulatory body.
- 5.10 Staying with the 2009 case LBC, having received the 'alert' and as was the policy, arranged on the 1st December 2009 for a member of their adult social care team to undertake a Risk Assessment, independent of the organisation (the L & D Hospital) in which the alleged abuse occurred and using a standard tool designed to gather further information to aid the investigation. This included an assessment of the AV's mental capacity. This was appropriately fed into the Strategy Meeting.
- 5.11 It is at the strategy meeting on the 4th December 2009 where the author believes a more robust approach might first have been adopted and then again following the Police interview with the AP on the 9th December 2009. Whilst appreciating we now have the benefit of

hindsight it is clear from the record of the Strategy Meeting and reports of the Police that the primary reason for not recommending anything other than a 'police interview' with the AP was because a prosecution would not be successful, the AV having given an inconsistent account of what happened in his interview with Police on the 1st December 2009. Following the subsequent police interview with the AP on the 9th December 2009, the police email communication to LBC concluded that the police were happy with the AP's explanation of what the AP was doing, when he was doing it and that he had acted appropriately. 'No further police action' was stated in this communication and on that basis neither LBC adult social care or L & D Hospital (HR) thought anything else needed to be done.

5.12 It should be said though, that the threshold of proof applied to Police Prosecutions and matters going before the Court is higher than that which is generally applied to safeguarding adults. In the 2009 case a safeguarding concern had been raised, the AV's story to his family had been consistent and they were concerned that the matter was not being taken forward. The question needs to be asked why more follow up wasn't initiated with the family given their dissatisfaction rather than leaving the initiative with them to make further contact. The story was also consistent to the social worker during his interview with the AV. Even though the police interview with the AV (at which no other family members attended) contained inconsistencies, unlike the threshold for a police prosecution there was sufficient concern raised that could/should have triggered discussion on the 'probability' or not of sexual abuse having taken place, the threshold of proof being lower and getting into consideration of the realms of probability. This is reinforced by the very strong views expressed by the family as to the consistency of the AV's account of what happened and also that of the equally consistent interview with the social worker. So one could argue that this should have generated a more robust 'Protection Plan' that included escalation to Senior Managers/Officers given the difference of reported interviews and strength of feeling of the family. Escalation to a Senior Nurse/Manager at the L & D Hospital, for example, may have led to the question being asked, "is the Hospital Trust satisfied with the conclusions and outcome of the police investigation and is further investigation required?"

5.13 As has already been stated in this report the 'Protection Plan', a document that implies a joint duty to protect, was significantly lacking in information and was a collective failure on the part of all agencies involved that is L & D Hospital, the Police and LBC Adult Social Services. There was nothing in the plan that could enable agencies to evidence the rationale for the one decision made, to interview the AP. A more robust 'Protection Plan' might also have led to a recommendation, as much for the AP's protection as anything, of closer supervision of the AP on his return to work. A consideration might also have been to include a 'Protection Plan' recommendation regards two nursing staff members attending personal care tasks of

patients on the ward, particularly bathing, for a specified period of time. Again this could have been seen as much as protecting the AP, as well as potential AV's, given the accusation that had been made against him. Ultimately the conclusions drawn may have still resulted in a collective view that abuse was unsubstantiated but a more robust 'Protection Plan' might also have resulted. In any case the author would contend that even had the AP have been innocent, good Human Resource practice would ordinarily include a plan of supervision to be introduced to protect the AP in the light of his experience of the accusations made.

- 5.14 With regards the Police investigation in 2009 it clearly involved interviews with the AV and the AP. The social worker who carried out the Risk Assessment was also present for the interview with the AV. It is clearly documented in the Strategy Meeting minutes and in the contemporaneous record sheet of the social worker that the AV was inconsistent in his account of what happened and following an interview with the AP the Police concluded a case could not proceed against the AP.
- 5.15 Again it is clear that the proper procedures in place at the time were followed but in terms of best practice the case was concluded rather abruptly without escalation to Senior or Specialist police officers in this field and without any follow up to the strong feelings expressed by the family as described earlier in this report. It should be said, rather like the previous commentary in this report on 'thresholds of proof', that the author is not suggesting a different outcome would have ensued as it is clear that it would have been difficult to pursue a case of this nature with inconsistent statements from the AV and therefore insufficient evidence to progress to court. However the question still needs to be asked as to whether there might have been a different outcome had the case been escalated or followed up with the family.
- 5.16 In reviewing this 2009 incident the author did receive an acknowledgement from Bedfordshire Police that although a formal review of the 2009 case had not been initiated, with hindsight, a sufficiently trained detective would not have closed the 2009 investigation in the manner it was closed. The Police had though, proactively, changed arrangements so that the Vulnerable Adult Investigating Unit undertaking such cases were not staffed by uniform police officers in plain clothes as they were in 2009; thus by the latter part of 2010 into 2011 were staffed by detectives or by the uniform officers in post who had undertaken an 18 month 'detective' training programme involving exams and a work based assessment process. Again it should be said that the Police recognised this gap before the 2011 incidents came to light in that during 2010 it was identified by the Police that the level of crimes the Vulnerable Adult Investigation Unit were investigating needed the training and expertise of detective officers to undertake those investigations. In essence Bedfordshire Police introduced an increase in the intensity of it's safeguarding

investigations at the same time as more intensive training and on the job supervision of it's police officers undertaking such duties.

2011 Cases – Practice and Procedural issues.

- 5.17 With regard to the 2011 cases, as has already been described in the 'Summary' section of this report in some detail, there was initial confusion and eventual clarity as to whether the first reported case was a security breach or a safeguarding matter. In any case the Ward Sister followed the appropriate procedure and raised it as a safeguarding 'alert' and reported the matter to the Director of Quality. Once it became clear, after the second reported incident in 2011, that this was a 'bigger issue' the Police very much took over and it became a large scale police investigation which naturally took primacy.
- 5.18 However it should be noted that a period of just over 3 weeks elapsed between the date of the first 2011 alert on the 11th January 2011 and the second alert on the 4th February 2011. This was largely due to the AV not making contact with the police but also the apparent indecisiveness shown up by respective agencies passing the responsibility to another to act. So that L & D Hospital rightly, initially, referred the incident as a safeguarding alert notifying the Police and CBC Social Services. CBC passed it back to the Police as they considered a Police investigation more appropriate with the rationale that the AV would receive victim support. The Police then passed it back again stating that as the AV had reported his complaint to the L & D Hospital, was living in the community and had capacity they, the hospital, should report the inconclusive findings of the investigation into his complaint to the AV and advise him to contact the Police to report the alleged abuse to them if he wished.
- 5.19 In the meantime the clock was ticking and time passing and the question needs to be asked whether this time period exposed other AV's, who had since come forward to report their experiences, to risk of abuse from the AP within that time period. The author has examined all of the relevant documents and in particular the police statements and evidence that would shed light on whether any of the other 14 victims might have been exposed to potential abuse by the AP between the 11th January 2011 and 4th February 2011; more particularly from the 17th January 2011 when the AV gave a more detailed description that led to the eventual identification of the AP rather than it being assumed that an intruder had come into the hospital. The records and evidence show that the AV on whom the alert came through on 4th February 2011 (as described earlier) reported that his alleged abuse took place on the evening of 26th January 2011. The AP was on the rota to work on this evening. As it transpired this AV did report his alleged abuse on the 4th February 2011 but it has to be assumed that had the first case, reported and becoming clearer on 17th January 2011, progressed more speedily this

incident might have been avoided, notwithstanding the apparent reluctance of the first AV in 2011 to report his complaint to the police.

5.20 The time period that elapsed between the 17th January 2011 and 4th February 2011, as described above, also raises the question as to why the AP was not suspended from duty earlier than he was. According to the records he was suspended as soon as the second 2011 alert was received on the 4th February 2011. The author would contend however that there was enough concern that came to light following the first 2011 AV's revised and more detailed account of his alleged abuse on the 17th January 2011, to have triggered suspension of the AP immediately or very soon afterwards. Although the AP was reported as being off sick on the 21st and 22nd January 2011 he was back at work on ward 17 again from the 23rd January 2011 until his suspension on the 4th February 2011 according to the records. Safe and good HR practice would determine that the AP should have been suspended from duty before he actually was.

5.21 The author has seen and read documents that clearly demonstrate excellent support and cooperation from L & D Hospital with regards the Police investigation. Access to staff, to staff personnel information, files and critical information on past and present patients on ward 17 was facilitated. The hospital set up a 'Control Group' which met several days each week involving key Senior/Ward/HR staff to ensure all actions were done correctly, that information requested by the Police was available and to manage and coordinate information, communication and the cooperation required. This involved working with Bedfordshire Police to contact all patients who had been on ward 17 during the period of the AP's employment as a result of which many came forward.

Safeguarding 'alerts' – weaknesses in the system.

5.22 The initial cases which came to light in 2011 exposed the weaknesses in the system and practice of managing and processing safeguarding 'alerts'. So far as L & D Hospital are concerned it was clear that they had failed in their responsibility to check that the systems, processes and routes they had in place in the Hospital were working effectively. It is acknowledged by the Hospital and clearly spelt out in the Care Quality Commission (CQC) 'Review of compliance' carried out in February 2011, inspection report published on 15th April 2011. This report describes the failure of L & D Hospital to report the alleged serious sexual assaults of 2011 to the National Patient Safety Agency (NPSA) and thus CQC. This in turn raised concerns as to the way the Hospital had reported any other previous allegations of abuse and there was clear evidence they had not. The CQC review identified that safeguarding alerts and referrals had not been routed consistently through to the lead authority, in this case LBC as the local authority in which the service at L & D Hospital is based. Alerts were instead being sent to the Local Authority based on the patient's home address

meaning no Local Authority, including the designated safeguarding lead Authority, had a clear and accurate overview and picture of safeguarding matters that had been raised at L & D Hospital. As the CQC report goes on to say as a consequence the identification of patterns, trends and links between alerts could not be made. Furthermore it was concluded that decision making and investigation strategies were being made without a clear understanding of wider issues that might impact on any given case.

5.23 The CQC report also refers to NHS Luton confirming that they had not been made aware or received information concerning referrals relating to patients from Central Bedfordshire Council (CBC) which they felt had impacted on their ability, as lead commissioners, to make an informed decision regards quality and safety of services provided. The Author would argue however that it was also NHS Luton's failure not to spot that the only information they ever consistently received concerned Luton based patients. The absence of information concerning referrals of patients living in Central Bedfordshire should have been obvious.

5.24 CQC concluded they had serious concerns regards the hospital's safeguarding arrangements and the adequacy of safeguarding training for staff; that the safeguarding protocols and procedures in place were confused, fragmented and had failed to ensure appropriate steps were taken when a safeguarding alert was made. Trends and patterns could not be easily identified and decision making and investigation strategies were independently driven without considering all relevant information. This they said had directly exposed people to risk of abuse and was a feature of the cases that came to light in January/February 2011. In March 2011 CQC issued warning notices to L & D Hospital in relation to 'outcome 7' safeguarding and 'outcome 6' co-operating with other providers.

5.25 It is clearly documented and confirmed in the interviews the author had with staff from L & D Hospital, NHS Luton, CBC and LBC that there was total confusion with regards to how alerts were routed and the 2011 cases did expose this. The alert and decision monitoring tool for the first case in 2011, who was a Central Bedfordshire resident, were not shared with LBC, the host authority for the L & D Hospital. Senior staff at L & D Hospital assumed all alerts were going to LBC and they were not. CBC had an informal arrangement with the L & D Hospital; that is because CBC had a designated hospital social work team, alerts relating to CBC residents were sent directly to the CBC safeguarding team for action. It had been believed by CBC, but not checked, that because all alerts were coordinated by the L & D Hospital safeguarding lead team information about CBC patients was shared with LBC but it wasn't, routinely. It is clear therefore that there was not an authority, and certainly not the host in the hospital, that had an overview of safeguarding alerts in the hospital so that patterns and trends could be more easily identified. LBC do not escape criticism

because neither did they pick up the fact that alerts for CBC residents were not being managed in the context of trends and patterns by them as the host authority.

- 5.26 It is also a fact that CQC were not notified by the L & D Hospital, via the NPSA in a timely way of the first cases in 2011 but neither did CBC send the alert or monitoring tool to CQC in the first case of 2011 as is required. This was identified and addressed soon after the 2011 cases by CBC as a gap in knowledge within the CBC safeguarding team.
- 5.27 So in summary the author's view is that none of the agencies responsible for 'alerts' were managing them effectively, at the time of the reports of alleged sexual abuse coming through relating to ward 17, either as individual organisations or collectively.

Human Resource Management Issues at Luton and Dunstable Hospital NHS Foundation Trust

- 5.28 This review has exposed a number of failures or weaknesses in staff either not understanding good and safe HR practice at the time or just not carrying it out. The author is aware that much has been done to improve staff awareness of good HR. For example there was evidence that annual appraisals were not always being completed at ward level. In response quarterly reviews with all staff were instigated in addition to annual appraisals incorporating an action and development/training plan for each staff member. Also developed has been specific supervision guidance for staff involved in ongoing investigations of safeguarding alerts and ensuring staff are supported at Strategy Meetings. The author is also aware that a referral is now made automatically to Occupational Health if a member of staff is suspended not leaving it to the suspended staff member to decide, as was the case for the AP as described in this review.
- 5.29 However weaknesses were clearly identified in this review in particular the failure to introduce closer supervision arrangements for the AP following the closing down of the 2009 safeguarding adults investigation and the failure to suspend the AP from duty until the 2009 investigation was completed, instead of which the AP continued from the 1st December 2009 to work in the day care unit on ward 17. There was also a failure to suspend the AP from duty sooner than he was in the 2011 phase. In summary although the author has seen clear evidence of improvement in HR practice over the past 18 months, the question as to whether the systems and arrangements were unsafe at the time, manifested in considerable staff confusion and lack of awareness regards safeguarding, still to some degree hangs over Luton and Dunstable Hospital.

Could abuse have been prevented?

- 5.30 The key question to be asked relates to the various shortcomings identified in this review of the case and by other organisations and documents such as CQC and the independent reports and audits, commissioned by L & D Hospital; that is, if instead the shortcomings were not evident would the alleged sexual abuse have been prevented? The author is of the opinion that the only certain way of preventing the alleged sexual abuse on ward 17 (and this is supported to a certain extent by the victims/relatives who were recently interviewed) would have been if the AP had always been accompanied by another member of the nursing staff whilst carrying out personal care duties on the ward (not the agreed practice at the time). In 2009 it has already been noted that the alleged abuse was not escalated nor was any consideration given to closer supervision of the AP or doubling up nursing staff on personal care interventions with patients. In this case, although it would have been better practice, it may not have made any difference in the end because the case could not proceed to prosecution because of an inconsistent account of what happened from the AV.
- 5.31 In 2011 however, overall weaknesses in the system have been identified in this review, in particular the timescale from receipt of the first alert to the case becoming a comprehensive Police investigation and the failure to suspend the AP earlier. It could be argued that this might have prevented at least one of the AV's from the abuse they experienced.

6. CHANGES IN POLICY/PRACTICE

Luton and Dunstable Hospital NHS Foundation Trust response.

- 6.1 Over 18 months have now passed since the incidents in January/February 2011 came to light. As has already been mentioned in this review CQC completed a Review of Compliance in February 2011, publishing an inspection report on the 15th April 2011, and judged that they had serious concerns that there were major failings across L & D Hospital's safeguarding arrangements. It should be noted that there was substantial change in the Senior Leadership of the L & D Hospital not too long after the 2011 incidents. The new Leadership of the hospital responded well and introduced a series of staff training, policy, procedure, process and practice changes that led to a further CQC Review of Compliance conducted in July 2011 and inspection report published on 13th October 2011. This report declared L & D Hospital were compliant, had made significant progress and that the Trust had worked closely with key partners to review and strengthen safeguarding processes and arrangements. Further that roles and responsibilities had been clarified and that all alerts/referrals were now being sent to LBC, as the host authority, to manage the investigation process and monitor outcomes. The CQC judgement concluded that people using the hospital service could expect to be protected because there were systems in place for the identification of reporting of all

allegations or concerns of potential abuse and that staff were now appropriately trained and had clearer and better guidance on how to safeguard people.

- 6.2 In December 2011 CQC prompted a follow up 'risk summit' as a mechanism for detailed discussion and assessment of risk areas across the L & D Hospital. At this summit, involving all relevant partner agencies, CQC expressed their growing confidence in the Trust's ability to continue to drive improvements forward.
- 6.3 June 2012 saw a further Review of Compliance undertaken by CQC to check that the improvements required had been made. The subsequent inspection report, published on 12th July 2012, was very positive and stated that L & D Hospital had met the standard for all 10 Outcomes reviewed at that time. This Review repeated the judgement that L & D Hospital were protecting people from the risk of abuse because they had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. This is a positive reflection of the tremendous amount of work and focus the L & D Hospital have had on safeguarding since early 2011.
- 6.4 As well as introducing more robust and comprehensive safeguarding training for all staff, the Trust have implemented the CQC assurance framework and organised an independent external review of nursing services at the hospital in May 2011. This involved a team of very experienced senior nurses, led by Denise Hagel (Independent Nurse Advisor and previously Director of Nursing at Colchester University Hospital Foundation Trust), carrying out a diagnostic review of nursing practice and standards but also focus on organisational systems and processes in the hospital. The review was carried out in May and June and presented on 27th July 2011 to the Chief Executive of L & D Hospital and the Chief Nurse of the East of England SHA. An external report into the audit findings for adult safeguarding in the hospital was also commissioned in 2011 from Health and Social Care Consultancy Ltd and a "Nursing Review Twelve Months on ..." was conducted in May 2012. Bi-monthly self assessments at ward level consisting of questions and observations to both patients and staff were introduced. Likewise bi-monthly internal peer assessments by senior nursing staff in areas of the hospital other than their own to quality assure the outcomes of the self assessments were implemented. External peer assessments by Senior Nurses from outside the area of the Trust were also introduced quarterly as was the creation of a whole set of new governance arrangements that focus on safeguarding. Staff have been trained appropriately, the supervision and appraisal of staff has been strengthened and guidance for staff on how to handle safeguarding matters is clearer and policies, procedures and processes have been updated and changed to address the confusion and poor arrangements for safeguarding CQC picked up in their review undertaken in February 2011 (report published 15th April 2011). The Leadership of the Trust have taken on board the recommendations

and lessons from this comprehensive menu of activities and it has been an impressive 'turn around' from such a serious position.

Working together on process, roles, responsibilities - particularly 'alerts'.

- 6.5 LBC and CBC have also worked together and also with L & D Hospital and NHS Luton to sharpen up on their shared responsibility for the process, roles and responsibilities for safeguarding adults and in particular 'alerts.' In this regard a significant report was taken to the Luton Safeguarding Adults Executive Board in August 2011 to approve a pathway for handling safeguarding 'alerts' whereby all referrals were passed in the first instance to LBC irrespective of where the patient lived and were logged by LBC Safeguarding Coordinator. In the case of CBC residents the 'alert' was then passed on to CBC who wanted to continue to lead on cases from their geographical area (approximately 40% of patients in L & D Hospital come from Central Bedfordshire). It should be noted that this agreed process still did not follow the Association of Directors of Adult Social Services (ADASS) protocol which requires the authority where the 'alert' takes place to lead on the safeguarding investigation. CQC did however agree to the proposed solution.
- 6.6 It became apparent to the author during his investigation and up to the time this report was being constructed that matters of 'alerts' and the carrying out of 'risk assessments' in clinical cases were still being debated and were not entirely resolved. This will be a matter picked up in the recommendations though it should be noted that although the author is now assured that all 'alerts' are passing through and are logged by LBC as the host authority he is of the firm opinion that the two Adult Safeguarding Boards should follow the ADASS protocol. There are ways in which this can be achieved without unnecessarily impacting on capacity or loss of control. One example would be to give full responsibility to LBC for all safeguarding investigations but have an allocated social worker(s) from CBC located within the LBC team to undertake the work with reporting arrangements back to CBC.

7. LESSONS TO BE LEARNED

Embedding and Sustainability

- 7.1 What this case overall has shown, with the benefit of hindsight, is how 'out of sorts' arrangements, systems, processes and staff can become if they are not monitored, maintained, supervised effectively and sustained in a continuous way. This raises the question of sustainability and embedding of the many positive changes that have been introduced since the 2011 incidents came to light particularly in regards to L & D Hospital. The new Leadership of the hospital have made an impressive menu of changes to policies, processes,

procedures, staff guidance and training and operational practice. The author has heard this directly from hospital staff who have described an improvement in policies and staff training and guidelines and an increased awareness of safeguarding, particularly heightened on ward 17. The L & D Hospital have implemented the CQC assurance framework; have introduced self assessments and internal peer assessments bi-monthly and external peer assessments quarterly by senior nurses from other parts of the region (reciprocal arrangement); as part of new governance structure audits are looked at monthly and the Trust have created a Clinical Outcomes and Safety Committee which reports through the Trust Board; the Chief Executive also endeavours to sign off every 'complaint' to pick up patterns and trends and has introduced what is known as "3x3" whereby non-executive and executive directors spend 3 hours every 3 months on wards with a crib sheet that is reported back to the Trust Board. For their part LBC and CBC together with NHS Luton have been constantly discussing and adapting the 'alert' pathways so as to have a system that is consistent, understood and enables the host authority, LBC, to pick up themes, trends and patterns. This was still under debate with a view to further improvement when the author was concluding his review.

- 7.2 The point to be made here is that although it is very positive indeed that individual agencies, particularly L & D Hospital, are making changes internally and putting in place governance and assurance frameworks to monitor implementation and sustainability; it is equally important that an agreed multi-agency 'whole system' approach is sustained and embedded. In other words there is little point in fixing, maintaining and sustaining one part of the system without fixing the other and this needs to be worked out and done together and then agreed, coordinated, implemented and monitored collectively. It should be for the two Adult Safeguarding Boards to hold all agencies to account in this regard.

Ensuring Human Resource best practice is embedded and closely monitored.

- 7.3 As described in the Areas of Inquiry section of this report this review exposed failures and weaknesses in the L & D Hospital HR arrangements in all probability as a manifestation of the system and process failures identified in the CQC inspection report of L & D Hospital published on the 15th April 2011 in which lack of understanding, awareness and confusion of staff regards safeguarding arrangements was identified.
- 7.4 In response the Trust should continue to assure itself that HR policies, procedures and best practice are being followed and should ensure regular monitoring and performance management of this takes place including at ward level. It may be advisable to introduce practice audits, sometimes unannounced, to ensure compliance.

Understanding potential perpetrators and assumptions.

- 7.5 There is some learning to be had for L & D Hospital in particular from understanding the way in which potential perpetrators operate and the practical arrangements to mitigate risks to vulnerable adults. In this case several hospital staff emphasised what a good, caring and popular individual the AP was and articulated the disbelief there still was amongst ward staff that he committed the alleged offences. Staff the author interviewed described being taken in and in one case even inferred that colleagues had ‘made it easy’ for the AP. The fact that the AP was able to spend reasonable amounts of time alone with patients, unseen or heard is testimony to this. This is a lesson about assumptions and that what one observes can occasionally, and in this instance potentially dangerously, conceal the reality. It could indeed have been that the AP was able to operate in a predatory yet clever and manipulative way and at the same time maintain his popularity. It has been a positive response by the L & D Hospital to introduce on ward 17 two staff attending patients if the caring episode is due to be a long time and intimate; for example, bathing, washing of private parts. The author was advised that the Trusts chaperoning policy, currently being updated, is used in conjunction with the Trusts Consent Policy whereby a male nurse is accompanied by a female nurse when delivering intimate care. However this is not the expectation when staff and patient are of the same sex unless the patient requests a chaperone. This still leaves patients potentially vulnerable to the type of alleged abuse committed in this case; although this is mitigated to an extent by the staff safety briefs, the author was advised, take place at the beginning of each shift when any vulnerable patients are identified and guidance regards care discussed. The L & D Hospital does however need to be sure that all potential risks are eliminated as far as is possible and practicable. To this end ward practice in this regard should continue to be regularly monitored and reviewed by the L & D Hospital and reported periodically to the two Adult Safeguarding Boards.
- 7.6 As a footnote to this section, although it is clearly not part of this review, in terms of similarities, albeit on a different scale, it is prudent for the two Adult Safeguarding Boards to be mindful of the National independent Department of Health inquiry into alleged abuse at Stoke Mandeville Hospital, Leeds General Infirmary, West London Mental Health Trust and Broadmoor Hospital overseen by former barrister Kate Lampard. The point being, the AP employed on ward 17 “enjoyed a positive reputation” as reportedly did Jimmy Savile in the recent revelations in the national media. The Joint Adult Safeguarding Board Sub Group should therefore be mindful of any future recommendations coming out of this National Review for the NHS locally and the new Clinical Commissioning Groups; in particular taking account of cultural, institutional learning and recommendations around alleged predatory, clever, manipulative behaviour in hospitals and other institutional settings. The local media interest in what emerges from the National

Review in the context of, and in comparison with, what allegedly happened on ward 17 is, in the view of the author, going to be considerable.

Mending and building better relationships

- 7.7 Without intending to state the obvious ‘working together’ and having positive and effective inter-agency relationships is critical to achieving the best outcomes regards safeguarding. Whilst the author does not consider poor relationships to have been a major feature or indeed of any significance to the outcome of the incidents of alleged abuse in 2009 and 2011 or this Independent Inquiry it is a fact that unresolved relationship issues will hamper continuing progress and current and future partnership/multi-agency working. The author heard of, and read about, historical and recent poor relationships, and has observed tensions and defensiveness particularly between NHS Luton and the L & D Hospital. Significant concern has been noted around this working relationship but to the credit, now, of both parties there is a recognition that this situation cannot be allowed to continue unchecked or unresolved and therefore needs to be urgently addressed. The author was encouraged by the steps being taken to address these tensions and resolve matters including NHS Luton, recently, commissioning an independent review of the system from a ‘safeguarding’ lead who works in a Strategic Health Authority in another region of the Country. This is essential to moving into the new World of commissioning next year when the L & D Hospital will need to develop and sustain positive working relationships with the new Luton and Bedfordshire Clinical Commissioning Groups which will replace the PCT’s of NHS Luton and NHS Bedfordshire.

Assumptions about practice

- 7.8 One of the obvious lessons to learn is for agencies not to make assumptions about what is happening in practice or to assume that other agencies are carrying out the expectations of the other. Agencies individually and collectively need to assure themselves and put arrangements in place that monitor and check that all staff understand the system, are clear about their responsibilities, know from where to get expert advice and apply the agreed policies, procedures and system in practice. The way safeguarding pathways and ‘alerts’ was being managed is a classic example in this case. L & D Hospital were assuming that LBC were managing all ‘alerts’ not just passing them on to CBC without making the connections on patterns and trends. The L & D Hospital had a responsibility to check that the systems, processes and routes they had in place in the hospital were understood and working effectively. Likewise CBC having agreed an informal arrangement with the L & D Hospital to receive alerts direct also assumed that LBC were getting all alerts including CBC’s and would therefore pick up trends/patterns.

- 7.9 What is also abundantly clear is that having two systems of alerts, having two separate hospital social work teams and safeguarding arrangements was confusing for staff working in L & D Hospital. This was clearly compounded by the fact that at the time of the ward 17 alerts there was clear evidence that staff in L & D Hospital showed uncertainty on what to do, who to speak too, underpinned by a general lack of awareness of safeguarding vulnerable adults and inadequate training. The lesson to be learnt is not to make assumptions and also to ensure that all staff from all agencies working in the system are clear about the arrangements in place and their own responsibilities. It is though, equally clear that it is a collective responsibility to simplify and join up the systems and arrangements so far as is possible and practicable. There are national guidelines and protocols available in that regard and LBC and CBC should make a concerted effort to learn from how others adopt these protocols and guidance successfully in similar circumstances to those that exist in L & D Hospital. As has already been stated the author considers that the ADASS protocol should be followed.

Review of Luton and Dunstable Hospital management of 'alerts'

- 7.10 Often when matters of safeguarding issues of this nature come to light one of the responses can be to introduce an overly risk averse and process driven approach which can in itself become a constraint to learning and developing better practice. There is some evidence of this manifested in the very high volumes of alerts being processed through the hospital of which L & D Hospital Management are clearly aware. To this end it is suggested that the L & D Hospital review its alerting process so that staff are able to own the process of raising a safeguarding alert. An example might be for the hospital to introduce the use of the multi-agency referral form which asks staff to record why they believe they are reporting abuse or neglect. This would be instead of completing an incident form and would, with the right training, enable staff to gain a greater understanding of safeguarding through engaging with the process in this way.

Clear escalation arrangements

- 7.11 The comprehensive and detailed documents and evidence gathered shows that procedures in place at the time were followed, notwithstanding the confusion over alerts/pathways, but, as has been described in the "Areas of Inquiry" section of this report, the 2009 alert, in particular, lacked escalation to more Senior and/or experienced staff in safeguarding adults who might have spotted issues earlier which could have resulted in a more robust approach. This applied to the L & D Hospital and also the Bedfordshire Police in particular in 2009 but also to LBC and all agencies that contributed to the very limited 'Protection Plan' signed off on the 4th December 2009 at the Strategy Meeting. This was a collective failure and is a lesson in ensuring all

agencies have a clear procedure for escalation with all staff being clear who the Named and Designated managers/senior professionals are to whom they refer.

Leadership and sustainability

- 7.12 The impressive leadership, effectiveness and good practice shown by Chief Officers and other Leaders in the “Task and Finish Group” in working together and affecting positive changes in their own organisations and collectively needs to be filtered down through their respective organisations. To this end a continuation of the multi-agency pan-Bedfordshire sub groups of the two safeguarding boards, which have been successful and a good example of partnership working, is desirable. Filtering down needs to be led from the top with clear messages and expectations communicated regards cooperation, joint working and problem solving. A culture of working together at all levels, be it senior management, middle management, first line management or operational should be fostered, developed and expected. In learning from ‘Leadership’ it would be advisable to put in place a formal arrangement, say a forum, for both Local authorities, the L & D Hospital and NHS Luton to meet regularly at middle management level (with relevant other expertise input) with specific reference to safeguarding and the learning from safeguarding investigations. This would include the examination of the outcomes of investigations to identify themes, trends and patterns; to hold individual agencies to account for any outstanding actions; for NHS Luton to provide an overview of areas they wish to focus on from a quality monitoring perspective. This would require senior enough representation to take issues forward and should be practice focussed and a practical working group.
- 7.13 Equally, in the same ‘filtering down the organisations’ theme, it would be beneficial to arrange a less formal forum to provide the opportunity for NHS Luton front line staff and social work teams to link closely regarding the assessment of risk on a case by case basis and to use the forum as an opportunity to discuss case issues. This may reduce the numbers of cases escalated unnecessarily to Senior Management.

Review of social work arrangements in Luton and Dunstable Hospital

- 7.14 In referring to the need to learn lessons from confusion in the hospital over alerts and the complexity of working with two Councils the author believes it is necessary to review these arrangements. Coordination between the two local authority social work teams and facilitating a simpler, clearer arrangement in the hospital for hospital staff is critical. Ideally this could be achieved through a joint team or co-location or as a minimum the respective team managers meeting regularly to share issues and review processes so as to provide assurance that understanding and ways of working are consistent. This will be an

issue that needs to be resolved together with the L & D Hospital as the author understands that the logistics of location of social work teams and lack of sufficient rooms/space in the hospital is a constraint to adhering to tight safeguarding timescales.

8. RECOMMENDATIONS

- 8.1 Luton and Dunstable Hospital NHS Foundation Trust should ensure it maintains and sustains its current commitment to closely performance manage and monitor safeguarding adults arrangements and continues to drive service improvement in this area.
- 8.2 Luton and Dunstable Hospital NHS Foundation Trust should continue to assure itself that Human Resource policies, procedures and best practice are being adhered to, ensuring regular monitoring and performance management, including at ward level. The introduction of practice audits, sometimes unannounced, should be considered to ensure compliance.
- 8.3 Whilst it is appreciated that always having two members of staff assisting vulnerable adults in personal care tasks is impractical, it is strongly recommended that Luton and Dunstable Hospital NHS Foundation Trust introduce measures that can check that vulnerable patients are safeguarded. In this regard it would be advisable to closely monitor and ensure that staff safety briefs at the beginning of all shifts always identify and consider the needs of vulnerable individuals. Regular practice audits should be considered to ensure compliance. Performance and monitoring information in this regard should be reported periodically to the two Adult Safeguarding Boards of Luton and Bedford and Central Bedfordshire.
- 8.4 NHS Luton (and it's successor, Luton Clinical Commissioning Group) and Luton and Dunstable Hospital NHS Foundation Trust should implement any positive recommendations that arise out of the Independent Review that was recently commissioned to focus on the 'relationship' between the two organisations.
- 8.5 All agencies should check and ensure they have clear and agreed escalation procedures with Named and Designated managers/professionals to whom staff can refer.
- 8.6 Positive Leadership should continue. To this end it is recommended that:
 - a) The multi-agency pan-Bedfordshire sub groups of the two safeguarding boards continue to meet to resolve pan-Bedfordshire issues.
 - b) A forum for relevant middle managers and professionals from Central Bedfordshire Council, Luton Borough Council, NHS

Luton (and successor organisations Luton and Bedfordshire Clinical Commissioning Groups, in the future) and Luton and Dunstable Hospital NHS Foundation Trust be created to meet regularly. This forum should focus on learning from safeguarding investigations and seek to identify themes, trends and patterns whilst holding partner agencies to account for outstanding safeguarding actions.

- c) A less formal arrangement be put in place when front line staff of NHS Luton and the Luton Borough Council and Central Bedfordshire Council social work teams meet to discuss individual case issues together.

8.7 Luton and Bedford and Central Bedfordshire Adult Safeguarding Boards, with representation at Senior most levels of participating organisations, need to establish an assurance and performance information framework that enables and monitors the sustainability and embedding of the positive changes to practice/systems/processes that have been introduced by Luton and Dunstable Hospital NHS Foundation Trust, Luton Borough Council and Central Bedfordshire Council. A 'whole system' approach to this should be adopted.

8.8 Luton and Bedford and Central Bedfordshire Adult Safeguarding Boards, with representation at Senior most levels of participating organisations, should continuously assure themselves that all partner agencies' staff are appropriately trained and kept up to date regards adult safeguarding procedures, processes and practice guidance. Practice audits should be undertaken to assess the level of compliance with the guidance.

8.9 Luton and Bedford and Central Bedfordshire Adult Safeguarding Boards, with representation at Senior most levels of participating organisations, should ensure they develop a strategic vision for cross border arrangements relating to safeguarding adults arrangements.

8.10 a) Luton Borough Council and Central Bedfordshire Council primarily, but with the involvement of NHS Luton and Luton and Dunstable Hospital NHS Foundation Trust, need to finally resolve the 'alert' and 'risk assessment' for clinical cases arrangements.

- b) The author strongly recommends that the two Adult Safeguarding Boards of Luton and Bedford and Central Bedfordshire should follow the Association of Directors of Adult Social Services (ADASS) protocol.

- c) In that context Luton Borough Council and Central Bedfordshire Council should seek learning and guidance from other authorities in the Country that have, in similar circumstances, adopted the ADASS protocol and guidance successfully. The two Adult Safeguarding

Boards should hold the respective agencies to account for resolving this matter.

- 8.11 Luton Borough Council and Central Bedfordshire Council should jointly review their current separate social work team arrangements in Luton and Dunstable Hospital with a view to creating ideally a joint team and/or colocation or as a minimum formalising regular team managers' meetings. The Luton and Dunstable Hospital NHS Foundation Trust would need to be engaged in this process.
 - 8.12 Consideration should be given to the way in which the findings, lessons to be learned and recommendations of this review are to be communicated and shared with those surviving victims and their relatives and the relatives of the late alleged perpetrator who wish to have sight of the report.
 - 8.13 The Joint Adult Safeguarding Board Sub Group should prepare to take account of any lessons and recommendations, for the NHS locally and emerging Clinical Commissioning Groups, arising out of the National independent Department of Health inquiry into Stoke Mandeville, Leeds General Infirmary, West London Mental Health Trust and Broadmoor Hospital.
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