Clive Safeguarding Adults Review

7 Point Briefing

01 Background

This is a discretionary safeguarding adult review (section 44(4) Care Act 2014 conducted jointly by Staffordshire and Stoke Safeguarding Adults Board and Cheshire East Safeguarding Adults Board. It was commissioned in response to two recommendations made in an NHS England – Midlands independent review relating to the care and support given to Clive Treacey.

One recommendation concerned whether Clive and other residents at a residential centre in Cheshire East had been appropriately safeguarded from sexual abuse by a person in a position of trust, and whether there had been trauma-aware practice subsequently to support Clive.

The second recommendation concerned the responses by Staffordshire County Council, the local authority responsible for Clive, and by other services to complaints from Clive's family about the quality of care and support provided.

02 Achieving Best Evidence

Allegations that Clive had been sexually abused first emerged in 1993. Clive was removed from the residential centre but loss of records from that time has made it difficult to establish the quality of police and safeguarding inquiries. However, there is no evidence that the allegations were put to the staff member who continued to work at the residential centre.

Subsequent opportunities to revisit the allegations occurred in 1999, 2011 and 2015. Whilst recognising how law relating to adult safeguarding has evolved, it does not appear that the allegations were put to the person who had been in a position of trust. There were missed opportunities to achieve best evidence, to follow through on agreed safeguarding and investigation plans.

03 PIPOT

The review has highlighted the importance of staff across services following agreed procedures in response to allegations of abuse or neglect by people in positions of trust. A review of the historic evidence found that there were also missed opportunities to refer and then to investigate adult safeguarding concerns. All staff should ensure that they are aware of, and follow procedures in relation adult safeguarding concerns, particularly where there are allegations regarding a person in a position of trust.

04 Collaboration

There were shortcomings in the exchange of information between placement commissioners and providers, such that some staff were unaware of the allegations that Clive had been sexually abused. As a result, the trauma that Clive had experienced was often not recognised and there were only limited occasions when Clive was offered therapeutic support to work through the impact of abuse. There were shortcomings in clarifying the roles of responsibilities of the services involved, for example the two police forces, and placing and host authorities. Roles and responsibilities must be clear in order to achieve best evidence. Statutory guidance outlines the requirements to be followed by placing and host commissioners, with particular reference to out of authority placements

05 Complaints

Complaints from families are information to be taken seriously. There are legal rules to be followed when complaints are received about the quality of care. When complaints about care quality are suggestive of provider concerns and also of adult safeguarding concerns, how these separate processes interlink must be clear for practitioners, managers, Investigations must ensure sufficient independence to provide assurance about the degree of scrutiny involved. This review is one in a lengthening list of reports that focus on abuse/neglect in institutional settings and closed environments.

06 Accountability

The purpose of a safeguarding adult review is to learn lessons in order to promote practice improvement and service development. Lost records of historical events, dating back to 1993, complicated the search to understand what had happened and to reflect on whether Clive, and other residents at a centre, had been protected, and whether Clive had received appropriate care and support. Recording and record retention are important for accountability and for making meaningful a person's right to private and family life. Those involved in this review have recognised the work still to be done to embed making safeguarding personal and to ensure a "think family" approach that values the information family members can provide, values the support they provide and responds candidly to the concerns they express.

07 Recommendations

The review includes recommendations for the development of national guidance on responding to concerns about People in positions of trust, and strengthening guidance on investigations. Qualifying and continuing professional development should contain opportunities to develop skills in achieving best evidence.

It recommends that roles of placing and host commissioners should be included in primary legislation, and that audits should be completed locally of how current responsibilities are reflected in practice.

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

Abuse must stop

STOP ADULT ABUSE

everyone's business

Cheshire East Safeguarding Adults Board