A Safeguarding Adult Review commissioned to respond to two recommendations contained within an NHS England independent review concerned with the effectiveness of safeguarding responses to alleged sexual abuse and poor quality care.

Clive

A Safeguarding Adults Review for Staffordshire and Stoke Safeguarding Adults Board and Cheshire East Safeguarding Adults Board (March 2024)

Professor Michael Preston-Shoot

Contents

Section One: Introduction 2

Section Two: Findings and Analysis in Response to Recommendation 8 6

Section Three: Findings and Analysis in Response to Recommendation 7 30

Section Four: Safeguarding Assurance in 2023 42

Section Five: Conclusion 57

Section One: Introduction

1.1. In 2022 NHS England and Improvement – Midlands published an independent review into the circumstances surrounding the death of Clive Treacey and his experiences as a child and young adult when living in care settings. The review provides a pen portrait of Clive, his skills, interests, achievements and ambitions. It covers areas where good practice was found in education, care provision and specialist epilepsy care. It found shortcomings across several practice and policy areas, including adult safeguarding. The report is essential reading for everyone involved in seeking to transform education, health, safeguarding and care and support outcomes for children, young people and adults who receive services as a result of learning disabilities. It is referenced in the Whorlton Hall Safeguarding Adults Review published by Durham Safeguarding Adults Partnership (2023).

1.2. The pen portrait of Clive in the NHS England (Midlands) independent review, and a similar portrait of Clive prepared by his sister for publication alongside this safeguarding adult review remind us that in essence this is a human story. The portraits provide excellent insights into Clive, the person. It is another human story that should inspire practitioners, managers, safeguarding adults boards, regulatory bodies and policy makers to aim for transformative change to prevent and safeguard adults from abuse by people in positions of trust, and to provide services that promote wellbeing.

1.3. In relation to safeguarding the independent review made two core recommendations, as follows:

1.3.1. Recommendation 8 specified four time zones when abuse was disclosed and/or concerns were raised, namely 1993, 1999, 2011 and 2015. It recommended that the legal framework and procedures in place at the relevant time points be explored to determine the adequacy of investigations, outcomes and actions, including consideration of risk to others. The evidence that led to this recommendation also recorded the impact of trauma and observed the absence of trauma-informed practice.

1.3.2. Recommendation 7 was addressed to local authorities and CCGs (now ICBs). It recommended that adult safeguarding processes be reviewed to ensure that they are robust and in line with national guidance.

1.4. In response, Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards have jointly commissioned this discretionary safeguarding adults review, the statutory mandate for which resides in section 44(4) Care Act 2014. This section provides that a Safeguarding Adults Board may commission a review in any case involving an adult with needs for care and support where the mandatory criteria in sections 44 (1) (2) (3) are not fully met.

1.5. This safeguarding adult review adopts a proportionate approach so as not to duplicate the review activity and report completed by NHS England and Improvement. Accordingly, the two Safeguarding Adults Boards jointly established a panel of senior representatives of the main agencies involved to oversee the safeguarding adult review. The panel was independently chaired. The author of this safeguarding adult review reported to the panel, which agreed the following methodology with Clive's family.

1.5.1. For each of the four time zones identified in recommendation 8 of the independent review, the services and agencies involved at the time would be asked for full disclosure of the records they hold, including copies of adult safeguarding policies and procedures. Judged by the standards pertaining at the time, each service and agency would also be asked to reflect on their responses to the safeguarding concerns.

1.5.2. Clive's family would also be asked for any documents they hold that the family considers relevant to each of these four time zones. NHS England and Improvement would also be asked for any information that pertains to this recommendation that is not contained within the report of the independent review.

1.5.3. The legal rules in place at the time of each time zone, and the local adult safeguarding policies and procedures, would be presented against which the adequacy of investigations, outcomes and actions could be compared.

1.5.4. The independent review acknowledged that the legal rules have developed over time. Moreover, each Safeguarding Adults Board has a statutory mandate, derived from section 43 Care Act 2014 and accompanying statutory guidance, to seek assurance about the effectiveness of adult safeguarding procedures and practice now.

1.5.5. Accordingly, this safeguarding adult review will also consider the evidence for what happens now when allegations of sexual abuse are disclosed, reported and responded to; in other words the effectiveness of safeguarding responses. This aspect of the review will be pursued through a learning event involving practitioners, operational managers and strategic leaders, and available audit outcomes. It will include a focus on the evidence of trauma-aware and trauma-informed practice.

1.5.6. For each of the four time zones, the services and agencies to which the requests for information and reflective analysis will be directed are: placement commissioner, placement provider, CCG/ICB on behalf of predecessor organisations covering the areas of the placing commissioner and location of the provider, local authority where the provider is located, local authority for the placing commissioner, Care Quality Commission, and police service.

1.5.7. In relation to recommendation 7, the services involved with Clive and his family would be asked to provide documentary evidence relating to safeguarding complaints submitted by Clive and his family, and safeguarding alerts.

1.5.8. Clive's family would also be asked for any documents they hold relating to safeguarding complaints they submitted and responses received, and any safeguarding alerts they referred and responses to them. NHS England and Improvement would also be asked for any information that pertains to this recommendation that is not contained within the report of the independent review.

1.5.9. Judged by the standards pertaining at the time, each service and agency will also be asked to reflect on their responses to the safeguarding complaints and concerns. Once again, the legal rules relating to complaints procedures and safeguarding alerts have developed over the years. Accordingly, at a learning event, the safeguarding adults review will consider the effectiveness of responses now to safeguarding complaints and concerns that are referred.

1.5.10. The services and agencies to which the requests for information and reflective analysis will be directed are: placement commissioner, placement provider, CCG/ICB on behalf of predecessor organisations covering the areas of the placing commissioner and location of the provider, local authority where the provider is located, local authority for the placing commissioner, Care Quality Commission, and police service.

1.6. Clive's family have commented on the terms of reference and the methodology for this safeguarding adult review. Thereafter, they have shared their observations about the

safeguarding response at different points in Clive's life, and about the adequacy of responses to complaints and safeguarding alerts. They have shared documentary records that they hold. Finally, they have commented on the report for this safeguarding adult review whilst it was still in draft form.

1.7. In respect of recommendation 7, local authorities and ICBs involved throughout Clive's contact with services as an adult were asked to respond explicitly to the following questions:

1.6.1. What records do you have of safeguarding concerns raised by Clive's family?
1.6.2. What records do you have of safeguarding concerns raised by professionals?
1.6.3. How did your organisation respond to these safeguarding concerns?
1.6.4. What records do you have of safeguarding complaints raised by Clive's family and how did your organisation respond?
1.6.5. What records do you have of any escalations of concern raised by professionals and how did your organisation respond?
1.6.6. What evidence of assurance do you have that adult safeguarding practice complies with national guidance?
1.6.7. What evidence of assurance do you have that decision-making regarding referred adult safeguarding concerns, and the practice of adult safeguarding enquiries are robust?

1.7. In relation to recommendation 8, the following questions were asked of Cheshire East Council and Staffordshire County Council, and also of Cheshire Police:

1.7.1. What records do you hold of notification around 1993 of allegations of sexual abuse, and of your organisation's response to those allegations with respect to Clive and to others who might have also been at risk?

1.8. In respect of recommendation 8, the following questions were asked of Cheshire East Council and Staffordshire County Council, and also of Cheshire Police and Staffordshire Police:

1.8.1. What records do you hold of notification around 1998 and 1999 that the alleged perpetrator of sexual abuse in 1993 had renewed contact with Clive?
1.8.2. How did your organisation respond with respect to safeguarding Clive and others who might also have been at risk?

1.9. The independent review also highlighted occasions in 2011 and again in 2015 when Clive disclosed information pertaining to the historic allegations of sexual abuse. The following questions were asked of all the agencies and services involved with Clive at this time:
1.9.1. What records do you hold relating to Clive's disclosure of historic sexual abuse?
1.9.2. How did your organisation respond with respect to safeguarding Clive and others who might also have been at risk?

1.10. It was also relevant to ask what further investigations had been completed since the independent review was commissioned and since its publication. All the services and organisations involved were asked to confirm what investigations or enquiries they have conducted since 2015 and what their outcome has been. The review will cover the most recent investigative review led by Cheshire Police in 2021/22 to ensure that recent practice as well as the historical matters are included.

1.11. This approach was agreed by the review panel at its meeting on 17th February 2023. The initial information requested from the various services and agencies involved was received by the author at the beginning of May. The following agencies submitted information:

1.11.1. Cheshire East Council
1.11.2. Cheshire Police
1.11.3. David Lewis Centre
1.11.4. Midlands Partnership NHS Foundation Trust
1.11.5. St Andrew's Healthcare
1.11.6. Staffordshire Police
1.11.7. Staffordshire and Stoke ICB
1.11.8. Staffordshire County Council.

1.12. Additional information was requested and obtained from the following agencies at the beginning of August 2023, namely:

1.12.1. Surrey Police
1.12.2. Nottinghamshire Police
1.12.3. Northamptonshire County Council
1.12.4. Lingfield Hospital School
1.12.5. Richmond Mews

1.13. A learning event was held on 12th September 2023 in order to further identify and explore learning about the safeguarding response in relation to Clive and others in the settings where he was living but also to inquire into the enablers and barriers for effective safeguarding of individuals who are currently residing and receiving services in care settings.

1.14. The review panel endorsed the report on 17th October 2023. Staffordshire and Stoke Safeguarding Adults Board and Cheshire East Safeguarding Adults Board received the report at a joint meeting on 28th November 2023. Following consultation with Clive's sister, final revisions were made to the report in February 2024.

Section Two: Findings and Analysis in Response to Recommendation 8

2.1. Each of the time points highlighted in the independent review will be addressed in turn, concluding with a forward focus that reflects on the position now. Each of the time points follows the same structure, namely:

2.1.1. A narrative of events taken from a detailed timeline[1] that had been prepared to support the production of the independent review, integrated with published material in the safeguarding section of the independent review;
2.1.2. The reflective commentary included in the detailed timeline prepared for the independent review alongside the details in the section on safeguarding in that independent review;
2.1.3. A statement of law, policy/statutory guidance and practice guidance setting out expectations for practice at the time;
2.1.4. The factual information provided by the agencies involved for this safeguarding adult review;
2.1.5. Findings of this safeguarding adult review regarding the practice and management of practice.

2.2. As the independent review acknowledged, legislation has evolved over time. For that reason, and in line with the mandate given to Safeguarding Adults Boards to seek assurance about the effectiveness of adult safeguarding, the present and forward focus is important. This will be covered in section four and will consider whether, if similar events were to transpire now, individuals like Clive would be protected and their wellbeing enhanced. Recommendations, where appropriate, will be offered in the name of building on the transformation of care.

Recommendation 8: Episode 1993

Narrative

2.3. During a visit around December 1992 Clive asked his sister to process a roll of film. He was a keen photographer and would often ask his family to process photos. The processed photos revealed indecent images that were thought to have been taken of Clive by another individual. The photos were reported to the police who interviewed Clive[2]. The family reported that the process was overwhelming for him and he was unable to provide a statement at the time. The family shared that Clive went into shock and shutdown as he often would if things hurt him.

2.4. Reports from the family and subsequent records indicate that Clive was the victim of grooming and sexual abuse by a care worker at the David Lewis Centre, who was considered a trusted member of staff. Clive considered the member of staff a friend and struggled to come to terms with it as abuse; he felt that the member of staff loved him. The family shared that Clive's records were found at the carer's home for which he was arrested and charged with theft, but

[1] The detailed timeline was not published by NHS England – Midlands as part of their independent reviewer. The timeline is a detailed table that recorded sources of evidence, a summary and the sequence of events. NHS England – Midlands helpfully provided this detailed timeline in order to assist this safeguarding adult review. This is gratefully acknowledged.
[2] This SAR has been advised that Cheshire Police believe that it was Staffordshire Police to whom the report was sent.

the police could not pursue any action as there was insufficient evidence. They agreed to keep the file open should Clive ever wish to make a statement[3].

2.5. The family explained that they were kept informed but were excluded from the internal investigation and it is unclear what action, if any, was taken following the investigation by the provider and commissioning organisations to safeguard Clive and others.

2.6. Clive was subsequently assessed to be moved. Clive's family describe these events as having a significant impact on his mental health. They sought to help him through this experience, which was very difficult. The family report that neither Clive nor the family received any emotional or therapeutic support from services at the time. The family witnessed a dramatic change in his behaviour following this trauma and feel that it continued to affect him throughout his life. Clive was moved on a safeguarding order in March 1993 aged 23.

Independent review commentary

2.7. Safeguarding- protection from harm: A review of records and information for this LeDeR review by Staffordshire Police confirms that "*Cheshire Police had received information that Clive was a victim of serious sexual offences whilst a resident at the David Lewis Centre*." The review therefore takes the view that that Clive was the victim of grooming and sexual abuse, from which services failed to protect him at the time from harm.

2.8. No further records have been made available to the review to determine how this serious issue was followed up by the provider, the police, those responsible for safeguarding and the responsible commissioning authority at the time. It is unknown if any action was taken to protect Clive or other residents from this individual or if any action was taken by the provider itself to put safeguards in place. However, it is known that subsequent providers and Clive's responsible authority, Staffordshire County Council, were unaware that a police investigation into sexual abuse had taken place which allowed the perpetrator to continue to reach Clive at subsequent placements up until 2002.

2.9. Lack of needs assessment and support arising from experience of abuse: Clive was swiftly moved on and the family share that there was no consideration given to the impact of these events on Clive and the emotional or therapeutic support he might need at that point in time. Nor was any significant assessment and support in relation to this specific trauma provided in years to come when providers became aware, despite Clive struggling with anxiety and challenging behaviours.

Law and Guidance in 1993

Adult safeguarding

2.10. In 1993 there was no specific legislation or national guidance on adult safeguarding or adult protection. Proposals from the Law Commission that the law should be expanded to include a

[3] In their contribution to this SAR Cheshire Police have advised that the staff member was indeed arrested for theft offences but was not charged with theft offences. Similarly, Cheshire Police have advised that any offence can be revisited pending further evidence. However, this specific offence of theft was not finalised or pending on the proviso that Clive made a complaint. The theft allegation and decision was regardless of Clive making a complaint.

duty to investigate significant harm were not adopted by government. Duties towards disabled people were contained within the Chronically Sick and Disabled Persons Act 1970 and the Disabled Persons Act 1986 but neither contained provisions relating to adult safeguarding or protection. The High Court's inherent jurisdiction and the Court of Protection were potentially available on application for protection orders of "vulnerable people."

Residential care

2.11. Section 21 National Assistance Act 1948 required local authorities to provide residential accommodation to those who because of disability needed care and attention that would otherwise not be available to them. Policy guidance[4] that elaborated on duties within the NHS and Community Care Act 1990 required that care plans should specify responsibility for monitoring and review of placements, and that reviews should be fully recorded. After initial placement reviews, thereafter annual needs-led reviews were required by law. Judicial reviews at the time sometimes found local authorities at fault for failing to conduct regular reviews or to provide written plans[5].

2.12. Two further local authority circulars[6], or policy guidance, clarified where responsibility lay between local authorities. The authority where an individual had been placed was required to meet a person's urgent needs. When an individual was placed in another local authority's area, the placing authority retained responsibility for the placement but could request provision by the host authority of support services.

Regulation and inspection

2.13. Registration was initially legislated for in the Registered Homes Act 1984. The Act required providers to notify the registration authority within 24 hours of any event which affected the wellbeing of any resident. Section 48 NHS and Community Care Act 1990 required local authorities to establish arms-length inspection units, independent of normal local authority management structures and directly accountable to the Director of Social Services. Their purpose was to inspect standards, to evaluate the quality of care provided and the quality of service users' life experiences. Policy guidance required an annual report to councillors[7].

Disclosure of convictions

2.14. The Registered Care Homes (Amendment) Regulations 1991 required applicants for registration to disclose criminal convictions and police checks to be completed.

Offences

2.15. The Sexual Offences Act 1956 made it an offence to have sexual intercourse with a person knowing them to be "*of arrested or incomplete development of mind, which includes severe*

---

[4] Department of Health (1990) Community Care in the Next Decade and Beyond. Policy guidance or statutory guidance is issued under section 7 Local Authority Social Services Act 1970 and must be adhered to unless exceptional reasons justify departure from its requirements.
[5] Braye, S. and Preston-Shoot, M. (1992) Practising Social Work Law. Basingstoke: Macmillan.
[6] LAC (93) 7 and LAC (93) 10.
[7] LAC (94) 16.

impairment of intelligence and social functioning." It would have been important, therefore, to have determined the degree of severity of mental disability.

2.16. The Sexual Offences Act 1967 legalised homosexual acts if they were consensual and between men over the age of 21.

2.17. Section 127 Mental Health Act 1983 included an offence to ill-treat a mentally disordered patient who was in custody or care.

2.18. The Offences against the Person Act 1861 included offences of assault, assault occasioning actual bodily harm and grievous bodily harm.

Investigations

2.19. Learning disabled adults were entitled to be accompanied by an Appropriate Adult when being interviewed by the police[8]. Although parents could act as Appropriate Adult, they might not know what the role involves and requires. Social Workers were therefore considered more appropriate for the role and responsibility.

2.20. The Crown Prosecution Service (CPS) was established in 1986. Police investigations were required to consider whether a particular case met the two thresholds of evidential and public interest tests. In effect this is a decision-making threshold to decide whether or not the case should be forwarded by police to the CPS. Where the evidential test was not met, the CPS were expected to support police to action plan what further enquiries needed to be conducted to gather that additional evidence for the CPS to be able to make a 'charging decision'.

Information Submitted from Agencies

2.21. Cheshire East Council has stated that it holds no records in relation to the 1993 allegations of sexual abuse. The Council has also stated that it was unable to respond at the time as it was unaware of the allegations.

2.22. There are no surviving Cheshire Police records or documents held that refer to 1993 reporting concerns or crimes to Cheshire Police. There is no surviving evidence that Cheshire Police were made aware by Clive's family, David Lewis Centre, Staffordshire Council or Staffordshire Police in regards to 1993 concerns.

2.23. The David Lewis Centre searched its archived records and has reported the following. "*There is no safeguarding policy that can be found within archived records from the time Clive spent at David Lewis. This was pre Care Act and although there was likely 'protection' procedures in place there is no evidence of this. Within the archived records found there is no record of any safeguarding concern being raised. It is evident from records viewed that during the period of time that Clive spent at David Lewis there is no reference to a safeguarding concern, allegation or referral being made.*"

[8] Police and Criminal Evidence Act 1984.

2.24. Staffordshire Police have reported that they hold no records containing notification in 1993 of allegations of sexual abuse.

2.25. Staffordshire County Council has reported as follows. "*Paper file records dated prior to 2006 have been destroyed, we have been unable to identify any records saved to our electronic records system from 1993.*"

Commentary

2.26. The lack of contemporaneous documents from 1993 renders it very difficult to comment on the adequacy or otherwise of the steps taken to protect Clive and other residents at the David Lewis Centre at the time. As the Centre commented in its submission for this SAR, "*From the limited records available from Clive's time at David Lewis 1989-1993 it is difficult to establish what the process was and what should have happened without speculation*." However, it would be reasonable to expect employers at that time to have had human resources systems in place to investigate concerns and to protect service users whilst these investigations were underway.

2.27. Cheshire Police moved to computerised records in 1999. This allowed for "*digital recording and logging crimes*." The loss of records means that it is impossible to ascertain if and how Clive was interviewed regarding concerns about sexual abuse, and if the alleged perpetrator was interviewed. Systems that allowed for immediate access by one police force to information held by another police force were not well developed at the time. Staffordshire County Council paper file records prior to 2006 have been destroyed and electronic records do not contain any saved information from 1993 regarding Clive. Nonetheless, expectations were clear about how potential (sexual) crimes were to be investigated and how the CPS was to be involved in decision-making.

2.28. There was insufficient recognition in 1993 in law of adult safeguarding and systems were not well developed for information-sharing between placing commissioners and host local authorities. There was no national system for the vetting of staff with unsupervised contact with "*vulnerable adults*" or for the inspection and quality assurance of services. There was no national system for reporting individuals who might be unfit to work with "*vulnerable adults*."

2.29. Reference in the independent review to Clive having been removed from placement at the David Lewis Centre on a "*safeguarding order*" is puzzling. Clive's family have confirmed that no-one at the time, or subsequently, held a power of attorney and no application was made to the Court of Protection or High Court.

2.30. It does appear that the alleged perpetrator continued to work at the David Lewis Centre, probably until 1999. There is no record of the concerns having been put to him. It has been suggested during the collation of information for this SAR that he held an administrative position although the independent review refers to him as a care worker[9]. Whilst Clive had been moved following the concerns raised, it is impossible to confirm whether risk to other residents had been considered. It seems probable that no action was taken to protect other service users at the David Lewis Centre at the time.

---

[9] Given this discrepancy, this SAR will refer to a staff member unless recording verbatim what has been published in the independent review.

Recommendation 8: Episode 1999

Narrative

2.31. On a day when Clive was taken into hospital for surgery, the family arrived to find the carer accused of having abused Clive at the David Lewis Centre in his room. Unknown to the family this individual had been visiting Clive at this and prior care settings, presenting himself as a friend. The family notified the Police at the time but were informed that no action could be taken if Clive was unwilling to make a statement. The family were shocked and deeply concerned that the suspected perpetrator had been allowed access by providers to see Clive for such a long time unknown to them. A complaint was raised with Lichfield Council[10] and the family sought to access council records to establish what action had been taken to protect Clive and others following the initial safeguarding and police investigation. The family report being denied access to these records.

2.32. The care worker had now established a relationship over many years with Clive and the family were left struggling to protect Clive from an individual they recognised to be abusing him at the same time as managing his wishes to see a man that he considered to be his friend.

2.33. In July 1998, Clive required a laparotomy to assess and repair damage to his bladder and bowel. He recovered from the operation and was given some help to adopt safer sex practices. The family firmly believed that his behaviour was connected to the suspected inappropriate sexual relationship that Clive continued to have with the care worker.

2.34. The notes of a meeting held at Lichfield Police Station in July 1998 document that the concerns were followed up by Lichfield Social Services and Lichfield Police[11] as a safeguarding issue. Enquiries were made with Clive, his family, Cheshire Police, his prior care provider, current placement provider and local social services. It was confirmed that his current placement provider had raised concerns to social care about the individual visiting Clive, "*but as Clive was an adult and welcomed these visits from [name withheld], his privacy had been respected*."

2.35. Clive was referred to a sexual assessment clinic and offered a short series of psycho-sexual assessment sessions. The community nurse supporting Clive raised concerns about the relationship and reported that Clive had very limited sexual knowledge.

2.36. The enquiries culminated in a case discussion on 23rd February 1999 to "*consider if further police enquiries/investigations were necessary regarding Clive's relationship with a member of staff at the David Lewis Centre*." The case discussion notes indicate that professionals were unclear whether the relationship was consensual. The notes also record concerns gleaned from conversations with Clive about the inappropriate and potentially sexual nature of the relationship, noting that another man was involved and that the care worker gave Clive money. There was concern that the suspected perpetrator was previously Clive's care worker and might continue to be in positions of power putting others at risk. The meeting concluded unanimously

[10] This SAR has been advised that for accuracy it should have been stated that this was with Staffordshire County Council adult services based in Lichfield.
[11] For accuracy, this SAR has been informed that this should read Staffordshire Police.

that Staffordshire police should make further enquiries with Cheshire police, but there are no further records to establish what action followed, if any. Family believe that this incident of abuse changed the course of Clive's life. There does not appear to have been any concerned curiosity or scrutiny about the additional man who accompanied the alleged perpetrator on some visits to Clive. The family recognised him to have been another resident at the David Lewis Centre. This does seem to have been omission in respect of ensuring the safety of other residents at the Centre.

Independent review commentary

2.37. Safeguarding: The records and information by today's standards suggest quite strongly that Clive was the victim of grooming and sexual abuse. The response from services to these events raise serious issues on a number of levels:

- Protection from harm for Clive: No records of the safeguarding and police investigations that took place in 1993 followed Clive. Social services and subsequent providers responsible for overseeing Clive's care were unaware of the history of suspected abuse in [the] David Lewis Centre and there appears to be no action taken to safeguard Clive or others in the years that followed. This raises questions about the urgency and robustness of police and safeguarding processes at the time to protect Clive and others from harm.
- Clarity about vulnerability and consent: Although the perpetrator was known to be a care worker in a position of power and concerns were raised, there was confusion and lack of clarity about whether this was a consensual relationship. No action was taken on a number of occasions when concerns were raised to ascertain capacity and it was assumed to be consensual.
- Therapeutic support: As part of the enquiry in 1999 there were some "*psycho-sexual assessment sessions*", and conversations held with Clive, but beyond this there was no formal assessment or emotional support offered to Clive to help him understand and address the impact of these events in the years that followed. The family were also not offered any support to manage what appears to be a case of grooming over many years.
- Future care planning: Although records suggest that some providers did become aware of the history of sexual abuse information, it was not communicated formally as part of the admission process. For example there is no reference to it in the specific section on previous trauma of the St Andrew's pre-admission report. Overall, there is no clear indication that future care plans specifically recognised the impact of such a trauma and the support he might need.
- Sexual education and support: It was not until 1999, when referred to a sexual assessment clinic, that Clive first received any education around sexual awareness. The input was brief and the clinic confirmed his understanding was extremely limited. The specific incident requiring bowel surgery goes on to be well documented in Clive's records with varying interpretation of the underlying issues. In some cases, it is recorded as self-harm and a risk, in others it's seen as an expression of Clive's sexual desires. Later care records indicate that he struggled to understand his feelings and referred to himself as "*having a sex problem*." Although there is reference to these issues on an ongoing basis throughout Clive's records, an attempt to comprehensively understand Clive's sexual behaviours in the context of the abuse and put in place support is missing.

Law and Guidance in 1999

2.38. The legal rules and policy guidance relating to adult safeguarding/protection, sexual offences, inspection of care settings, vetting of staff, and the provision of residential care had not changed

from that outlined above for 1993. There also remained an absence of primary legislation relating to mental capacity, with concerns about whether a person had the capacity to consent to sexual relationships having to be referred to the courts. Access to health and to social care records had been introduced between 1987 and 1991. The Data Protection Act 1998 outlined rights of access to personal data, its rectification and erasure. It also outlined circumstances when access could be restricted, including if likely to cause serious harm to the individual or another person, if held for the purposes of detection and prosecution of a crime, or if it would prejudice the performance of health and/or social care functions.

Information submitted from agencies

2.39. Cheshire East Council and the David Lewis Centre hold no records that relate to events in 1998 and 1999.

2.40. Cheshire Police have confirmed holding some records relating to the theft of documents by the staff member. "*There are no specific details, records or discussions as to how and who alerted Cheshire Police to the offence of theft of medical records by [name withheld]. This is common practice in this date period for a crime to be investigated, arrested and finalised without rationale surrounding it … There are no records around concerns of sexual offences by [name withheld] towards Clive and no reference to disclosures made by Clive in 1999. In fact, Cheshire Police during this investigation specifically requested Staffordshire Police re-visit Clive for the sole purpose of gaining disclosure of a sexual nature, Clive denied any abuse by [the staff member]. There is reference to [the staff member] being asked on Interview if he had a sexual relationship with Clive, which he denied. [The staff member] was not arrested for any sexual offences*."

2.41. Information supplied by Cheshire Police includes a summary of an interview with an executive at the David Lewis Centre who confirmed that the staff member had no right or authority to remove Clive's records. Outline details have been provided of the custody record (May 1999) and the sequence of decision-making (June 1999) that resulted in no further action. By this time the staff member had resigned from his post. Cheshire Police sent a letter to another executive at the David Lewis Centre that outlined the reasons for the decision not to recommend prosecution. Namely: "*(1) The David Lewis System for booking out material was flawed and allowed unauthorised persons to obtain documents and then have unaccounted possession of them for 2 years before being detected (believed to be under review). (2) [The staff member] stated he acquired the notes openly and had every intention of returning them, both of these issues would undermine the prosecution case should it be brought before the court. (3) There is no evidence that the relationship between [staff member] and Clive was improper*."

2.42. Cheshire Police have also provided information regarding safeguarding of Clive and other residents, namely: "*The documents covering 1999 do not make specific reference to safeguarding as a heading. However, at the time of the 1999 investigation a designated FPU (Family Protection Unit) was already established and staffed by PIP2 detectives[12] and managed by a Detective Sergeant and Inspector trained in Safeguarding. Cheshire Police had identified and prioritised adult and child abuse during this timeframe and had committed time and resources into staffing the department*."

---

[12] PIP refers to Professional Investigators Programme. Level 1 comprises frontline officers and CID staff. Level 2 comprises more experienced CID offers and teams.

2.43. Cheshire Police have further commented that: "*It is also salient to point out that the FPU do not investigate theft crimes and therefore by taking on the 1999 investigation in the manner, urgency and detail that they did, clearly demonstrates the safeguarding priority. The investigation as detailed in the 'form 201' refers to multi agency and cross border information sharing and communication and makes reference to the David Lewis Centre having had no previous concerns or allegations against [the staff member]. The same form makes reference to Staffordshire Police updating Clive's family on the NFA decision through lack of evidence of any sexual offences, identifying Staffordshire Police as the lead agency for this investigation*."

2.44. Cheshire Police have concluded as follows. "*Despite the suspicion that Clive may have been a victim of sexual offences, there was no evidence in 1999 that a crime had occurred or that Clive was a victim of sexual offences. Cheshire Police records make no mention of possessing or knowing about any indecent photographs of Clive and at this point Clive has denied any improper or sexual relationship with [the staff member]. In 1999 Clive had made no disclosures of any kind that would have enabled Cheshire Police to justify an arrest or initiate any intrusive safeguarding investigations around other residents. Staffordshire Police held and retained documents and took primacy for the 1999 investigation, therefore safeguarding should have been discussed as a joint/cross border action.*"

2.45. In a follow-up submission Cheshire Police have stated that "*the decision not to prosecute this offence [of theft] was based on [the staff member's] intention not to permanently deprive DLC or Clive of the paperwork; this is recorded and [was] ratified by [a] Superintendent."* Cheshire Police have also commented on what would have been expected police practice in 1999. "*… expected practice in 1999 would have been to identify an offence, record sufficiently on a paper record an investigation by the relevant department and supervised by a person of the rank above. Expected practice would have been for the offender for theft to be arrested and interviewed. Any decision made regarding disposal would be documented and usually ratified by a detective Inspector. The expected practice would also have included notification to all relevant persons (victim, family, witnesses). Again, expected practice would have been for Cheshire Police to have held discussions with agencies to support the safeguarding of the victim and suspect. We are aware that this took place in Staffordshire, but Cheshire Police were not invited to attend.*"

2.46. In this case expected practice was followed except in three areas, namely: "*the NFA decision was ratified by a Superintendent. There is no documentary evidence as to why. Staffordshire were asked to notify the family of the outcome of the investigation; there is no documentary evidence why this was or that this was completed. Conclusions could be drawn this was because they were already in contact with the family and had developed a relationship with them. Cheshire Police were not invited to the strategy discussions for Clive. Of note: the Interview tapes are no longer available and there is no transcript of the interview.*"

2.47. Staffordshire Police have confirmed that no records, hard copy or digital, can be found as having been retained. Based on available records, it appears that Cheshire Police took primacy for the investigation regarding the staff member's possession of files relating to Clive. There appear to have been diverse impressions regarding whether or not Staffordshire Police had primacy for the investigation at this time of any sexual offences that might have been committed.

2.48. Staffordshire County Council have confirmed that paper records prior to 2006 have been destroyed. However, the Council does hold two electronic records and has disclosed the following. "*These refer to the incident of sexual abuse concerns towards Clive by [name withheld]. One of these documents is a report for a case discussion in February 1999 and attached is the record of a meeting held at Lichfield Police Station on 27th July 1998. This was a multi-agency meeting held with police, social care and health. It was raised here that there were concerns about the relationship Clive had with a person from the David Lewis Centre and the sexualised behaviours that Clive had been displaying recently. Clive has been receiving input from the Community Learning Disability Nurses around relationships and sexual behaviour. Further actions were identified as follows –*

- *Social Worker to visit Clive's mother to discuss the current situation and to try to find out more about Clive's friend.*
- *Police will make enquiries with Cheshire Police regarding this man.*
- *Social worker to make contact [with current placement provider] for a copy of Clive's notes*
- *It was agreed that, at this stage, information would be shared with police for possible wider/public issues as this may involve a member of staff.*"[13]

2.49. The Council's submission continues: "*The report details a timeline of events and has been completed ahead of a meeting to be held on the 23/02/1999. This highlight(s) concerns raised by family about the behaviour of the man from the David Lewis Centre– referred to as [initial withheld], and that they were aware that a meeting was being held but that they would not be involved in that discussion due to issues of confidentiality. The family are reported as being supportive of this meeting and for police looking further into the matter. The report states that Clive has had sessions with the nurses, and reports that [initial withheld] is his best friend and likes to see him. However, Clive also shows distress at some of the behaviours he has been displaying that are of a sexual behaviour. There are comments from the social worker recognising Clive's vulnerability but that he has a right to express himself. The report states the following – Chronology of events giving rise to concern for Clive's protection, within Staffordshire Social Services "Protection of Vulnerable Adults Policy*."

2.50. The second document is a record of the case conference held on 23rd February 1999. This was attended by a social worker, team manager, Staffordshire police from CID, community nurses, and GP. This was called following further concerns about Clive continuing to see the man from the David Lewis Centre. In this meeting the community nurses noted that there "*had been no concerns about Clive until he went to the David Lewis Centre*." Staffordshire police stated that they would speak to Cheshire Police and that they wanted to speak to this man. Logistics around this were discussed as was the potential impact on Clive. "*Community nurses and an advocate would support Clive as needed. Social Worker would keep family informed as to the actions that were to be taken. Follow up discussion between Police and the social worker was arranged for 5th March to see how this was progressing*."

---

[13] Midlands Partnership University NHS Foundation Trust, in a trawl through Clive's health records, have also located a report of this meeting. The report outlines that Clive had recently disclosed to the social worker he was *"in a relationship with someone from the David Lewis Centre."* He had spoken about the same *"friend"* to a Nurse Manager at Holly Lodge during a recent sexuality assessment. Recommendations from this meeting included for the social worker to *"visit Clive's mother to discuss the current situation and find out more about Clive's friend."* And for local Police to *"follow up with Cheshire Police"* about the person in question.

2.51. Midlands Partnership University NHS Foundation Trust have located an additional document in Clive's health records. Dated 23rd December 1999, it is a copy of a confidential report for a Vulnerable Adults Policy Case Discussion written by the same senior social worker as the report in July 1998. It contains a chronology of events (1998 – 1999) related to concerns about the nature of Clive's friendship/relationship with a gentleman referred to as "*[initial withheld]*". The report states that Clive's family were aware of this relationship, had significant concerns and had contacted social care. The report states the social worker had been discussing the situation with the police and that further meetings were planned. The report outlines that Clive had disclosed having a relationship with a member of staff from the David Lewis Centre. It also outlines that he had discussed his relationship with "*[initial withheld]*" during sex awareness sessions with a nurse and clinical psychologist in the community learning disability team.

Commentary

2.52. There is indication that in 1999 Staffordshire County Council had a Protection of Vulnerable Adults Policy as this is referred to in the minutes recorded. This would seem to suggest that at this time Staffordshire were considering best practice as determined by guidance from the Local Government Association and ADASS (Association of Directors of Adult Social Services). There is also indication that there was recognition of wider risks to others, and this was recorded in the minutes.

2.53. The minutes of the case discussion held on 23rd February 1999 do refer briefly to a meeting held on 27th July 1998, but details are sparse. The minutes record that neither Clive nor anyone else had made a clear allegation or complaint to the police, and questioned whether Clive was consenting to a sexual relationship. There is no record of any discussion as to whether Clive had the mental capacity to consent to such a relationship. The case discussion concluded that further enquiries needed to be made and there is, indeed, reference to the implications for other residents at the David Lewis Centre. However, no follow-up documentary evidence has been made available.

2.54. From the documentary evidence it is not possible to establish how much information relating to concerns and allegations in 1993 were known to practitioners and agencies investigating concerns expressed in 1999. Nor is it possible to establish precisely what allegations were explored with the staff member employed by the David Lewis Centre and how Clive was supported to raise any concerns himself. It is not possible to establish conclusively whether or not Clive was interviewed in 1998/1999 in relation to events in 1993. It does appear, however, that the staff member was not interviewed by police in 1999 explicitly regarding allegations of sexual abuse. This was a missed opportunity to investigate thoroughly what had happened to Clive, whether he was still at risk, and whether other adults had been abused and were still at risk.

2.55. The analysis of Clive's records, conducted helpfully by Midlands Partnership University NHS Foundation Trust, comments that, when reports were written in 1999, it appears that there was still ongoing contact between Clive and "*[the staff member]*". Records at the time concluded that *"Clive has not given any indication he wants contact with this person to end. In fact, he talks endearingly about this person being his 'best friend'. Clive has been given support, and will continue to be given support, to discuss anything he is unsure or troubled about. Clive has made*

no 'allegation' about this person, but this needs to be acknowledged within the context of his learning disability and subsequent vulnerability."

2.56. The submission by Midlands Partnership University NHS Foundation Trust observes further that it is unclear if either of the reports dated 1998 or 1999 were shared with inpatient staff at Stonefield House during Clive's admission in 2002.

2.57. Information obtained for this safeguarding adult review, which it seems does not appear in the independent review, appears to contradict the statement that there had been no concerns prior to 1993. It illustrates an apparent neglect of Clive's history and the importance of placement commissioners and providers exchanging information routinely. Prior to placement at the David Lewis Centre, Clive was resident at Lingfield Hospital School. Their records from 1988 contain a letter from a health centre that records concerns from staff and from his mother about what Clive was voicing about sex.

2.58. There is additional information contained in the minutes of the February 1999 meeting that it appears is not included in the NHS England independent review. The minutes state that the family were not wanting the alleged perpetrator to come to the house, that he was calling to see Clive at home, and that they were trying "*to avoid this person coming to the house*" and that "*they were doing their utmost to see that they are not left alone together*." The minutes do not record from whom this information had been obtained or the degree of seriousness that was attached to it in terms of risk to Clive. Whilst recognising that Clive had not at this point made a complaint, the minutes indicate that Staffordshire police wished to interview the alleged perpetrator. Unfortunately, the loss of records renders it impossible to explain why this was not done[14].

2.59. Further concerns about shortcomings relating to information-sharing, and about some confusion relating to when and where Clive might have been sexually abused, arises from a third document uncovered by Midlands Partnership University NHS Foundation Trust in a trawl of Clive's health records. There is a very vague reference documented by the Assistant Respite Manager of a Respite Centre on 20th July 1998. It states that on 19th July 1998, the Assistant Manager had had a conversation with Clive's father: *"Dad shared some details of Clive's past. At Richmond Mews, he established a friendship with a man who ended up taking advantage of Clive sexually. Clive becomes very threatening and protective when this gentleman is mentioned. Clive's parents do not want Clive contacting this gentleman and definitely do not want this man at Hockley."* There is no reference to the Respite Centre in the independent review although there is reference to Lichfield Day Services that Clive was accessing at the time when living with his parents. Richmond Mews was the second placement after Clive had left the David Lewis Centre.

2.60. The absence of records means that it appears that lines of enquiry agreed at various safeguarding meetings were not explored to a conclusion. This potentially left Clive, and other residents, exposed to ongoing risk of abuse or exploitation.

[14] Information that the alleged perpetrator was visiting Clive when he was living with his mother is also contained in the witness statement that Clive's sister gave much later to the police. The alleged perpetrator was often accompanied by another non-verbal male and Clive would turn on his family if he was not allowed to see someone he considered a friend.

2.61. Available records lead to a conclusion that there was lack of agreement between the two police forces involved as to which held primacy for the investigation of sexual abuse and exploitation. Cross-border information-sharing once again emerges as a theme.

2.62. The independent review documented that the family had requested access to certain records and that this had been refused. Reasons for such a refusal should have been given to the family so that they could challenge the decision if they wished to do so. Clive's family have observed a discrepancy between what they have read in this safeguarding adult review, namely that the police did not prosecute the staff member in relation to the files he had taken without authorisation (section 2.41) and what they were told at a meeting in January 2022 attended by representatives of the two police forces and the two local authorities involved. At this meeting the family had understood that the staff member was prosecuted for holding more than one file and that this heightened their concerns that Clive would not have been the only victim. It is also the case that whether prosecuted or not, the possession of several files should have been a red flag to trigger further investigation if there were other victims.

2.63. There are no formal minutes of this January 2022 meeting. This makes it difficult to conclusively resolve the divergent understandings held by Clive's sister and the two police forces. Agreed minutes of such important meetings should always be kept. However, there is an email sent by NHS England to those who attended the meeting. This summarises the key points and actions arising from the meeting, as follows:

2.63.1 "We discussed two potential reviews and the appropriate sequence and management of them:

- A potential criminal investigation into the allegations of sexual abuse experienced by Clive and potentially other victims to be led by the Police.
- An independent review, to be commissioned and led jointly by Staffordshire County Council and Cheshire East Council, to look at the safeguarding response to the allegations of sexual abuse, the processes and legal framework that were in place on each of the occasions (1993, 1999, 2011, 2015) when the alleged abuse was disclosed, or concerns were raised by staff or family and the adequacy of the responses … Both Cheshire East and Staffordshire Councils agreed at today's meeting that a joint review between the two councils should be pursued.

2.63.2 Colleagues discussed whether there is a criminal investigation to pursue here. It was agreed that Staffordshire and Cheshire Police colleagues would urgently meet to review the information and evidence available and determine whether to pursue a criminal justice outcome (meeting to be held this week beginning 31/1/22)

- If it is agreed that a criminal investigation is to be pursued, this will be led by Staffordshire and Cheshire Police who will convene a statutory meeting with Staffordshire and Cheshire Councils to determine what the investigation should look like taking into consideration potential other victims. If a criminal investigation is pursued, the wider joint independent Review into the safeguarding response led by the Councils, will need to await the conclusion of this investigation …
- If a criminal investigation is pursued, it will be done so in line with a 2022 understanding of sexual abuse.
- If it's is deemed that a criminal investigation cannot be pursed, the joint independent review to proceed as planned."

Recommendation 8: Episode 2011

Narrative

2.64. In April 2011, for the first time, Clive disclosed to a member of staff a detailed account of the sexual abuse perpetrated by the care worker at the David Lewis Centre. Police[15] attended to interview Clive and an internal investigation meeting was held on 25th May 2011. Staffordshire Police confirmed that "*Staffordshire Social Services alerted Staffordshire Police to concerns reported to them by staff at St. Georges Hospital, Stafford that Clive – an inpatient – had disclosed being a victim of serious sexual offences*." However, no records were available to confirm the outcome of the investigations. The family shared that no further action was taken due to the time that had passed.

Independent review commentary

2.65. Trauma support: Although there is some reference to psychological support, there is no evidence of further detailed discussions at subsequent professionals' meetings following the investigation to consider what support Clive might need and that care plans were updated to take on board the issues of abuse. There are brief references in care records of subsequent placements, including one from Clive's psychologist at St Andrew's which references that the impact of this abuse may underline some of his behaviours, but there is no acknowledgement of this in care plans or details of action taken to support Clive.

2.66. Safeguarding: Again, it is noted that meetings were held to investigate the issue of sexual abuse, but there is no information that any action followed. Records about the detail of this abuse did not follow Clive through his different placements and reference to sexual abuse anecdotally appears in amongst records with inaccuracies.

Law and Guidance in 2011

2.67. By 2011 significant changes had occurred within the legislative and guidance framework for adult safeguarding, mental capacity, inspection and regulation of the workforce and care provider services, and sexual offences.

Adult safeguarding

2.68. In 2000[16] policy guidance was introduced, known as "*No Secrets*." The guidance required effective inter-agency and inter-professional collaboration and specified that allegations of abuse/neglect should be investigated to establish the facts, assess the needs of the vulnerable adult for protection, support and redress, and decide what follow-up action should be taken regarding the perpetrator. Joint investigations were encouraged to facilitate the sharing of evidence and to avoid repeated interviewing. Advocacy was to be provided where this would

---

[15] This was Staffordshire police.
[16] Department of Health (2000) No Secrets. Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse.

support the vulnerable adult to engage in an investigation. In 2005 the Association of Directors of Social Services issued practice guidance in the form of standards for adult protection[17].

Residential care

2.69. Placement provision was still governed by the legal rules previously referred to. The "*No Secrets*" policy guidance included a reference back to LAC[18] (93) 7 on ordinary residence with respect to out of authority placements. It reasserted that responsibility remained with the placing authority and required that procedures should identify the responsibilities of, and action to be taken by (1) the authority where the abuse occurred in respect of monitoring and review of services and overall responsibility for adult protection; (2) registering body in fulfilling its regulatory function; (3) placing authority's continuing duty of care to the abused person.

Regulation and inspection

2.70. The Care Standards Act 2000 created regulatory councils and the requirement that social workers should be registered with the General Social Care Council. The Health and Social Care Act 2008 established the Care Quality Commission and the system for registration, regulation and inspection of care settings. This system included notification of any concerns of possible abuse and/or neglect.

Disclosure of convictions

2.71. The Care Standards Act 2000 and subsequently the Safeguarding Vulnerable Groups Act 2006 created and then refined the system for identifying people considered unsuitable to work with "*vulnerable adults*." The 2000 Act created the vetting and barring scheme whilst the 2006 Act established the Independent Safeguarding Authority. Care providers were now required to refer people when misconduct was found or suspected, even if they had transferred to a non-caring role. Care providers were also required to check the list of people who had been considered unsuitable for care work prior to offering employment.

Offences and investigations

2.72. The law on sexual offences developed with the Sexual Offences (Amendment) Act 2000, the Sexual Offences Act 2003, and the Domestic Violence, Crime and Victims Act 2004. The 2003 Act in particular created a range of offences concerned with abuse of trust. It created specific offences against people with severe learning disabilities who might or might not have been able to consent. This included conduct involving sexually explicit images. The Youth Justice and Criminal Evidence Act 1999 introduced special measures to assist vulnerable witnesses in giving evidence in criminal proceedings. The Police and Criminal Evidence Act 1984 was still in force in relation to the provision of an Appropriate Adult, as detailed earlier.

Mental capacity

[17] ADSS (2005) Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work.

[18] Local Authority Circular.

2.73. The Mental Capacity Act 2005 had been introduced. Section 44 created a specific offence of ill-treatment or neglect of a person who lacks capacity. Deprivation of Liberty Safeguards were introduced via the Mental Health Act 2007. The 2005 Act required both a functional (section 3) and diagnostic (section 2) assessment of capacity when authoritative doubt existed. Capacity assessments were to be time and decision specific.

Information submitted from agencies

2.74. There are no Cheshire Police records or documents held in regards to Clive or any alleged perpetrator referring to 2011 disclosures, reporting concerns or crimes to Cheshire Police by Staffordshire Police or family members. There is no record of any concerns, complaints or cross-border information sharing from Staffordshire Police in relation to the disclosures and strategy discussions in 2011.

2.75. Midlands Partnership NHS Foundation Trust have supplied the following information. "*Clive made a disclosure of historical sexual abuse to a staff nurse and a student nurse on the evening of 1st April 2011, the information was entered into a safeguarding adult referral form and faxed to the local authority on 2nd April in addition to faxing the referral form over to Clive's social worker who was also contacted and the information shared verbally over the phone and a Trust incident form completed. The social worker confirmed that he would need to discuss this with the police, police attended the ward to speak to Clive on 12th April 2011. A strategy meeting was convened on 15th April and the consultant and ward staff attended. Police attended the ward again on 6th May and a further strategy meeting was planned for 12th May. However, there is no evidence in the records that this meeting took place*." The Midlands Partnership NHS Foundation Trust submission observes that: "*Safeguarding concerns were raised in a timely way in line with expected practice and the ward team contributed to the planning discussion and supported Clive in speaking to the police*."

2.76. Staffordshire County Council records for 4th April 2011 include notification of "*sexual abuse 20 years previous*." The minutes of the 15th April strategy meeting record the following:

2.76.1 Police to undertake video interview in a planned way with support from [placement] and with input from Clive's advocate.
2.76.2 The interview by the police will be planned for the first week in May and [named worker] will advise [named practitioner] when the date is set so that he may liaise with [placement provider].
2.76.3 [Placement provider] to formulate Risk Management Plan and plan for post-interview period.
2.76.4 Police to decide if there is enough evidence to proceed post interview.
2.76.5 Family to be notified of situation by [named practitioner] post interview with police input. Family to be given the opportunity to speak to [named practitioner] and [named worker].
2.76.6 An investigation review meeting will be held on 12th May at [placement provider].

2.77. Staffordshire County Council records for 27th May 2011 describe the outcome of the investigation review meeting as the "*police are not taking any further action as there is insufficient evidence*." The records provide no further details.

2.78. A record for 11th July 2011 refers to minutes of a meeting regarding Clive held on 6th May 2011 at [the placement provider], including discussion with Clive regarding [the alleged perpetrator at

the David Lewis Centre] and sexual abuse. Following this there is no further reference to these concerns or actions taken to support Clive regarding this allegation.

2.79. Staffordshire Police have confirmed their awareness of Clive's disclosure in 2011. Their records state that "*Staffordshire Health Care Professionals informed Staffordshire Police of the disclosure relating to a complaint from Clive of serious sexual offences perpetrated in Surrey*." Staffordshire Police retain the police incident report and police officer notes of the interview with Clive.

2.80. The Staffordshire Police submission states as follows. "*In 2011 Staffordshire Police Control Room personnel recorded an Incident for police response. Detective Officers were allocated the initial investigation. This included attendance at the Staffordshire Hospital, contact with Clive and medical professionals, participation at partnership multi-agency meetings and liaison with Surrey Police for their further investigation and resolution*." Staffordshire Police have not been able to identify what the final resolution of this episode was. In their view Surrey Police were responsible for leading this investigation into the allegation of historic abuse.

2.81. Surrey Police have reported that Clive was not known to their systems. There is no surviving record of contact from Staffordshire Police, possibly due to transfer of records onto a new system in 2014.

Commentary

2.82. The response to Clive's initial disclosure was timely and the convening of strategy meetings was good practice. It appears that Clive was supported to engage with staff responsible for investigating the disclosure and Clive's right to advocacy was recognised. However, the records are incomplete, for example regarding liaison with Clive's family and the outcome of the investigation. No actual outcome has been recorded and it does not appear that consideration was given to whether any other residents had been or were at risk. There is no reference to notification to the Care Quality Commission of the disclosure.

2.83. Clive had been detained under section 3 Mental Health Act 1983 prior to this episode. On discharge from section 3, Clive would have been eligible for an after-care plan (section 117 Mental Health Act 1983). This should have included arrangements to prevent further mental ill-health, which would have been an opportunity to explore with Clive his lived experiences, including sexual abuse.

2.84. The reference in Staffordshire Police records to Surrey Police is puzzling since, if the historic allegations of abuse related to events at the David Lewis Centre, as appears the case, this service was located in Cheshire. It is possible that this confusion originates from an interview with Clive and his mental health advocate in early May 2011. The interview was conducted by Staffordshire Police with staff nurses from his then placement in attendance. Clive is recorded as stating that he met the alleged perpetrator at the setting where he was placed prior to his transfer to the David Lewis Centre. That placement was in Surrey. In that interview Clive describes sexual activity at the person's own accommodation and is recorded as stating that he knew what was happening was "*rude*."

2.85. This SAR author has also been informed that there were other discrepancies in Clive's account that would have undermined any prosecution. Apparently, Clive did not disclose information relating to a staff member at the David Lewis Centre at this time and also intimated that he had taken photographs of himself by propping his camera up and using a pole to press the button. There are no records to establish how sensitively Clive was interviewed, and whether he felt conflicted, embarrassed or anxious about what he as being asked to talk about. Clive's sister has recorded in her witness statement that Clive felt that he was in trouble when he was spoken to about these events.

Recommendation 8: Episode 2015

Narrative

2.86. On 15th October 2015, Clive disclosed instances of historic sexual abuse. Clive reported that he continued to experience dreams and nightmares of this abuse including symbolic dreams such as being chased by wolves in the forest. Clive stated that "*he did not wish to recount the incident again, but only wishes to receive support for his anxiety.*" Clive's psychiatrist set three treatment goals: to talk about his dreams/nightmares and how to cope with these, to raise any issues he has on the ward and to learn coping strategies when he is feeling anxious or agitated. The team discussed that this disclosure explains why Clive does not like it when staff wake him by shaking his arm; Clive has often reported that he does not like it when staff touch him when they wake him.

Independent review commentary

2.87. Support for historic sexual abuse and trauma: This is one of a few occasions that the history of Clive's sexual abuse is picked up and psychological support offered. It is not clear from care plans that this was formally built into Clive's care plans. Clive's psychiatrist reflected in later records that this may have had an impact on the presentation of his behaviour; however, it's not clear that this is picked up in positive behavioural support plans, guidance on use of physical intervention or discharge planning to inform future care. There does not appear to have been any referral to safeguarding or the police about this disclosure.

Law and Guidance in 2015

Adult safeguarding

2.88. "*No Secrets*" had been replaced by primary legislation, Care Act 2014, which placed adult safeguarding on a statutory footing. Specifically, section 42 outlined a new duty to enquire when an adult with care and support needs was experiencing or at risk of abuse/neglect and, owing to their care and support needs, appeared unable to protect themselves from that abuse/neglect. Section 44 provided for safeguarding adult reviews and outlined the criteria where a Safeguarding Adult Board was required to commission a review and where it had discretion to do so. The adult safeguarding requirements in the Care Act 2014 have been further defined in statutory guidance.

Residential care

2.89. The same statutory guidance outlined requirements for placement reviews. It also set out the roles and responsibilities of placement commissioners and of host authorities for out of area placements. Guidance[19] to Clinical Commissioning Groups (CCGs) recognised cross-border challenges, requiring them to notify host CCGs when placing patients out of area, to support partnership working. It recognised the need to improve communication and co-ordination between commissioning CCGs and localities in order to monitor the quality and continuity of care.

Regulation and inspection

2.90. No changes had occurred since the previous episode in 2011.

Disclosure of convictions

2.91. The Protection of Freedoms Act 2012 created a new disclosure and barring service.

Offences and investigations

2.92. The Domestic Violence, Crime and Victims (Amendment) Act 2012 created a new offence of causing or allowing a "*vulnerable adult*" to suffer serious harm. The Criminal Justice and Courts Act 2015 added an offence of reckless and intentional behaviour by healthcare staff.

Mental capacity

2.93. No changes had occurred since the previous episode in 2011.

Information submitted from agencies

2.94. Cheshire Police only became aware of Clive's disclosures in 2015 during their investigation in 2022, details of which are given later in this report.

2.95. Clive was resident within St Andrew's Healthcare when he disclosed historic sexual abuse during a home visit on 15th October 2015. Their record contains the following information: "*Clive went on a home visit today at 11:15am with 2 escorts. Clive's mood has been variable throughout the day and he was calm and settled when we left Northampton to visit his mother. When we got there he was elated in mood, laughing and giggling a lot. Clive seemed very happy to see his family, his mother, aunty [name withheld] and his sister [name withheld]. Clive was in a chatty mood and during the conversation he started talking of something that had happened in the past regarding [DLC employee] an ex carer. Clive stated that he "was in a naughty rude video club which used to cost him £600." At this point his sister said that he is trying to say something about his past and he has never mentioned this topic before and she was concerned and wanted it to be raised further. At this stage, Clive presented sad in mood and staff reassured Clive's sister that we will pass the message to investigate further to the appropriate staff. Clive stood up and he asked to speak to staff in private so they went to a different room and Clive stated '' He*

[19] National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare) (2012).

doesn't like talking about it because it makes him sad''. Staff reassured Clive that he could talk to staff anytime he wishes to and they both returned back to lounge."

2.96. St Andrew's Healthcare in their submission have been unable to find any records which suggested that family members had previously shared information with St Andrew's Healthcare staff in relation to historical allegations of sexual abuse. Similarly, the organisation has been unable to find any records which suggested that other professionals had shared information with St Andrew's Healthcare staff in relation to historical allegations of sexual abuse.

2.97. A social worker at St Andrew's made two record entries on 16th October. The first details a conversation with Clive and the second with his mother. In the first he made further disclosures regarding "*rude videos*" and "*rude books*" involving the David Lewis Centre employee. In the conversation between the social worker and Clive's mother, there was recognition that Clive had confused some of the details. However, when the family had seen Clive together with [name withheld – DLC employee], they had felt uncomfortable about the relationship. Clive had "*clamped up*" when the issue had been investigated previously. His mother knew about the videos "*but because Clive avoided speaking about it; nothing had been said further about them until yesterday. She said the family was horrified and moved away from the subject."*

2.98. His mother is recorded as saying that she believed Clive had paid for some of the videos. The record continues: "… *Clive was telling the family he wasn't well before talking to them about things that had gone on in his bedroom. [His mother] explained that when things were being investigated, Clive used a pencil up his back passage. She believes Clive is willing to talk about things again but is vulnerable to self-harm because he is discussing risks in his bedroom. She said that she believes her son is crying for help over the memories that are flooding back and she wants Clive to be safe. [His mother] asked that items aren't taken from Clive's room because he will become anxious over this like he did before. She explained that Clive doesn't understand why staff remove items so he will get distressed. She asked that a male work with Clive over this issue rather than a female. She said it's a fine line but she believes her son is extremely vulnerable at present and needs to be supported so that his health doesn't deteriorate."*

2.99. A nursing note dated 19th October records a conversation between a staff member and Clive's father regarding "*a disclosure Clive made about sexual abuse from a care-taker when he was a teenager. At the time, this was followed up by the police, but Clive did not cooperate with the police process and therefore it was dropped. Clive continues to report experiencing dreams and nightmares of this abuse including symbolic dreams such as being chased by wolves in the forest. Clive's father informed [the staff member] that the perpetrator of the abuse is no longer alive. He added that this is the first time Clive has disclosed this information in detail, because the perpetrator told Clive to keep it a secret, which he did until he could no longer remain silent. Clive's father is supportive of interventions to support Clive's emotional distress but advised staff not to pry into this excessively in order to reduce distress to Clive through re-living the experience."*

2.100. A psychology note dated 19th October describes a psychology session in which Clive described in some detail the historic events. The record reports that, at times, Clive appeared to "*mix up events*." Nonetheless, his description of events was "*graphic*" and included "*watching rude videos and naughty books*", "*kissing each other, taking each other's clothes off, playing*

around upside down, and mutual masturbation." Clive stated that this was [the DLC worker's} idea and that he had been told to keep it a secret.

2.101. The psychologist recorded their opinion as follows: "*Clive appears to internalise those events as if they were caused by his "sex illness", and worries that they may happen again if he becomes unwell. Clive appears traumatised by those early life experiences, and described as having "true dreams and nightmares", like being chased up by "a werewolf up the forest who wants to lick me" Clive said that we would like to meet for 12 psychology sessions (and then review) on the goals described below, but he explicitly said he would not want to discuss the past incidents with the care-taker (name withheld) in our sessions, "because it brings up the naughtiness in me". Clive said that he wants to address his worries about safety on the ward, around guidelines for staff to relate to him in ways that don't bring his trauma memories up. He also said that he fears his dreams may come true and cause "my epileptic fits".*

2.102. The psychologist recorded the planned approach, as follows: "(1) *To meet with Clive for 12 sessions to discuss: His dreams and nightmares he may have daily; If unhappy about something on the ward, and talk through solutions; Ways to calm self down and worry less about daily thoughts or events; (2) to provide guidelines to the staff on ways to interact when Clive in presenting unwell; (3) pass this information to the unit's team and social worker."*

2.103. St Andrew's Healthcare have not been able to find any evidence that Clive's disclosures were escalated outside of the organisation "*and it would appear that staff reacted to family noting that this had previously been considered by the police and as such there is no evidence that charity staff made contact with the police in relation to this allegation. There is no written evidence that staff contacted local authority professionals involved in Clive's care at the time to confirm and further review any actions taken previously in relation to these actions. There is no evidence that a Datix record was completed at the time in relation to Clive disclosing these allegations. This action would have been expected as part of recording expectations at the time. There is no record of a safeguarding referral being submitted to either the local safeguarding assurance team or the team that would have covered where Clive would have been living at the time of the allegations. There is documented evidence that safeguarding referrals were submitted to the local safeguarding assurance team in relation to Clive in regards to concerns raised on the ward; therefore, it is apparent that the ward social worker would have been aware of the processes for making such referrals.*"

2.104. From the records St Andrew's Healthcare have only been able to establish that four of the planned twelve sessions with a psychologist took place.

2.105. The St Andrew's Healthcare submission also observes that: "*Due to the apparent lack of engagement with external safeguarding partners and the police it is difficult to confirm that any consideration had been given to an organisational response with respect to safeguarding others who might also have been at risk*."

2.106. Staffordshire Police have no record of being informed in 2015 of Clive's disclosures whilst resident at St Andrew's.

2.107. Staffordshire County Council do not have any record of safeguarding concerns being raised in 2015 relating to the historical sexual abuse allegations.

2.108. From the point of Clive's admission to an acute setting under the Mental Health Act 1983 in 2007, the local NHS commissioners were responsible for the commissioning of his care and this responsibility continued until he died in 2017. The Staffordshire and Stoke-on-Trent Integrated Care Board have confirmed that there is no record of predecessor organisations for the area, Clinical Commissioning Groups, having been informed of Clive's 2015 disclosures.

Commentary

2.109. The planned provision of psychology sessions to address the traumatic legacy of sexual abuse was good practice although it does not appear that all of the planned sessions were provided. Liaison with the family following Clive's disclosures was good practice and there is evidence of making safeguarding personal in respect of Clive's wishes and feelings being clearly documented.

2.110. However, judged by the standards of the time, including legal duties within the Care Act 2014, there were shortcomings. The St Andrew's Healthcare submission is correct to highlight the omission of any referral of safeguarding concerns using the criteria in section 42(1) Care Act 2014. Nor at the time does there appear to have been consideration of a referral to the Northamptonshire Safeguarding Adults Board using the criteria for mandatory and discretionary safeguarding adult reviews in section 44 Care Act 2014. The Care Act 2014 statutory guidance is clear that such an initial referral would be to the Board in the area where the person is residing. That Board would then engage with any other Board covering the area of the placing authority to establish which would lead on determining the outcome of the referral.

2.111. There is no record held by St Andrew's Healthcare that the Care Quality Commission were informed. Nor does it appear that the Clinical Commissioning Group responsible for arranging the placement were informed. Nor does it appear that any police force was informed.

2.112. Historic information about Clive's lived experiences, specifically allegations of abuse by a person in a position of trust, does not appear to have followed Clive as he transferred between placements. This is also a clear shortcoming in terms of information-sharing.

2.113. There does not appear to have been any referral using the provisions of the Safeguarding Vulnerable Groups Act 2006 and Protection of Freedoms Act 2012.

2.114. As a consequence, there does not appear to have been any consideration of whether other adults had experienced or been at risk of abuse from the alleged perpetrator.

Recommendation 8: Subsequent safeguarding investigation

2.115. The terms of reference for this review included a focus on investigations conducted since the independent review was commissioned and subsequently published.

Information submitted from agencies

2.116. Cheshire Police have provided information relating to their investigation into sexual offences between 1993 and 2011. "*Cheshire Police instigated a sexual offence investigation on 10th March*

2022 for offences between 1993 and 2011. The Constabulary became aware of the incidents as a direct result of a multi-agency meeting and the {independent} review. The police investigation was necessary to accurately investigate historical offences involving Clive." A detective from their public protection unit was allocated. Documents were obtained from Staffordshire Police and Adult Social Care and a witness statement from Clive's sister was taken. Cheshire Police have stated that the investigation considered safeguarding in respect of Clive and other residents at the David Lewis Centre. "*Enquiries were made with David Lewis Centre managers who confirmed they had spoken to a variety of staff who still worked for them and no-one had raised any concerns regarding[the alleged perpetrator] towards Clive or others. The Centre confirmed that no other residents then or since have raised any concerns regarding [the staff member]*."

2.117. However, when Cheshire Police sought to arrest and interview the alleged perpetrator in June 2022, it was discovered that he had died in January 2022. "*A rationale of findings was written by the officer in charge of the investigation and reviewed by a supervisor and a No Further Action decision concluded the investigation, given that there was no living victim, no complaint, no detailed disclosure and no evidence to take to CPS.*" The rationale for this decision was further elaborated by Cheshire Police as follows: "*At the point of investigation there was no corroborative evidence, other than basic disclosure notes taken, no ABE [achieving best evidence] and no supporting evidence to suggest [the alleged perpetrator] had offended against any other person. … It was agreed by [the detective inspector] from Cheshire Police and DLC senior managers that it would be inappropriate to approach residents, given the length of time and their mental health complexities to ask them directly about [the alleged perpetrator] without grounds or suspicion they had been a victim/witness.*"

2.118. In their submission the David Lewis Centre have confirmed that the Centre made staff records available to Cheshire Police. The Centre have reported that: "*all staff still employed by David Lewis who were employed at the same time as Clive's placement were approached with regards to what they may or may not know about the allegation. Unfortunately no member of staff still employed directly supported Clive and therefore no knowledge of the allegation could be shared*."

Commentary

2.119. Information provided by Cheshire Police on their 2022 investigation reports that the David Lewis Centre employee did not leave their job until after the theft allegation was raised in 1999. Considered by today's standards this would be judged to have left residents potentially at risk until criminal and adult safeguarding investigations had been completed. Cheshire Police have also observed that in 1993 and in 1999 there was no disclosure and barring service to notify as this provision was not established until 2012.

2.120. Clive's sister has provided a copy of her witness statement. In it she attributes Clive's behaviour to the trauma of sexual abuse in 1993 and observes that concerns were shared with the police and with Staffordshire County Council at the time. She notes that Clive would become angry if he was not allowed to see the alleged perpetrator. She observes that subsequent placements were not made aware of the concerns that had emerged when Clive was resident at the David Lewis Centre and that the alleged perpetrator had been allowed to visit Clive,

including at his mother's address. The statement includes reference to a decision taken in 2011 that the events complained of were too historic to proceed with.

2.121. The following conclusions appear justified based on the evidence that remains available. Firstly, there were missed opportunities to put the concerns and allegations that surfaced in 1993 to the alleged perpetrator, who had been in a position of trust. This meant that Clive and other residents continued to be exposed to potential risk. Secondly, Clive was only belatedly offered psychological support to address the trauma surrounding the events of 1993 and their legacy. Thirdly, there is evidence prior to 1993 of Clive expressing his sexuality; there is evidence that this was known to his mother and a placement provider, but there is no record of psychological support having been made available. Fourthly, there is no recorded assessment as to whether Clive, using the criteria in the Mental Capacity Act 2005 (and prior law), had capacity to consent to a sexual relationship. Finally, information about Clive's lived experiences was not routinely passed between placement providers.

2.122. The independent review concluded that there had been a lack of knowledge and understanding of safeguarding duties. Judged by the surviving records and against the legal rules pertaining at the time, there were shortcomings in investigating what had taken place and in safeguarding Clive and other residents.

Police retention of records

2.123. Both the NHS England independent review and this safeguarding adult review have been hampered by the absence of police records. There is now national guidance on police record management[20], initially published in 2005. There was no national guidance in existence in 1993 or 1998/1999, key time episodes that have been explored herein. Rather, retention was subject to local office policy and therefore retention was unlikely to have been consistent across a police force or between police forces. Especially during the earlier episodes many records would have been paper only and even if papers were retained, the standard of filing systems was often variable. Some records were not retained or transferred when police forces moved to electronic systems, in addition to which there might have been a "weeding" policy with records being retained or deleted according to the level of seriousness attached to them.

2.124. One outcome of the Bichard Inquiry[21] was the introduction of the police national database to ease information-sharing and connectivity between forces. This resource would have been available for the key episodes in 2011 and beyond. It would be appropriate for the two police forces involved in this review to consider how they would record enquiries from other police forces now. It is important to restate a person's right to private and family life and that this includes access to available information to understand how decisions have been reached.

[20] College of Policing (2023) Code of Practice on Police Information and Records Management.
[21] The Bichard Inquiry Report (2004). London: The Stationery Office.

Section Three: Findings and Analysis in Response to Recommendation 7

3.1. Recommendation 7 in the independent review was addressed to local authorities and clinical commissioning groups (now integrated care boards). It recommended that adult safeguarding processes should be reviewed to ensure that they are robust and in line with national guidance.

3.2. The services involved with Clive and his family were asked to provide documentary evidence relating to safeguarding complaints submitted by Clive and his family, and safeguarding alerts. Clive's family were also asked for any documents they hold relating to safeguarding complaints they submitted and responses received, and any safeguarding alerts they referred and responses to them. Material for this part of the safeguarding adult review has also been taken with permission from the detailed unpublished timeline provided by NHS England – Midlands and from their published final report.

3.3. Judged by the standards pertaining at the time, each service and agency was also asked to reflect on their responses to the safeguarding complaints and concerns. Once again, the legal rules relating to complaints procedures and safeguarding alerts have developed over the years. Accordingly, at a learning event, those present reflected on the effectiveness of responses now to safeguarding complaints and concerns that are referred. Their feedback will be covered in section four.

Relevant law and guidance

3.4. For the period covered by this SAR, relevant law relating to complaints procedures began with section 50 NHS and Community Care Act 1990. This required local authorities to establish complaints procedures. This requirement was developed by the Complaints Procedure Directions 1990. The legal rules underpinning complaints procedures were further developed by the Health and Social Care (Community Health and Standards) Act 2003 and the Local Authority Social Services and NHS Complaints (England) Regulations 2009. There are three stages to the complaints procedure, namely an informal stage, the first formal stage and a review stage. An independent (of the local authority) element was only introduced at the third, review stage. Case law, research and decisions by the Local Government Ombudsman (now the Local Government and Social Care Ombudsman) have sometimes been critical of local authorities for failing to manage these procedures fairly. In addition concerns have been expressed that service user and care-giver knowledge of complaints procedures is poor, that advocacy support is poorly developed, and that the procedures are insufficiently independent of the local authority[22].

3.5. As explained in the previous section, the law relating to adult safeguarding developed over time. This began with the publication of policy guidance in 2000, "*No Secrets*", which remained in place until the Care Act 2014. The requirements relating to the duty to enquire in section 42 Care Act 2014 were introduced on 1st April 2015.

Narrative from the independent review – placement at David Lewis Centre

[22] For detail, see Braye, S. and Preston-Shoot, M. (2016) Practising Social Work Law (4th ed). London: Palgrave; Preston-Shoot, M. (2019) Making Good Decisions: Law for Social Work Practice (2nd ed). London: Red Globe Press.

3.6. In 1989 (aged 19) Clive moved to David Lewis Centre (DLC) in Cheshire. The DLC was a residential setting providing education, medical and therapeutic support for people with learning disabilities, epilepsy, and autism. It was recognised as centre of excellence for epilepsy. When the family were first introduced to the centre, they describe being guided around a nice new area and were under the impression that Clive would have his own room. However, arriving unannounced after Clive's move, the family reported raising serious concerns about the state of his living conditions. They found Clive living not in a room of his own, but a large dormitory that they described as filthy.

3.7. A year or so after arriving at the DLC, the family visited Clive on his birthday and reported finding Clive lying in faeces and sodden bed linen. Clive's father raised further serious concerns to the DLC and authorities that day about the neglect of his son and that his medical needs were not being addressed. The family describe the DLC as having been very insular and not engaging well at the time with external agencies for support.

3.8. Clive started to deteriorate rapidly (seizure activity and behaviour) whilst there. By Clive's next birthday a year later the family found Clive ill and in bed. The family tried to get him up, but the severity of seizure activity meant it was not possible. Parents met with the doctor in charge to ask about Clive's deterioration, medications, seizure activity, why he was so sedated and what was being done about it. Assurances were again given at the time.

Independent review commentary

3.9. Care quality: There are no care records available to understand how Clive's physical and mental health needs were being supported at the DLC. However, the quality of care described by Clive's family indicates that it was poor with concerns about the management of his epilepsy, levels of sedation and neglect that led to deterioration in his physical and mental health. There were no records available to understand if and how quality of care was regularly being reviewed by the commissioning authority, the family describe limited involvement and being placed out of area would have made this more difficult.

Information submitted from agencies

3.10. The David Lewis Centre has been unable to identify within its records any reference to a safeguarding concern, allegation or referral. No safeguarding policy from this time has been found in its archived records.

3.11. The David Lewis Centre has found within its archived records one complaint from Clive's family. This related to horticultural work that Clive appeared to cease due to his epilepsy. There was also concern around difficulties the family were facing when Clive stayed with them at the family home. Concern was also recorded following a physical altercation between Clive and a fellow resident. From records this was referred to the Matron, Matron wrote to Clive to acknowledge the incident but there is no record of further actions taken. The Centre has acknowledged that the sparsity of archived records renders it difficult to establish what process was followed.

3.12. Cheshire East Council[23] have been unable to find within its archived case records any reference to Clive and safeguarding concerns. Similarly the Council's available archived records contain no reference to complaints received from Clive's family.

3.13. Staffordshire County Council have not been able to provide any information relating to this period.

Commentary

3.14. The paucity of available information relating to complaints and safeguarding concerns means that it is difficult to be assured that, at the time of these events, there was sufficient regulatory oversight of Clive's placement and adequate attention to his care and support needs, wellbeing and dignity.

3.15. The witness statement provided by Clive's sister in 2022 expresses the view that the David Lewis centre was not homely. She observes that the family consistently complained about his treatment there. There had been periodic concerns regarding what nowadays would be termed neglect, acts of omission and organisational abuse in closed or semi-closed institutional environments[24] but legal rules and procedures for inspection, quality assurance and investigation of provider concerns were undeveloped.

Narrative from the independent review – subsequent placements to 2014

3.16. The narrative from the independent review does not reference safeguarding concerns or formal complaints from the family until 2014. During 1997/1998 the narrative refers to the family having raised concerns about Clive's seizures and deteriorating health, which they felt were not taken seriously. In 1999 the narrative records concern that no records of safeguarding and police investigations in 1993 had followed Clive and that no action had been taken to safeguard Clive and others.

3.17. In 2006/2007 Clive and his family expressed concern about the regime and programme in a placement, with the manager reportedly refusing to allow an advocate for Clive on site. The narrative notes the absence of records to ascertain what action commissioners took to oversee the quality of care and concern about the behaviour of the manager towards Clive. In 2010 the narrative records family concern about the inappropriateness of a hospital environment. It observes the shortage of alternative placements and the very limited oversight by commissioners of the quality of care and appropriateness of the setting. It observes that annual social circumstances reports, compiled by different social workers, relied heavily on historical information and past reports.

Information submitted from agencies

---

[23] Cheshire East did not become a unitary authority until 2009. Prior to this Cheshire County Council was the named local authority.

[24] See Butler, I. and Drakeford, M. (2005) Scandals, Social Policy and Social Welfare (2nd ed). Bristol: Policy Press,

3.18. Staffordshire County Council have identified some information pertaining to this period. In early November 2006 social work records contain an entry that Clive's family were concerned about the level of care he was receiving in a supported living placement. In later May 2007 the family were recorded as being very concerned about placement staff attitudes towards Clive. This led to a meeting to discuss the family's concerns. The information provided by the Council observes that "*the meeting minutes reflect the discussion which would suggest that weight of opinion was centred on the views of professionals as opposed to the family of Clive*."

3.19. In May 2009 family members expressed concerns to a social worker about Clive's lack of progress at a hospital where he had been detained under section 3 Mental Health Act 1983. These concerns resurfaced in November 2010 when the family made a formal complaint about the lack of appropriate treatment for Clive and the lack of progress he had made. They intended to challenge renewal of section 3 detention. Family concerns that Clive was not receiving correct medical treatment were discussed at a Mental Health Review Tribunal and in an email to a social worker from Clive's sister in January 2011.

3.20. Staffordshire County Council records also contain details of safeguarding concerns. Minutes of a meeting held on 3rd June 2010 "*under the vulnerable adults procedure*" focused on bruising that had been discovered on Clive's back and arms. It was reported that Clive's father had also noticed the bruising and reported it to the police. The family were reported to be frustrated at Clive's perceived lack of progress in his placement and wanted him to be moved elsewhere. It was agreed to provide information to the police and to conduct, initially, an informal internal investigation led by someone not employed by the placement provider. A more formal investigation would be conducted if further concerns emerged. Staff were to speak with Clive and his family about the outcome of this meeting.

3.21. A follow up "*vulnerable adult meeting*" was held on 12th July 2010. The investigation had been concluded and the outcome was that there was insufficient evidence as to how the bruising had occurred. It was noted that "*recordings at [the placement provider] were not always up to date and the chair raised concerns about this … [the placement provider] said that they would raise concerns with staff as to how they are maintaining records, acknowledging that these are not being done as they should*."

3.22. On 11th October 2010 Staffordshire County Council received an adult safeguarding referral from the placement provider. Clive had assaulted another resident, the police had been called and Clive had been placed in seclusion.

3.23. For 3rd April 2012 there is a record of a strategy discussion held regarding an incident where Clive had been grabbed by another resident at [his placement], this was the second incident between them. It is recorded that the adult who had grabbed Clive was put on 1-1 and Clive was to be moving to [another placement] so it was closed with no further action needed. Two safeguarding referrals had been received on 30th and 31st March from the placement provider.

3.24. A safeguarding referral was received from the placement provider on 27th June 2012. "*Clive had come back from a home visit and alleged that his mother had hit him hard in the stomach. Staff who were with Clive at the visit have both stated that they were with Clive at all times and did not witness any such incident*." The vulnerable adult process ceased at this time as there was no evidence of abuse.

3.25. Staffordshire County Council also hold records of concerns raised by professionals. In April 2006 a referral was sent to community learning disability nurses following an increase in Clive's challenging behaviour. A letter was also received from an advocacy service reporting Clive's wish to move homes. In early May 2006 a referral was sent to community learning disability services regarding epilepsy, behaviour and signs of depression.

3.26. On 5th July 2012, following Clive's transfer to St Andrew's, a community healthcare nurse raised concerns from the previous placement provider about the transfer and was advised to refer to the Care Quality Commission and to the local authority in Northamptonshire. The concerns have been recorded as follows but there is no indication of any further action taken by Staffordshire County Council:

3.26.1. Senior Staff Nurse appeared to have little knowledge of epilepsy or medications administered in the treatment of this condition.

3.26.2. Placement has been identified as a long term placement, however staff at St Andrews stated it was an assessment unit.

3.26.3. Staff felt the unit smelt of urine.

3.26.4. A staff member discussed the use of seclusion and how often it would be utilised, however this was not utilised by [the previous placement].

3.27. For 16th April 2013 Staffordshire County Council hold a record of a Care Programme Approach (CPA) review held at St Andrews wherein it is stated that there had been an adult protection incident but neither the Primary Care Trust (PCT) nor social worker in Staffordshire had been informed. A Staffordshire social worker contacted a Northampton social care team and ascertained that Northampton had been informed of the incident but not the outcome. The Staffordshire social worker asked to be informed of future incidents and left contact details.

3.28. There is no indication of any actions taken by Staffordshire County Council in response to this concern.

3.29. Northamptonshire County Council records for January 2013 contain receipt of an adult safeguarding concern regarding physical abuse by hospital staff. Their records for November 2013 contain receipt of another safeguarding concern for physical abuse, the allegation being that Clive had been pushed out of bed. The records for both concerns contain reference to an enquiry having been undertaken external to the local authority. Northamptonshire County Council have reported that information was shared about safeguarding concerns with Staffordshire County Council in April 2013.

3.30. Midlands Partnership University NHS Foundation Trust have provided information relating to Clive's two placements in Stonefield House, the first in 2002, the second between 2007 and 2012. The surviving paper records include clinical notes and reports. A considerable number of pages have proved difficult or impossible to read. "*This is because either the handwriting in the handwritten notes is illegible, there has been poor image reproduction, or the quality of original documents was poor*." This highlights again the theme of recording standards.

3.31. The records contain no information from the placement commissioner, Staffordshire County Council. "*There are numerous summaries of Clive's past placements in the clinical notes and meeting minutes from various meetings held on the ward in both 2002 and between 2007 and*

2012. This information about Clive's past history appears to largely come from social workers within the Council. Clive's experiences in these placements tends to focus on his complex behavioural needs and/or his needs related to his epilepsy in each setting." At a ward-based case conference in April 2002, "*the social worker present shared the background to current admission (summarising recent difficulties) and details of some past placements. No reference to previous allegations of sexual abuse (or more recent concerns about this) formed part of the background history shared at this meeting.*" Similarly, the referral received in December 2006 referenced different residential homes and specialist placements but only noted challenging behaviour and poorly managed epilepsy.

3.32. This reinforces a theme already introduced, namely shortcomings in information-sharing between commissioners and placement providers. Indeed, the last referral for Midlands Partnership services in 2015[25], from a complex case nurse acting on behalf of commissioners, contained no past placement history but focused on providing details of Clive's current placement and his readiness for discharge.

3.33. Midlands Partnership University NHS Foundation Trust, in their review of Clive's health records, have not found anything to indicate "[DLC staff member]" was in contact with Clive during his inpatient admissions to Stonefield. Nothing to indicate this is outlined in any of the care programme approach (CPA) or other meeting minutes reviewed. In a CPA Report dated 28th May 2002, there is a line which states *"Clive is trying to build a special friendship and attempts to socialise."* However, there is no additional context to provide clarity about who is being referred to in the report or the nature of the *"special friendship."* This again raises the theme of poor recording.

3.34. Midlands Partnership University NHS Foundation Trust have identified four complaints from members of Clive's family during his admissions to Stonefield House. None relate to sexual or safeguarding concerns of a sexual nature. "*The complaints received are listed in date order below:*

3.33.1. Clive's mother complained on 30/4/2002 when there was some confusion about the family having access to the ward to say goodbye after a visit.

3.33.2. Clive's aunt complained on 27/04/2009 on behalf of herself and other family members due to an allegation of unprofessional conduct from a nurse on the ward when Clive appeared to have a seizure during a phone call home. A Serious Untoward Investigation took place and actions in relation to conduct were undertaken as per policy at the time.

3.33.3. A Clinical Review undertaken on 09/10/2010 following use of seclusion. Positive recommendations for future practice were taken forward.

3.33.4. *Clive's father complained on 20/10/10 about a variety of aspects of his son's care and treatment on the ward. An investigation was undertaken and the Trust shared the outcome of the investigation and recommendations with Clive's father as per policy at the time*."

Commentary

3.34. From the records held by the agencies involved, it is often unclear what actions were taken. In this respect the narrative accounts provided by the agencies involved are sometimes critical of recording standards.

[25] To the Transforming Care Programme Team.

3.35. Whilst there are occasional records of *No Secrets* guidance having been followed with respect to investigation of adult safeguarding concerns, more often it appears that incidents and referrals were seen through a lens of provider concerns. Similarly, the information submitted by agencies records expressed concerns about the appropriateness of particular placements, the quality of care provided and Clive's lack of progress and/or deterioration, but complaints procedures do not appear to have been utilised.

3.36. The advice given in 2012 appears partially incorrect as responsibility for Clive would have rested with commissioners of the placement and not with the host authority. The lack of an outcome to the 2013 adult safeguarding incident was unsatisfactory.

3.37. There are significant gaps in information-sharing between commissioners and placement providers, involving also social workers who held case responsibility for Clive. This is a repetitive finding in safeguarding adult reviews[26].

Narrative from the independent review – 2014/2015

3.38. In July 2014, Clive moved ward again with the patient group and staff to the Althorp Ward in a different building within St Andrew's grounds due to a service reconfiguration exercise. Clive found the move again to be stressful. Clive's family at this point had become seriously concerned about Clive's quality of care and the impact of the environment, which they felt was the underlying cause of his deterioration. They struggled to have their voices heard and raised formal complaints to St Andrews in July 2014. The family also sought help from several agencies including the CQC, who advised that this would need to be raised with the provider. It was not until the end of September 2014 that they received a formal response to their complaints following engagement of commissioners.

Independent review commentary

3.39. Complaints process/ oversight of care quality: The family report facing significant challenges in having their voices and concerns heard by the provider and wider organisations responsible for quality of care. There was limited involvement of social care and health commissioners throughout Clive's time at St Andrews beyond attendance at some annual reviews and the completion of social circumstances reports. There is no evidence of quality visits to review the appropriateness of the placement taking place before 2015 (Transforming Care Team established). An in-house social worker from St Andrew's was supporting Clive and the responsibility of social care was transferred in 2014 from Staffordshire County Council to Northamptonshire County Council, which further challenged continuity of oversight. The basis of this transfer is unclear.

Information submitted from agencies

3.40. On 26th August 2014 St Andrew's social work department informed a Staffordshire social worker that they had made a referral to Northamptonshire County Council following an allegation which Clive made about staff. He reported that a staff member had roughly grabbed

[26] For example, East Sussex Safeguarding Adults Board (2017) SAR Adult A.

his arm following him having a seizure. They further stated that the incident was not founded as the other staff member who was present reported that Clive was having a seizure and was incontinent of urine. While getting him changed he became aggressive and a staff member had used restraint whilst another member helped with dressing him. There is no indication of any actions taken by Staffordshire County Council in response to this concern.

3.41. Northamptonshire County Council records for August 2014 contain an adult safeguarding concern relating to significant restraint having been used following a seizure. This concern is recorded as having been investigated by the hospital rather than by the local authority. Contact was made with Staffordshire County Council regarding this concern.

Commentary

3.42. There is no other reference to events at this time included in the information submitted from agencies. This includes any transfer of formal responsibility for Clive from Staffordshire to Northamptonshire County Council. Of concern is whether there was sufficient independence in the inquiry into the August 2014 safeguarding concern. Indeed, the independent review was also critical of providers conducting their own investigations. Based on available information, it is questionable whether concerns about Clive's experiences of poor care were adequately investigated and addressed. Concerns about out of area placements, especially involving long-stays in institutional settings, were well-known by this time[27]. Government's transforming care policy was one outcome.

Narrative from the independent review – 2016/2017 (1)

3.43. On 19th January 2016 the newly appointed Transforming Care (TC) lead met with Clive's mother, father and sister for the first time. Records note that they were very upset and angry, having felt they had previously been unheard when raising concerns. The family reported that they were worried about the amount of time he spent in his room, stating that he didn't appear to be encouraged to engage in activities or leave the grounds; they reported that he often looked "*unkempt*" and was still in his pyjamas in the late afternoon. They were anxious regarding behaviours that could lead to self-harm as they felt he was often left in his room with little supervision. Clive's sister had stated that his condition had significantly deteriorated since being on Althorp Ward and was anxious to see him moved.

3.44. On 25th January 2016, the TC lead met with Clive's resident social worker at St Andrew's who provided guided access to Clive's electronic records and showed the TC lead around the ward. The social worker looked back over Clive's records from the previous 8 weeks and it was noted that Clive had accessed the community 3 times during this period: once to attend the dentist, once to attend the opticians and one episode of home leave. The only other time Clive had left the ward in the last 3-month period was to visit the on-site café. Clive's social worker reported that he refused to engage in physio or OT, but that he did see the psychologist. Clive had only engaged in one "*cooking activity*" with the OT, this was in August 2015 and nothing since. It was noted that Althorp being a brain injury ward "*made it difficult to meet the needs of a learning*

[27] Flynn, M. (2012) Winterbourne View Hospital: A Serious Case Review. South Gloucestershire Safeguarding Adults Board. Department of Health (2012) Transforming Care: A National Response to Winterbourne View Hospital. Department of Health Review, Final Report.

disability client as the ward routines don't allow flexibility." Concerns were also raised about the management of Clive's epilepsy, seizure monitoring and management of sleep apnoea. There were also concerns about the approach to behavioural support, records indicated there was a positive behavioural support plan in place, but it appeared that staff were not sufficiently aware of the plan and had not received training regarding positive behavioural support. A brief meeting also took place with Clive, who shared that he did not like living there and wanted to move back closer to home. The outcome of the meeting was that the placement for Clive on the Althorp ward was not suitable and that TC Team would be looking to move Clive on as soon as possible.

Independent review commentary

3.45. Inappropriate care provision & care quality: The process for commissioning St Andrew's ABI was largely led by the inpatient Responsible Clinician at the time with limited input from social care and health commissioners. The level of scrutiny and accountability to ensure the placement was safe and appropriate was lacking. Clive remained in this environment for four years despite concerns raised by his family to the provider, commissioners and the CQC. The visit to St Andrew's by the TC team appears to be the first detailed review of the effectiveness and quality of Clive's care in hospital since his admission in 2007. The view of the team was that the Acquired Brain Injury ward was inappropriate to Clive needs and concerns were raised about the quality of care.

Narrative from the independent review – 2016/2017 (2)

3.46. In March 2016 following a visit to see Clive, a safeguarding alert was raised by the family who reported having found Clive asleep in his room at 2pm, unkempt without a CPAP machine. The family reported being told by staff that the machine was removed from the room as per the care plan to encourage him to leave his room. The family were concerned that Clive was being neglected and that the CPAP machine was being used in a punitive manner. Clive's care plan confirmed that Clive's machine was not to be left in his room during the day due to the risk of breakage and also to "*encourage him not return to his room as per the programme until evening time*." On 23rd March 2016, case notes from Northamptonshire County Council show that a high-level inter-agency concern was raised about the "*ongoing lack of care to the extent that health and wellbeing could deteriorate significantly*" and a safeguarding investigation was opened. The Council asked St Andrew's to carry out an internal investigation. The case notes confirm that the claims were found to be unsubstantiated and that an action was taken to update Clive's care plan to ensure the CPAP machine was not removed from his room. Due to the level of concerns raised, the issues were also formally raised to the CQC by the TC lead.

Independent review commentary

3.47. Safeguarding: Case notes from Northamptonshire County Council indicate that concerns were raised to the safeguarding lead by the Transforming Care Team about the quality and impartiality of the internal investigation "*as the investigation had been opened up to ward staff at St Andrew's to complete*" who had been negative about Clive and failed to acknowledge that the incident occurred. A number of safeguarding incidents were raised to the County Council during Clive's time at St Andrews, the vast majority were referred for internal review. This review raises concerns about robustness and impartiality of such serious reviews being led by the services involved to ensure individuals are kept safe.

Commentary

3.48. Northamptonshire County Council hold two records of safeguarding concerns, one for January 2016 and one for March 2016. The first refers to Clive sustaining a fractured ankle, possibly it asserts self-inflicted. The second refers to the CPAP machine having been removed and also to alleged poor care. The Council have indicated that these safeguarding concerns were reported to Staffordshire County Council, with discussion as to why St Andrews had been asked to enquire into them.

3.49. Section 42(2) Care Act 2014 provides that a local authority may cause an adult safeguarding enquiry to be conducted by another service/agency. However, if it exercises this discretion, the local authority remains responsible for ensuring the adequacy of any enquiry. It must also be satisfied with decision-making about whether or not a safeguarding plan was required as a result of the enquiry.

3.50. Given that the safeguarding concerns related to care quality in a placement, it is questionable whether it was appropriate for the local authority to pass responsibility for an enquiry to that provider.

Narrative from the independent review – 2016/2017 (3)

3.51. On 30th January 2017 Clive made a call to his sister at 8pm and explained that he was packing and leaving [his placement] and suggested the police were coming. The family believe there was an altercation with staff earlier that evening which caused Clive to pack his suitcase. This followed a telephone message that Clive had left for his father two days previously, which caused his family to be concerned about the quality of care Clive was receiving.

Independent review commentary

3.52. Safeguarding: Clive's family remained concerned about the lack of consideration of all available CCTV footage. Based on the footage they reviewed themselves they were particularly concerned with the actions of some staff seen to be flashing torches in the direction of Clive's room. They believe that there was an altercation of some sort and that Clive was in fact upset that evening, hence the call he made to his family.

3.53. Nottinghamshire Police have reviewed the new CCTV footage that emerged during the course of this review and confirm that footage does show that two staff members appear to flash their torches as they are in the corridor. They report that they cannot see any actions by staff on the CCTV that they would identify as abuse or neglect that would reach either a criminal or safeguarding threshold.

Commentary

3.54. No information has been provided for this safeguarding adults review relating to any formal use of a local authority's complaints procedures. Whilst there is repetitive evidence of concern about the quality of care that Clive was receiving in different placements, there were only

occasional referrals of adult safeguarding concerns and there is little evidence of placement reviews or of provider concerns procedures having been used.

Agency concluding reflections regarding recommendation 7

3.55. Staffordshire County Council have observed that in 1999 it had a policy in place for the protection of vulnerable adults. Following publication of *No Secrets* national policy guidance, it developed an inter-agency policy for vulnerable adults and established both a specialist adult protection team and a multi-agency board. The council suggests that these developments promoted greater awareness of abuse and neglect, including of wider risks to others, and followed what was considered best practice at the time.

3.56. Following introduction of the Care Act 2014 Staffordshire and Stoke on Trent adult safeguarding policies and procedures were developed. Training and support was provided and continues to be available, with staff encouraged to complete refresher training.

3.57. Prior to 2006 Staffordshire County Council accept that recording of safeguarding decision making appears to be limited, although this might be partially explained by the loss of records. From 2006 it observes that there is increasing awareness of potential risks with a clearer process becoming noticeable. Reference is made to the inter-agency procedures and there is paperwork and records being kept of outcomes and actions taken. The council observe that it did develop its response to safeguarding concerns in line with best practice and guidance at the time and reference is made to this through case records when policy and procedures are referred to in meetings. However, it accepts that the robustness of investigations is not clear and there were no follow up or reviews of actions taken.

3.58. Enquiries at this time were centred around meetings of professionals, with the adult and/or their representatives appearing to be on the periphery of the investigation. Concerns raised by family members that would certainly now be seen as safeguarding concerns were mainly dealt with as complaints and there does not always appear to have been engagement with Clive at these times. There is also some indication of professionals being seen as the experts.

3.59. Cheshire East have also identified that prior to the Care Act 2014, policies and procedures were developed in line with *No Secrets* policy guidance. These focused on inter-agency policies, procedures and guidance; on procedures for reporting allegations, concerns or suspicions of abuse; and guidance for practitioners involved in reporting and investigating abuse. The implementation of the Care Act 2014 required significant developments in policies and procedures. These developments are included in section four.

3.60. In its submission Staffordshire and Stoke ICB has commented that detailed analysis has been hampered by the limited access to NHS commissioning records of predecessor organisations. However, it appears evident from reviewing the records held by the ICB that there was never any escalation of safeguarding concerns, including those referred by the family, by other services to the CCG as commissioner. This highlights again the theme of information-sharing between the services involved.

3.61. The ICB also observes that archived records held from the CCG relate to the family's concerns raised in writing to the Chief Executive of Stafford and Surrounds CCG in May 2016 around the delays in the current system to secure a tenancy and 'home for life' for Clive.. There

is no reference to any allegation of abuse or neglect within this correspondence and as such the Chief Executive appears to have addressed the concerns that were brought to his attention. From archived records the ICB believes that Clive's family did not include any safeguarding concerns or safeguarding complaints within direct communications sent to the CCG.

Commentary

3.62. Some of the findings from both the independent review and this safeguarding adult review find echoes in other SARs. For example, concerns regarding local authority triage decisions when they pass safeguarding concerns onto a provider service[28], and how complaints are handled in the context of provider and adult safeguarding concerns[29]. Other reviews have also expressed concern at the weakness of statutory and practice guidance regarding out of authority placements and have recommended that duties on the sharing of information between placing commissioners and host authorities should be specified in primary legislation[30].

[28] Camden Safeguarding Adults Board (2022) SAR Mark.
[29] For example, Teeswide Safeguarding Adults Board (2022) SAR Stephen.
[30] Devon Safeguarding Adults Board (2019) SAR Atlas Care Homes.

Section Four: Safeguarding Assurance in 2023

4.1. The terms of reference for this review include a focus on present-day levels of assurance that safeguarding concerns, and specifically allegations of sexual abuse by people in positions of trust, would be fully investigated in order to protect the individual concerned and others who might also be at risk. In addition to providing Staffordshire and Stoke Safeguarding Adults Board and Cheshire East Safeguarding Adults Board with a level of assurance, the hope and intention is also to offer Clive's family assurance that lessons have been learned. The family believe that Clive was failed by the services and agencies who were responsible for keeping him safe and those who did not recognise the very significant life-altering trauma he experienced. There were missed opportunities to investigate what had happened, to protect and support Clive, and to explore whether other residents were also at risk. The family have wanted Clive and his experiences "*to be seen*" and for there to be "*a legacy for Clive*." The family have wanted those involved to consider whether there were other victims. The family are seeking assurances for "*the good of all*" who are receiving care and support and have felt that to date they have carried the responsibility for questioning past and current practice, and for ensuring that lessons are learned. **Recommendation One**: Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should provide Clive's sister with assurance about the outcomes of all the recommendations in this safeguarding adult review.

Information submitted from agencies

4.2. The David Lewis Centre have advised that an independent review of current safeguarding procedures has been completed. Its submission states that its safeguarding policy has also been reviewed as part of the ICB safeguarding commissioning standards group and assurance visit in November 2022 and that it complies with regulations about the process to follow with regards to referrals to the police and local authorities.

4.3. An internal strategy group has reviewed the outcomes of the implementation of the recommendations from the NHS England and Improvement review. This has prompted an internal review of epilepsy and sudden unexpected death in epilepsy risk and seizure management plans. The Centre is also reviewing trauma-informed care and how it is embedded in practice.

4.4. Midlands Partnership NHS Foundation Trust have advised that their current practice would require any incident to be recorded as a safeguarding adult incident with a sub category of allegation against a healthcare professional. "*This would automatically alert the Trust safeguarding team who would contact the ward and support with safeguarding process. If this was a current case then the expectation would be that the Trust safeguarding team would have followed the case through and ensured that any follow up meetings took place until a conclusion regarding outcome/next steps was reached. This would have been documented within the patient records under the sub heading Safeguarding.*"

4.5. Cheshire Police have commented on what has changed since 1999 and what would be expected practice now. "*National Crime Recording Standards were introduced in 2002, they are reviewed and updated regularly. Sexual offences reported to Cheshire Police are recorded and*

investigated. Investigations are managed digitally (Niche), therefore documentary evidence and enquiry logs are all in one place and accessible. Governance and supervisory oversight of investigations is managed through a stringent performance framework. Development of a Sexual Assault Referral Centre (SARC). Improvements in the way we investigate Rape and Serious Sexual Assault (RASSO) offences. Cross border strategy meetings are now more robust and more informed to manage safeguarding. Officers would complete a Vulnerable Person Assessment (VPA) for onward referral to appropriate agencies. Statutory Review Officers would review and consider referral to the Safeguarding Adults Board for consideration of a Safeguarding Adults Review."

4.6. FPU has now evolved to Protecting Vulnerable People (PVP). A simple theft crime would be investigated by our AIT (area investigation team) of PIP1 officers. Although [the staff member] could be considered to be in a position of trust, the papers were held by DLC and the theft took place without the involvement of Clive, therefore the investigation would sit with a PIP 1 investigator. If a similar allegation of theft were to be reported now, a crime would be recorded on the Niche system, this would be appropriately allocated to a PIP1 officer to investigate. An investigative plan would be documented, the victims code complied with, and the investigation supervised by a sergeant to ensure a prompt and effective investigation. At the conclusion of the investigation, a decision would be made with a police supervisor regarding an appropriate outcome. If the full code test was not met, the supervisor has autonomy to make an NFA decision or appropriate disposal.

4.7. The safeguarding element of this cross-border comparison would be documented with regards to responsibilities of Police Forces, details of discussions, strategy meetings and any risk would also be documented and shared fully with actions assigned. Any additional crimes which may come to light would also be crimed as per National Crime Recording Standards and investigated. If there was an allegation of a sexual offence by [the staff member] on Clive today, then a crime would be recorded, this would be allocated to a PIP 2 officer within PVP and investigated proportionately. An investigative plan would be documented, the victims code complied with, and the investigation supervised by a sergeant to ensure a prompt and effective investigation. The victim would be interviewed in line with Achieving Best Evidence. At the conclusion of the investigation, a decision would be made with a police supervisor regarding an appropriate outcome. If the full code test was not met, the supervisor has autonomy to make an NFA decision or appropriate disposal. As part of this victim strategy a decision would be made jointly who was best placed to inform the family and keep them updated; this may not be the host force, if it is felt that [another force has a rapport already.

4.8. Staffordshire Police have reported that: "*a complaint of the nature subject of this SAR, immediately attracts a unique incident report for grading of response and a unique crime reference with a clear audit trail of investigation. That response is likely to be directed to specialist Detective Officers and accountability includes an Investigation Plan supported and reviewed by supervisory and senior Detective Officers – through to resolution. In the event that following from the response phase and a review of the Investigation Plan it is established that an offence appears to have been committed on another Police area where identified lines of enquiry are necessary – as is the case with this SAR – details of that liaison and agreement would be recorded including the requisite name, role and department of the individual identified to continue with the investigation to resolution and all original investigative material gathered during the response phase would be forwarded*."

4.9. Staffordshire Police have further advised the following. "*A comprehensive set of Staffordshire Police Policy and Procedure exists in the pertinent disciplines of Incident Recording, Crime Recording and Crime Investigation. It was different and perhaps not as robust historically – particularly in 1999 – and as a consequence frustrating for the recovery of material to inform the LeDeR Review or the SAR. Similarly, a comprehensive set of Staffordshire Police Policy and Procedure exists in respect of the identification and management of risks to persons, with a particular focus on any individual considered vulnerable. Historically a database – 'Guardian' – captured that detail exclusively, but was confined to children. Over the years, with advances in data storage and computerisation it evolved into a more inclusive Vulnerability – Children and Adult – Database and now has been absorbed by a single Database – 'NICHE.' "*

4.10. Staffordshire Police have also reported that further change includes specialist police investigation teams of police officers and police staff who have undergone enhanced levels of training and professional development. "*Information exchange protocols have advanced to allow for [an] accountable and transparent multi-agency response. Strategy discussions are well embedded and provide the framework to identify and allocate proportionate and justified investigation plans and safeguarding tactics – whether single or multi-agency in design, ownership and delivery to resolution*."

4.11. In a follow-up submission, Staffordshire Police have advised as follows: "*Staffordshire Police has specialist teams who deal with sexual offences, dependent on whether they are a child or adult following a review of their care and support needs. Any vulnerability identified will require a capability / capacity assessment prior to any video interview. This can be a previous diagnosis from a medical practitioner or new request via appointed Social / care worker. Should the victim lack capacity, officers can still obtain an account, but will be disclosed for any future judicial process. Any interview will take place with an identified social worker / family member or intermediary from the National Crime Agency list. Only officers specially trained in video interviews will lead and they will be aware of the victim's vulnerabilities. Officers who are in initial contact should be Specially Trained Officers (STO) to deal with serious sexual offences and all new recruits are being trained to this standard. Serious and more complex cases are dealt with via accredited detectives …. There is a clear command structure in place across directorates and a multi-agency case conference will identify force leads. Should victims need to attend court there are a number of special measures which can be applied for, to assist a specific identified vulnerability*."

4.12. Similarly, Staffordshire Police have stated the following: "*In respect of CPS and Police, there are clearly identified processes in place to obtain early advice, dependent on whether officers are seeking a remand of a suspect into custody, or obtaining advice prior to the evidential threshold test is met. Prosecution paperwork must have supervisors' comments recorded to explain their rationale on whether the threshold test or full code test is met. If there are any public interest matters and the victim's wishes. Victim-less prosecutions do occur, but of course can be difficult to deal with without independent witnesses or forensic evidence to support the threshold of beyond all reasonable doubt. Vulnerable victims will have an identified appointed person to contact for regular victim updates (family member / care/social worker). Officers will update the crime recording system with a clear victim contract and any contact is recorded which is time/date stamped."*

4.13. Cheshire East Council have advised that the current policy has been developed by Safeguarding Adults Boards across the Northwest to meet the statutory requirements of the Care Act 2014. All the Northwest region is signed up to the same policy. In addition to the NW ADASS Policy, Cheshire East has many adult safeguarding policies which govern practice. All local authority safeguarding policies are held on a Safeguarding SHAREPOINT site and multi-agency policy, procedures, guidance and information can be found on the Safeguarding Board Website. North West ADASS have a regional PIPOT (People in Positions of Trust) policy, and Cheshire East Council has a local PIPOT Policy which mirrors this. The Head of Adult Safeguarding is the PIPOT lead for incidents which occur in a PIPOTs private life and may impact on their practice role.

4.14. Cheshire East Council have produced an Organisational and Large-Scale Enquiry Safeguarding Policy which governs safeguarding practice with care providers. The policy is based on best practice, including NICE Guidance – Safeguarding Adults in Care Homes Overview | Safeguarding adults in care homes | Guidance | NICE Feb 2021. A Standard Operating Procedure underpins processes.

4.15. The Safeguarding Adults Board seeks assurance via partners regarding adherence to their own policies and procedures, by requesting annual single agency reports and conducting joint frontline visits and facilitating multi-agency audits. The SAB produces an Annual Report, including Stories of Difference, which is scrutinised by Elected Members. In January 2023 the David Lewis Centre shared a recent safeguarding case example and short interview with a family member sharing his lived experience of the impact and process.

4.16. To assess whether current practice complies with national legislation, Cheshire East have adopted a number of measures. Monthly Overarching Safeguarding Performance Reports are produced to measure volume, timeliness, types of abuse and Making Safeguarding Personal outcomes. The reports are shared with Directors, Senior Managers and Practitioners. The Safeguarding Performance Officer also undertakes deep dives and bespoke performance reports which highlight activity and compliance. Cheshire East conducts Making Safeguarding Personal Audits on a quarterly basis. Areas of good practice and areas for improvement are shared with practitioners and managers.

4.17. Low Level Care Concerns are submitted electronically by care providers. There are 19 care concern domains. Every care concern is screened to see whether it is at the correct level. Care concerns from all providers are collated into a monthly report. This enables staff to identify themes and trends. A multi-agency meeting is held each month to share information and to address specific issues for care providers. An example of good practice is the work which was undertaken with pharmacists to improve medication issues in certain care homes.

4.18. The weekly numbers of safeguarding concerns and care concerns are submitted to the Head of Service and Director each week. During 2021 – 2022 a total of 5039 safeguarding concerns and 3870 care concerns were received by Cheshire East Council. The number of care providers rated as GOOD or OUTSTANDING in Cheshire East has risen from 68% in 2019 to 79.8% in January 2023.

4.19. Cheshire East Council have confirmed that staff training has developed alongside legislative changes and a training framework includes adult safeguarding. Practitioner guides and bulletins are also produced. The Safeguarding Adults Board has two trainers who provide training

specifically for care providers and other Board partners. The Board also uses social media to raise awareness about adult safeguarding.

4.20. All care providers are required to meet contractual standards and be registered with the Care Quality Commission. Quality Assurance Officers from the local authority and ICB work collaboratively to monitor care provider compliance. Where information, intelligence, complaints or safeguarding/care concerns indicate that a provider may not be fulfilling their duties, there is a targeted approach to working with them to address the issues. Where there are indicators of organisational abuse or neglect, the provider will be required to produce an action plan and regular reports. Local partners may provide additional support or training to assist with improvements. Placements may be suspended during this time. Where care providers are unable to improve or the risk is so high that residents are at extreme danger, the regulator or local authority may instigate a home closure. Information is shared at monthly contracts and safeguarding governance meetings.

4.21. Cheshire East has a procedure when placing someone in another authority. For safeguarding concerns which occur in another local authority, Cheshire East follows the national ADASS guidance. Best Interest Assessors provide additional intelligence when conducting DOLS assessments in care homes. Healthwatch also submit regular Enter and View Reports about care providers.

4.22. Local performance data indicates that Cheshire East Council receives the most safeguarding concerns from care providers. This could be interpreted as Cheshire East having lots of allegations of abuse in care settings OR it could indicate that the awareness about how to recognise, respond and report abuse is good, and that care providers are being transparent. When a safeguarding concern is submitted which relates to a care provider, Cheshire East has a dedicated Adult Safeguarding Provider Team who can respond in a consistent way. They also have oversight across the local authority and an ability to pick up themes and trends across care providers. The team have established excellent relationships with key partners including the Police, ICB, Commissioning and CQC.

4.23. The Local Authority will shortly be subject to a CQC Assurance Framework in the same way as care providers. This will provide an opportunity for an external evaluation of safeguarding activity and safe systems. Cheshire East is keen to ensure that all safeguarding activity is based on evidence and wants to hear from service users and families. The SAB has a dedicated Service User Group who influence Board activity. Monthly Safeguarding Reports and audits include Making Safeguarding Personal Outcomes. Further work is underway to triangulate feedback from service users, social workers and practice managers.

4.24. Each SAR is precipitated by an event and is an opportunity to consider whether national legislation and local guidance has been followed. The recommendations and learning from these reviews is shared with all partner agencies, with the aim of preventing further occurrence. Cheshire East has benefitted from dedicated sessions for staff to understand the purpose and processes of these reviews. Adult Social Care is also keen to learn from compliments and complaints, Local Government and Social Care Ombudsman cases as well as SARs held in other parts of the UK.

4.25. Whilst measures are in place to provide officers with tools and resources to implement legislation, Cheshire East recognises that staff work within organisations which are facing challenges in terms of budgets, recruitment, retention and increased demand.

4.26. Staffordshire County Council (SCC) have a specialist adult safeguarding team that receive, review and assess all safeguarding concerns that are referred to it. At this point initial risk is assessed and any immediate safeguards are identified and implemented. Information is gathered from relevant agencies within the MASH (Multi Agency Safeguarding Hub) which includes police and also agencies outside the MASH, such as GP, care providers and housing. The adult at the centre of this enquiry will also be contacted unless there are risks/concerns about this happening. These actions will determine if an enquiry under section 42 is required, if this will be a joint/multi-agency enquiry and who will be the lead agency.

4.27. Staffordshire County Council follow the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board policy and procedure, and this is in line with statutory guidance and underpinned by safeguarding principles and making safeguarding personal. Safeguarding enquiries are completed with the adult at the centre and safeguarding plans should be implemented when there is an ongoing risk of abuse and neglect and these should be reviewed.

4.28. SCC have previously had two internal independent audits completed that have identified that decisions are made in accordance with its policy and procedure along with statutory guidance. Following the outcome of the NHS England review of Clive's life and the initial recommendations, Staffordshire County Council completed an audit of safeguarding concerns. It reviewed 50 safeguarding concerns and compared outcomes for adults who have a learning disability and adults with other "*primary needs*". This was completed to identify if there was any obvious disparity in outcomes, for example progressing to section 42 or in involvement of other agencies. In particular SCC looked for evidence if there was a crime and if police were informed and subsequent criminal investigations. Whilst the initial findings didn't identify any discrepancy and could suggest that safeguarding practices are robust, it has been recognised that this is only a small proportion of safeguarding concerns.

4.29. Therefore, SCC complete monthly audits and case reflection sessions with those making safeguarding decisions and have redesigned and refreshed its training programme which commenced in April 2023. SCC recognise that there are continued areas of improvement and in engaging and supporting multi-agency enquiries to better support adults. The refreshed training is to ensure that safeguarding practice is in line with the principles of making safeguarding personal. This will also include revised mandatory training for all staff employed at the county council. Following a recent external review SCC have identified that it would benefit from a specific safeguarding quality assurance framework to embed and monitor practice across the services.

4.30. In May 2021 the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board completed a multi-agency case file audit relating to Persons in Positions of Trust (PIPOT). Lack of recording of data on age, gender and ethnicity was a significant issue, with the report concluding that no focused work could be completed regarding awareness until there was clearer data. "*This is an ongoing concern and efforts are being made to engage practitioners and encourage them to gather accurate data.*" Similarly concerns were identified about the lack of data relating to location of abuse and source of risk.

4.31. It was noted in Stoke-on-Trent that there were two care homes in particular that had a significant number of safeguarding referrals made. It was clarified that these two homes are currently in large scale enquiry and that there are professionals working with the homes to ensure that residents are safe.

4.32. Themes identified by the audit included the following:

4.32.1. "There are often concerns raised that may be more appropriate as quality concerns and only where there are multiple concerns regarding a care home or an individual would this then be raised as a safeguarding concern."

4.32.2. Where concerns were taken to the Police often there was not enough evidence to convict or the adult did not want the case progressed. It was recognised that although there was little police prosecution there were other sanctions against persons in a position of trust. The Police have used formal sanctions in these cases using Restorative Justice to ensure that young adults understand the consequences of their actions without entering the legal justice system. Where necessary there was contact with the Disclosure and Barring Service and the investigations have been added to their record to ensure that they do not work with vulnerable adults in the future. Other actions were taken by organisations that included suspending the source of risk pending investigation. Or an internal HR investigation. Other organisations introduced additional surveillance methods such as CCTV to ensure that any abuse can be identified and substantiated or prove that there is no abuse going on.

4.32.3. In some cases, the source of risk left the organisation before the investigation concluded. Some of the sources of risk do move between care homes and organisations which was identified as a concern.

4.32.4. Concerns were also voiced that due to COVID-19, and the need for more staff due to illness and understaffing, there may not have been as thorough background checks into carers. There was no evidence of this in the cases presented but it was raised as a potential concern.

4.32.5. There were staff entering the care industry for the first time who did not understand the needs and duties required from a carer. Caring is a minimum wage profession but requires a high level of personal and professional standards. This may lead to a lack of sufficient high-quality care staff for the Independent Care sector. It was recognised that this concern has been raised nationally that care has minimum pay and large responsibility. Carers may not always have the understanding that they are caring for vulnerable adults who may not have the capacity to make decisions and to treat them with dignity and respect. This was particularly noted in the cases shared regarding younger workers who have just entered the work force or when carers are managing challenging adults who may not have capacity.

4.32.6. In some cases professionals were taking the word of carers over that of the adult or of a new member of staff. It was considered that this could indicate a 'closed culture' and that a new starter may come across different practices and be able to identify and raise concerns more effectively due to their fresh perspective.

4.32.7. Some carers had built strong relationships with the adults that they care for but that this has led to a loss of professional conduct towards the adult such as dignity and respect. Cases were also identified where the adult may have made up the concern as they have a history of doing so. It was noted that no matter who raises the concern this is always investigated thoroughly.

4.32.8. There is often confusion between what is a quality concern and what is a safeguarding concern leading to an over reliance on safeguarding as the ideal place for all concerns.

4.33. Staffordshire County Council receive a high number of safeguarding concerns from providers such as care homes and care agencies, these represent up to 70% of all referrals received. These are not only looked at individually for a decision under section 42 of the Care Act but are also monitored through our quality assurance teams. Monthly meetings are held between the quality assurance and safeguarding teams to review services where risks appear to be escalating and monitoring and actions are discussed.

4.34. Safeguarding and quality teams work closely when concerns are raised within providers and multi-agency meetings are held including with providers as necessary. These may be under our enhanced provider monitoring or Large Scale Enquiry procedures, both of which are detailed in the SSASPB Safeguarding procedures.

4.35. Further to this SCC also hold monthly Quality and Safeguarding Information Sharing Meetings (QSISM) that is attended by both Staffordshire and Stoke on Trent Local authorities, ICB, CQC and Healthwatch. High Risk services are discussed with relevant information being shared by all agencies to address risk.

4.36. SCC safeguarding and quality assurance teams have been working together to provide information to providers regarding safeguarding concerns and provided flow charts and other useful links on a platform called MIDOS. We have also provided safeguarding training and forums to providers where their responsibilities and what they can expect from the local authority are discussed.

4.37. In relation to concerns relating to Persons in Positions of Trust, SCC have a reporting system in place which is monitored by the Designated Adult Safeguarding Manager, (DASM). Records are kept as appropriate when concerns are raised in relation to a person in position of Trust. Relevant multi agency meetings are held, as part of a section 42 enquiry and when no section 42 is required. Outcomes and actions are recorded and monitored.

4.38. Learning from incidents is also being embedded within SCC. We share relevant briefings from national SAR's and also encourage and support staff to attend learning events put on by the safeguarding board. Internally we monitor complaint outcomes and learning from SAR's etc through our Quality Review group that meets monthly. We identify areas for learning and look for appropriate ways to disseminate this either through training or updated guidance etc.

4.39. The Staffordshire and Stoke ICB have reported that "*safeguarding sits within the Chief Nurse's portfolio. There are now 2 additional layers of leadership which strengthens the team. Within the ICB Safeguarding team, there are 4 Adult Safeguarding and Nursing Home Support Nurses whose role it is to respond to allegations of abuse or neglect to those individuals who are in receipt of health funding where the allegation relates to the package of health commissioned support. The majority of the section 42 enquiries caused to the team are for independent sector services, but on occasion, this can be joint investigations with Police or Social Care. The team will also provide a response to incidents in acute settings both across NHS and independent sector mental health hospitals where the local authority has determined the need for external review. The team also complete enquiries where individuals have been placed within Staffordshire by external health commissioners and do this in partnership with the placing commissioner. The ICB Safeguarding Team are nurses, they will not respond to allegations of physical, sexual or financial abuse as these are led by Police or Social Care but a multi-agency review is often sought*."

4.40. Assurance around adult safeguarding practice within the boundaries of the ICB is achieved through the following:

4.40.1. Oversight arrangements within the Adult Safeguarding Board;

4.40.2. implementation of agreed multi-agency policies and procedures;

4.40.3. effective risk management processes monitored through a dedicated team of specialist safeguarding staff;

4.40.4. Oversight within the ICB Quality and Safety Committee (and previously in PCT and CCG Quality Committees);

4.40.5. Oversight at the ICB Board as part of the overall report on nursing and quality related matters. Again this is consistent with previous arrangements that existed in PCTs and CCGs although as safeguarding practices have emerged, it must be acknowledged that these arrangements have improved;

4.40.6. Further assurance is provider from SSASPB audit activity and through case management of all individuals placed by the ICB.

4.41. The ICB have commented further as follows. "*Since the evolution of the transforming care programme in 2015 there have been significant developments relating to the Transforming Care agenda. In summer 2017, although sadly after Clive's death, the CCG Chief Nurse took over the responsibility for this programme and over the subsequent 4 years led significant improvements in achievement of the targets outlined in Building the Right Support. In 2021 responsibility for this programme was transferred into North Staffordshire Combined Health Care Trust who have a specialist team to commission and oversee the care of people with learning disabilities and autism. In addition, there is now a dedicated Learning Disability and Autism Partnership Board; this Board includes individuals with lived experience. The Board has oversight of all commissioned services and will challenge inequalities*."

4.42. "*Internally the ICB has implemented the NHSE Host Commissioner Guidance published in January 2021 and has named individuals responsible for ensuring that any concerns in relation to the quality or safety of care for people with Learning Disability and Autism are listened to and action taken to address. In addition, all NHS commissioned services are required to provide detailed exceptions to the NHS standard contract with clearly defined requirements to ensure staff are effectively trained and safeguarding concerns are identified and actioned.*"

4.43. The ICB (and CCGs previously) are signed up and committed to the SSASPB multi-agency safeguarding procedures referenced within the suite of ICB Safeguarding Policies. The SSASPB procedures are written in addition to the safeguarding requirements within the NHS Standard Contract to ensure all health commissioned services are following the local processes. Additionally, it is a contractual requirement for health commissioned services to share by exception details of allegations made against their service including persons in a position of trust and subsequent management of those including changes to practice, education or referral to police, professional body, regulatory body or any other parallel process.

Commentary

4.44. The purpose of the learning event was to seek further assurance about adult safeguarding now. The learning event was well-attended by practitioners, operational managers, senior leaders and elected members from across the services that had been involved with Clive and in

providing information for the review. Those present explored the themes that had emerged from the documentary analysis reported thus far in this review.

People in positions of trust (PIPOT)

4.45. Whilst both Cheshire East and Staffordshire and Stoke Safeguarding Adults Boards have published procedures relating to allegations concerning people in positions of trust, not everyone appeared to know how to access them. It was acknowledged that suspected perpetrators might move between care settings, including across geographical boundaries, which highlighted the importance of further strengthening information-sharing, including across organisational borders. Challenges also remained in identifying and reporting people suspected of abusing their position of trust. Nonetheless, examples were given where successful prosecutions had been achieved in a context of regular meetings of senior and operational managers where there was now an approach of "*assertive commissioning*" and a "*low threshold for action*." However, responses to allegations of abuse by people in positions of trust have developed locally and/or regionally; there is no national policy, unlike in safeguarding children, that outlines requirements for this aspect of adult safeguarding. **Recommendation Two:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider utilising the escalation policy developed by the National Network for Safeguarding Adult Board Chairs with the Department of Health and Social Care to advocate for the development of national guidance with respect to people in positions of trust.

Achieving best evidence

4.46. Those attending the learning event felt that the enhancement of procedures and practice for responding to allegations against people in positions of trust had been facilitated by a greater recognition of "*achieving best evidence*." Practitioners and managers attending the learning event talked about a step-change in attitudes and an increased commitment to obtain evidence, including using reasonable adjustments (Equality Act 2010; Youth Justice and Criminal Evidence Act 1999). They referred to the training of police officers, to promote and ensure robust interviewing, and oversight through review by senior officers and use of case audits. They referred to the advantages that come from co-location of social workers and police officers, for example in Multi-Agency Safeguarding Hubs.

4.47. Nonetheless, those present recognised that there was more work to do in order to achieve best evidence, coupled with expressed concerns about timescales and delays that could add to the trauma experienced by those who had experienced abuse and were waiting for a final resolution. There is the variability in the availability of training on achieving best evidence in qualifying and post-qualifying education and training, for example of social workers, and concern regarding whether care providers would know how to respond when suspicions or allegations first emerge. Finally, regret was expressed that the use of pre-recorded videos and other measures to secure best evidence and to enable prosecutions were contained in youth justice legislation as opposed, for example, in adult safeguarding law. **Recommendation Three:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider recommending to Social Work England, the College of Policing, the British Medical Association, General Medical Council and the Nursing and Midwifery Council the development of achieving

best evidence training in qualifying education, and the provision of specialist investigating courses in post-qualifying training.

4.48. Analysis of safeguarding adult reviews has found only a low number of successful prosecutions where adults at risk have been victims of sexual abuse and sexual exploitation. There are also examples where safeguarding adult reviews have found evidence of sexual abuse and exploitation where the outcomes of investigations are unclear[31]. Guidance on safeguarding and investigations involving abuse of adults at risk was published in 2012[32] but this is pre-Care Act 2014 and does not appear to have been updated since. The consequent risk is that practice is evolving locally without an up-to-date national framework as guidance on best practice for achieving best evidence when working with vulnerable and intimidated adults at risk. **Recommendation Four:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider advocating via the National Network for SAB Chairs for revised investigative guidance with the College of Policing, Ministry of Justice and Home Office. Revised guidance should emphasise the importance of investigating whether other adults have been abused and/or exploited in addition to the person who has made the initial disclosure.

Securing prosecutions

4.49. Some frustration was expressed at the learning event towards the Crown Prosecution Services (CPS) in respect of their response to police investigations and recommendations where the evidence in chief has been provided by a person with learning disabilities and/or mental ill-health. This frustration revolved partly around the time taken to reach decisions that involved "*vulnerable victims*." It related also to the time taken to achieve disclosures, obtain evidence and prepare submissions, which can be traumatic for victims. It related also to communication; police officers with an in-depth understanding of a case needing to be able to communicate that through their file submissions. Case conferences had been found to facilitate this communication, and to promote understanding of the case and the victim.

4.50. Panel members have observed that with austerity measures resulting in substantial cut backs to both CPS and police resourcing, this has caused a much reduced level of contact between the two agencies. This has followed the withdrawal of CPS lawyers from police stations. This can also have an impact on clear communication with victims and families when evidential thresholds have not been met and therefore prosecutions are not proceeding. At least in some instances, panel members and those attending the learning event felt that the system had become dis-jointed, impacting on investigative and decision-making quality, and on the experiences of victims and families. It has been suggested that the issues arising from Clive's case are not unique, for example about the storage of information and the measures necessary to achieve best evidence. **Recommendation Five:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider initiating dialogue with the CPS and local police forces to explore service improvement that responds to the learning about thematic issues from this review.

[31] Preston-Shoot, M. Braye, S. Preston, O. Allen, K. & Spreadbury, K. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019 Findings for Sector Led Improvement.* London: Local Government Association and Directors of Adult Social Services. See SAR Leanne (Essex SAB) and SAR Jo (Stockport) as examples.

[32] National Policing Improvement Agency (2012) Guidance on Safeguarding and Investigating Abuse of Vulnerable Adults.

Out of authority placements

4.51. The statutory guidance that accompanies the Care Act 2014 clearly outlines the requirements on placing commissioners and host authorities. Practice guidance has also been issued[33]. Safeguarding adult reviews have reported that this guidance is not followed[34]. Those attending the learning event reported examples where the host authority did not know that someone had been placed in their area. This meant that safeguarding referrals were often the first notice of a placement. Whilst strategy meetings were being organised in response to safeguarding referrals, practitioners and managers agreed that it would have been helpful to know about people with complex needs being placed in their localities. **Recommendation Six:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider requesting that the National Network for SAB Chairs escalates this concern, namely that statutory guidance on roles and responsibilities regarding out of authority placements is insufficient, and that provision should be made in primary legislation. **Recommendation Seven:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider auditing local practice with respect to compliance with the statutory guidance when adults for whom the local authority or ICB are responsible are placed outside their home area.

Information-sharing

4.52. Those attending the learning event recognised shortcomings relating to information-sharing in their work with Clive – sharing of information between police forces and between commissioners and placement providers. The dominant view was that information-sharing had improved, including across borders and boundaries. Nonetheless, cross-border cooperation was seen as requiring "*more thought*" and this finds echoes in recent safeguarding adult reviews that have highlighted shortcomings in information-exchange between local authorities[35]. Also recognised was the importance of practitioners and managers knowing what information can be shared lawfully, and improving communication with families and within and between organisations and services.

4.53. Another aspect of information-sharing that was highlighted was obtaining information in order to understand as fully as possible the concern being referred, and sharing outcomes with those who had referred adult safeguarding concerns. In addition, concerns were expressed regarding the quality and specificity of the information being shared. For example, rather than simply saying that a person does or does not have mental capacity, it is essential to state capacity for what.

4.54. A sense was conveyed that where multi-agency safeguarding hubs had been established, co-location facilitated timely information-sharing and assessment between different professional disciplines. Reference was made to PIT STOP, or partnership integrated triage, that had been adopted in some areas to use information to respond early to need presented by children and their families. It was suggested that a similar system could be adopted with respect to adults in need of care and support and/or safeguarding, and those without care and support needs but at

---

[33] For example, NHS (2021) Learning Disability and Autism – Host Commissioner Guidance: Quality Oversight of CCG-commissioned Inpatient Care for People with Learning Disability and Autistic People.

[34] For example East Sussex SAB (2017) SAR Adult A.

[35] Blackpool SAB (2023) SAR Jessica and Sheffield SAB (2023) SAR PI.

risk. **Recommendation Eight:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider reviewing with partner agencies what further practice improvements and service developments can be made to promote information-sharing.

Recording

4.55. Access to files legislation began as a result of a successful campaign by Graham Gaskin, a care experienced young adult, to obtain information in order to understand what decisions had been taken about him and why. Accurate and comprehensive recording is an important source of information regarding someone's personhood and their life journey. Both the independent review and this safeguarding adult review have been hampered by loss and incomplete or unclear records. This was acknowledged at the learning event, that it had been difficult to retrieve historical information and that where records had survived, their quality in terms of legibility and clarity had often been poor. Such information is crucial to enable individuals and their families to understand significant events.

4.56. Those attending the learning event believed that recording practice had improved, for example with respect to investigation of potential crimes and decision-making in section 42 enquiries, but also recognised the need to develop good recording practice, for example to ensure that the outcomes of making safeguarding personal are recorded. Accurate and comprehensive recording was also seen as essential to enable all services to be more "*intelligence-led*." Records needed to be clear and succinct, enabling practitioners and managers to spot patterns and trends. Information-sharing and working together would also be facilitated if recording systems "*spoke to each other*." Examples were also given of where recording was being used proactively to identify trends and themes, for instance regarding care providers. **Recommendation Nine:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider undertaking regular multi-agency audits of recording practice.

Making safeguarding personal and thinking family

4.57. Those attending the learning event spoke of ongoing work to embed making safeguarding personal in practice, linking this with a strengths-based and trauma-informed approach to adult safeguarding work. Training had raised awareness and understanding of trauma and its impact, with "*significant improvements*" reported on trauma-informed awareness and practice, prompted by national guidance[36]. This has included engaging proactively in conversation with individuals rather than just waiting for something to emerge. However, a sense was conveyed that the journey to embed trauma-informed practice had begun, with more to do[37]. Similarly, better recognition of the wishes, feelings, concerns and desired outcomes of the adult themselves was also needed.

4.58. On "*thinking family*" those attending the learning event spoke of the importance of building a "*triangle of care*" and questioned whether services were now more effective in responding to the needs, views and concerns of family carers. One positive example of change, learning from situations where families have raised concerns about the quality of care and recognising that

---

[36] NICE (2018) Post-Traumatic Stress Disorder. Guidance NG116.

[37] An example was given at the learning event, namely Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (2022) SAR Andrew.

with Clive early warning signs around quality assurance were missed, is the introduction of a quality assurance form that members of the public, families and professionals can complete to raise care quality concerns. This prompts investigation, with outcomes relayed to those who have submitted referrals, and informs a risk rating of providers and where appropriate action plans that are overseen by a provider improvement response team. Quality and safeguarding monthly meetings provide an additional layer of assurance. **Recommendation Ten:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider seeking assurance about making safeguarding personal and about responding to family concerns surrounding quality of care through regular audits.

Supporting adult safeguarding practice

4.59. One positive development highlighted at the learning event was the accessibility and quality of safeguarding support now available, for example in NHS Trusts and ICBs. This included the provision of safeguarding supervision and had opened up an escalation pathway internally and externally when safeguarding concerns and referrals did not seem to be progressing. **Recommendation Eleven:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider seeking assurance regarding the use of safeguarding specialists in partner organisations to facilitate the resolution of complex adult safeguarding cases.

4.60. Some work was also reported at the learning event to turn policies into visual operating procedures to ensure that practitioners and operational managers understand expectations. The current context of adult safeguarding includes considerable concern about the experiences of people with learning disabilities and mental ill-health in closed cultures. Clive himself expressed concerns about care quality. His family on many occasions raised concerns about care quality. Section 4.52 has already highlighted one change in response. Nonetheless, a review of recent national guidance might also be helpful. **Recommendation Twelve:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider what learning might be taken into their local and regional procedures from ADASS guidance (undated) on "*Safeguarding People in Closed Environments*" and from CQC guidance (undated) on "*Identifying and Responding to Closed Culture*."

4.61. A word of caution for all involved in working with adults at risk was expressed at the learning event. Just because a referral has been sent to adult safeguarding should not mean that all responsibility for safeguarding has been passed over. Safeguarding remains everyone's business.

The contribution of Safeguarding Adults Boards

4.62. Safeguarding Adults Boards have a statutory mandate to seek assurance about the effectiveness of adult safeguarding practice and procedures. Ideally they provide a safe, supportive but also challenging environment in which constructive discussions can take place, with particular reference to repetitive or "*wicked*" issues. That Safeguarding Adults Boards have a leadership role in promoting change was acknowledged at the learning event.

4.63. Amongst the issues mentioned at the learning event in response to reflections on the work with Clive, often reflected in other safeguarding adult reviews were:

4.63.1. Ensuring that the most appropriate practitioner and service takes responsibility for mental capacity assessments rather than defaulting to the local authority, and that these assessments are thorough and clearly recorded;
4.63.2. Ensuring that practice embodies the values and principles enshrined in the Equality Act 2010 and the Human Rights Act 1998;
4.63.3. Supporting practitioners to express concerned curiosity and to hold conversations about issues that might be perceived as difficult, such as talking about sexual relationships, abuse and exploitation;
4.63.4. Providing not just training but also organisational support to implement the learning acquired so that it leads to enhanced competence;
4.63.5. Supporting staff to manage the increasing volume and complexity of practice;
4.63.6. Enabling practitioners through regular forums to bring their experiences and insights to inform service development and practice improvements;
4.63.7. Creating a culture that learns from mistakes, shortcomings and acts of omission;
4.63.8. Maintaining the strength of operational and strategic partnerships and the quality of working relationships in a context of staff churn.

Recommendation Thirteen: Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider how best to take forward dialogue about these “wicked” issues with senior leaders alongside practitioners and operational managers.

Section Five: Conclusion

5.1. This safeguarding adult review was commissioned in response to two recommendations from an independent review by NHS England – Midlands. Despite the terms of reference and methodology clearly aiming to achieve proportionality, there has inevitably been some repetition for Clive's family and for the agencies involved in terms of sourcing and providing information. Whilst the learning derived from this activity has hopefully been helpful, it might have been appropriate for those involved in the independent review to have highlighted concerns about adult safeguarding as soon as they emerged. This would have enabled earlier consideration of whether either the mandatory or discretionary criteria in section 44 Care Act 2014 were met and to determine whether a separate or joint review would follow.
Recommendation Fourteen: The West Midlands and North West regional groupings of Safeguarding Adults Boards should explore with NHS England whether a protocol can be developed for discussion of how to proceed when the criteria for a learning disability mortality review and a safeguarding adult review are both potentially met.

5.1.1. NHS England – Midlands, in their feedback on this report when in draft form, have indicated their strong support for this recommendation, observing that it "*builds on the recommendations made by Fiona Ritchie when she reviewed the Oliver McGowan LeDeR*[38] *and the need to effectively 'triage' LeDeR cases and ensure that they are on an appropriate investigation pathway.*"

5.1.2. There does not appear to have been a referral for a safeguarding adult review when Clive died. The aforementioned meeting in January 2022 between NHS England and the local authorities and police forces involved clearly discussed how the recommendations in the independent review would be taken forward using the mandate in section 44 Care Act 2014.

5.2. Staffordshire and Stoke ICB have included in their submission to this SAR several recommendations. "To ensure the safeguarding of all individuals and particularly the future of individuals such as Clive the following recommendations are imperative:

5.2.1. Assurance and review are required to ensure the described process for managing allegations against individuals within a position of trust is robust and remains fit for purpose and is consistently applied. This safeguarding adult review has addressed that point in recommendation one.

5.2.2. Further assurances are required from host commissioners external to Staffordshire of any escalation by independent sector providers, Regulators and local authority front door arrangements to ensure individual alerts for those placed out of area are shared with the placing authority and all relevant partners. This action needs to be in addition to the reviews monitored by the host commissioner. This safeguarding adult review has addressed these points in recommendations five and six.

5.2.3. The need to ensure any changes in presentation are explored and investigated by the relevant lead is paramount to provide assurance that this is not a result to trauma, abuse or neglect.

5.2.4. As an organisation that is subject to regular reform, the NHS (currently the ICB) needs to ensure that it maintains a high standard in relation to the storage and retention of records,

---

[38] Ritchie, F (October 2020) Independent Review into Thomas Oliver McGowan's LeDeR Process: Phase Two. NHS England.

correspondence and information to ensure that any future investigations and reviews do not encounter the same issues accessing historical information. This safeguarding adult review has addressed these points in recommendation eight.

5.2.5. All partners need to ensure that clear information sharing arrangements are in place, subject to regular review and fully understood and adhered to by relevant staff to avoid delays in highlighting emerging concerns in future. This safeguarding adult review has addressed this point in recommendation seven.

5.3. Staffordshire County Council (SCC) have also offered recommendations, namely:

5.3.1. As a result of the indication that Clive's views and wishes were not captured within safeguarding enquiries, SCC are to ensure that the principles of making safeguarding personal are embedded in practice, for example through an updated training programme, safeguarding 'surgeries' for frontline workers and managers, and audits. This safeguarding adult review has addressed this point in recommendation nine.

5.3.2. To promote the inclusion of families and carers through enquiries – ensuring views are valued, respected and appropriately addressed. This safeguarding adult review has addressed this point in recommendation nine.

5.3.3. Whilst there is indication of some multi-agency meetings – effective use of arrangements to consider broader risks and to make sure that relevant parties were present – for example, other local authorities and police forces.

5.4. Safeguarding Adults Boards have a responsibility to ensure that learning from safeguarding adult reviews results in practice improvement and service development. This was recognised at the learning event. **Recommendation Fifteen:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider two further learning events. The first to disseminate the findings of this review nationally. The second to bring partners together in one year's time to reflect on the outcome of the recommendations and to take forward any further learning.

5.5. Clive's sister has commented that services should "*see the person, hear the family*." During Clive's lifetime, his family sought to keep him safe as well as to support him to realise his dreams and ambitions, and to make the most of his talents and accomplishments, all of which are described in portraits of him (see section 1). Since his death, they have sought to establish what happened to Clive, and possibly to other adults at risk also. Most recently, Clive's sister has contributed to this review. It has been a long, and at times stressful journey. **Recommendation Sixteen:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should consider with commissioners what support can be provided to families following abuse in a care setting. **Recommendation Seventeen:** Staffordshire and Stoke, and Cheshire East Safeguarding Adults Boards should provide to families who wish to participate in safeguarding adult reviews a document that describes what they can expect from their involvement.