Dudley Safeguarding Adults Board and Dudley Safeguarding Children Board

Review of Safeguarding at the Dudley Group NHS Foundation Trust

Executive Summary

January 2014 - July 2014

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Independent Chair

12th August 2014

Dudley Safeguarding
protecting children, young people and adults at risk

Contents

Scope of Review

Given that concerns existed in respect of both adult and children safeguarding incidents and process, it was wholly appropriate that a joint review of the Dudley Group NHS Foundation Trust was conducted by Dudley Safeguarding Children and Adults Boards

The issues as presented did not meet the criteria for a Serious Case Review in respect of a child or vulnerable adult.

A panel was convened to examine policy and practice in respect of safeguarding at the Dudley Group NHS Foundation Trust. That panel comprised of selected board members, was chaired by the independent chair of both boards and reported its findings to subsequent board meetings.

Agencies represented on the panel included

- Dudley Metropolitan Borough Council Adult Social Care
- Dudley Metropolitan Borough Council Children Social Care
- Dudley Clinical Commissioning Group
- West Midlands Police
- Healthwatch
- Age UK
- Lay Representation
- Dudley Group NHS Foundation Trust

Terms of reference for the Review were

- To formulate an action plan resulting from the Dudley Safeguarding Children Board Section 11 Audit findings
- To recommend the necessary measures to address issues raised by the Dudley Safeguarding Adults Board peer review process
- To investigate all historical allegations in respect of restraint, mental capacity assessment and deprivation of liberty issues
- To establish a mechanism to ensure all future safeguarding allegations are properly referred and investigated by means of agreed and established multi agency processes
- To develop an internal and external communication strategy
- To address any other aspects that the panel considered necessary to seek assurance that the Dudley Group NHS Foundation Trust meet their safeguarding responsibilities.

Inspections were due to be conducted by the Clinical Commissioning Group (in respect of incident reporting arrangements with particular reference to the frail and elderly in February) and the Care Quality Commission (in respect of restraint, mental capacity

assessment and deprivation of liberty in March). There was a need to ensure a coordinated approach between these inspections and the safeguarding review.

In order to ensure such coordination it was agreed that

- Aims, objectives, terms of reference for each piece of work were shared, compared and agreed at the earliest opportunity
- That a representative from the safeguarding boards, the Dudley Clinical Commissioning Group (CCG) and Care Quality Commission (CQC) met regularly before, during and at the conclusion to review and compare progress
- That the Dudley Group NHS Foundation Trust were informed from the outset of the coordinated approach

Synopsis

On the 5th January 2014 allegations of the unlawful restraint of patients at Russell's Hall Hospital appeared in the Sunday Telegraph Newspaper. They were made by John Marchant, a previous head of security at the hospital. John Marchant had been employed by Interserve FM who are the Dudley Group NHS Foundation Trust's PFI provider of facilities management services. (Further allegations were made in the national media by David Ore another former member of staff at the hospital).

Included in the allegations were:

- that staff had routinely forced vulnerable patients to stay in their rooms – or even confined them to their beds - despite them posing no danger to anyone
- that his security guards had become so concerned about the practice that in one instance, they had refused to restrain a child and warned bosses the action was illegal
- that pensioners had been subject to restraints when all they wanted was to walk around a ward, or chat with fellow patients.
- that patients had been restrained for up to 12 hours and that during one two week period alone medical staff asked security guards to intervene on 80 different occasions

The Dudley Group NHS Foundation Trust emphatically denied the allegations.

On the 6th January 2014 the Dudley Safeguarding Children Board convened a Section 11 (Children Act 2004) Scrutiny Panel to consider the self-assessments of constituent agencies of their capacity and capability to safeguard children. This was a pre-planned exercise and totally unconnected to the newspaper allegations of the previous day. Whilst it should be emphasised that all agencies contributing to the process had areas of development, there were specific areas of improvement required by the Dudley Group NHS Foundation Trust.

Areas flagged included:

- Evidence of hearing the voice of the child
- Safer Recruitment Practices
- Attendance at child protection case conferences
- Attendance at Safeguarding Board meetings and seniority of membership

On the 10th January 2014, the Independent Chair of Dudley Safeguarding Adults and Children Boards met with the Deputy Director of Nursing at Russell's Hall Hospital to discuss the newspaper article. The allegations were refuted and assurances were provided. Those reassurances were passed on to a safeguarding children board meeting later that same day.

On the 15th January 2014, an anonymous referral was made via the CQC that an elderly male patient had been unlawfully restrained during an incident at the hospital on the 29th December 2013. A strategy meeting to discuss this incident was held on the 23rd January 2014. In attendance was the Safeguarding Board's Independent Chair as well as representatives from the Dudley CCG. In addition to the specific case, discussions were held about the wider concerns and the best way forward.

During the same week as the above strategy meeting was held, there was a Safeguarding Peer Challenge exercise undertaken by Stoke into adult safeguarding in Dudley. The key lines of enquiry were:

- Anticipating future pressures
- Customer experience and public and political awareness
- Robustness of partnerships
- How do we know that people are safe

Feedback was received on 27th January 2014. Whilst there were many positive aspects of the report, quite naturally there were areas for consideration. In respect of the Dudley Group NHS Foundation Trust, the panel from Stoke highlighted four areas:

- Quality of discharge
- Care of people with challenging behaviour
- Do Not Resuscitate (DNAR) policy
- Attendance at safeguarding board and robustness of partnership

Again it needs to be emphasised that areas for consideration recommended by the review panel were not limited to this agency but also to the wider Dudley health and social care community.

The Independent Chair of the safeguarding boards then, following a consultation process with all stakeholders, recommended a course of action which would:

- Allow both safeguarding boards in Dudley to adopt the most successful method of discharging their duty to hold a constituent agency to account in respect of keeping children and vulnerable adults safe from harm.
- Ensure effective interface with the CQC and the Dudley CCG to achieve similar aims in respect of quality of service and patient safety. A coordinated approach is of clear benefit in terms of information sharing, ensuring that comprehensive inspection/investigative processes join together to avoid duplication.
- Result in a transparent position where holding to account Dudley Group NHS Foundation Trust, which has been complemented by support from partner agencies, so that reassurance has been sought by all stakeholders and any necessary improvement is achieved.

The proposal encompassed the following:

- Given that concerns exist in respect of both adult and children safeguarding incidents and process, it was wholly appropriate that a joint board review of the Dudley Group NHS Foundation Trust be conducted.
- The issues that were currently known did not meet the criteria for a Serious Case Review or a Serious Adult Review.
- It was therefore proposed that a panel be convened to examine policy and practice in respect of safeguarding at the Dudley Group NHS Foundation Trust. That panel should comprise selected board members, be chaired by the independent chair of both boards and report its findings to a future board meeting.
- The Review Panel should be convened at the earliest opportunity. The panel should comprise Police, Dudley CCG, Adult and Children Social Care, Health Watch, Age UK, lay representation from the safeguarding boards and the Dudley Group themselves. The panel would have the mandate to:

    i. develop and agree an action plan resulting from the DSCB Section 11 Audit findings

    ii. adopt the necessary measures to address development needs of Dudley Group NHS Foundation Trust by the DSAB Peer Review Process

    iii. conduct an investigation into all historical allegations in respect of restraint, mental capacity assessment and deprivation of liberty issues

    iv. consider the establishment of a mechanism to ensure all future safeguarding allegations are properly referred and investigated by means of agreed and established multi-agency processes

    v. develop an internal and external communication strategy

    vi. address any other aspects that the panel consider necessary to seek assurance that the Dudley Group NHS Foundation Trust meet their safeguarding responsibilities.

Visits were due to be conducted by the Clinical Commissioning Group (with particular reference to the frail and elderly) in February and the CQC in their second wave of inspections. There was a need to ensure a coordinated approach between these inspections and the safeguarding review.

In order to ensure such coordination it was suggested that

- Aims, objectives, terms of reference for each piece of work were shared, compared and agreed at the earliest opportunity

- That a representative from the safeguarding boards, the Dudley CCG and CQC meet regularly before, during and at the conclusion to review and compare progress
- That the DGH were informed from the outset of our coordinated approach

The Reassurance Group met on four separate occasions between 21st February 2014 and 28th May 2014 and with the full cooperation of the Dudley Group, systematically worked through the issues.

Representatives of the Reassurance Group met with the two "whistle blowers" on 28th February and took a more in-depth record of their allegations than was contained in the media reports. The two individuals formally handed over a dossier in respect of the allegations and this was taken into the possession of the police member of the reassurance group for cataloguing and investigation.

In respect of the Section 11 Audit deficiencies, a refreshed and more comprehensive self-assessment was submitted. Whilst action will still be necessary to address all the issues, the reassurance group felt confident enough to remit this part of the review back to the Children Board Scrutiny process.

Similarly the areas for consideration identified by the Stoke peer review team were discussed and this was also been remitted back to the Adult Board for conclusion of improvement measures.

The Dudley Group NHS Foundation Trust reviewed all reported incidents of restraint since 2010.

The Chief Executive Officer of the Dudley Group NHS Foundation Trust authorised an independent review to establish the facts in respect of restraint and to clarify the Trust position against the national safeguarding standards.

The Review was based on policies, procedures, training, incident reports and public complaints from January 2010 to March 2014.

The findings of this review have resulted in recommendations for security officers and Dudley Group NHS Foundation Trust staff with regard to training and practice.

There were further developments in respect of policy, mental health assessments and communication.

The review specifically investigated the 27 restraint incidents reported by security officers in 2013 and whilst the majority were deemed to be appropriate, there were two incidents which were deemed to be unnecessary and excessive. The Dudley Group NHS Foundation Trust then stated its intention to widen this review to all incidents with physical contact from 2010 onwards. These numbered approximately 170 incidents.

The CQC conducted a two-day inspection at Russell's Hall hospital on the 26th and 27th March and a particular focus was the issue of unlawful restraint. The CQC inspector spoke to both security and medical staff at managerial and practitioner levels and specifically gained input from the learning disabilities nurse. Initial indications were that all those interviews gave a positive position and described the right direction of travel. That having

been said, it was noted that security staff could benefit from knowing more about dementia, mental capacity and associated issues whilst ward staff could also benefit from knowing when, and when not, to call security officers.

The Dudley CCG conducted a review of incident recording at Russells Hall Hospital on 1st April and did not discover anything of concern.

The two individuals who made the allegations met the Police on 3rd April and indicated that there may be further incidents than they first reported to the reassurance group on 28th February.

All further allegations of unlawful restraint were comprehensively investigated by the police who informed the whistle blowers on 13th May 2014 that …

'The police investigation has now concluded and we have found no evidence of the unlawful detention of patients who had mental capacity and therefore the threshold for criminality has not been met. From the detailed enquiry we have undertaken, we are satisfied that patient restraint applied was either to protect the patient and/or protect other patients and staff from risk of injury or harm'.

Although all historic allegations made by the two whistle blowers had been reviewed by the police there were two current live investigations still underway at this point.

A further news item about unlawful restraint at Russells Hall Hospital appeared in the Daily Mail on 27th May 2014.

The pan board reassurance group met again on 28th May 2014. It was satisfied that the issues in respect of the Section 11 Audit and the Peer Review findings had been addressed. It noted the outcome of the police investigation into historic allegations of unlawful restraint. It felt that the two current and still outstanding allegations could be effectively dealt with by the normal safeguarding processes.

The Independent Chair of the Safeguarding Boards wrote to John Marchant and David Ore on 19th June 2014 informing them of the outcome of the review.

On the 28th July 2014 the police concluded their investigations in to the remaining two cases. In both, they found the level of restraint to be proportionate and in the interests of protecting staff or patients.

0n 31st July 2014 safeguarding meetings were held in respect of these two cases. No further action was deemed necessary.

Chronology of Events

Date	Event
5th January 2014	Allegations of unlawful restraint appear in the Sunday Telegraph newspaper
6th January 2014	Section 11 Audit Scrutiny Meeting receives self- audit from Dudley Group NHS Trust. Areas for potential improvement identified
10th January 2014	Meeting between Independent Safeguarding Chair and Dudley Group NHS Trust to discuss allegations. See Appendix 1 for details
10th January 2014	Initial feedback provided to Dudley Safeguarding Children Board
15th January 2014	Anonymous referral received regarding alleged incident of unlawful restraint at Russell's Hall Hospital on 29th December 2013
23rd January 2014	Strategy meeting regarding above referral held. Independent Chair of Board, CQC and Dudley CCG representatives in attendance
27th January 2014	Feedback received from Adult Safeguarding Peer Review (conducted the week previously) suggests areas for consideration in respect of the Dudley Group NHS Trust
4th February 2014	Safeguarding Board Independent Chair circulates document proposing course of action to be adopted to address issues
7th February 2014	Developments to date discussed at Dudley Safeguarding Adult Board meeting
10th February 2014	Meeting between Chief Executive Dudley Group NHS Trust and Independent Chair Safeguarding Boards to discuss above proposals
21st February 2014	Pan Safeguarding Board Reassurance Group meeting convened
28th February 2014	Meeting held with the two individuals making the allegations of unlawful restraint
28th February 2014	2nd meeting of Pan Safeguarding Board Reassurance Group
20th March 2014	3rd meeting of Pan Safeguarding Board Reassurance Group
26th and 27th March 2014	CQC Inspection of Dudley Group NHS Trust
1st April 2014	Dudley CCG Inspection of Incident Recording
3rd April 2014	Further meeting between police and whistle blowers
4th April 2014	Update to DSAB and briefing of Chief Exec, Leader of Council and MPs
13th May 2014	Police investigation into allegations of unlawful restraint concluded. Criminal threshold not met. Incidents of restraint deemed necessary and justified. Whistle blower informed
27th May 2014	Further press coverage in Daily Mail
28th May 2014	Pan Board Reassurance Group Meeting
19th June 2014	Whistle blowers informed of findings of Pan Board Reassurance Group
30th June 2014	Reply received from whistle blowers claiming whitewash
28th July 2014	Police investigation into final two current allegations concluded as NFA
31st July 2014	Safeguarding meetings on two final cases held. No further action deemed necessary

Conclusions and Recommendations

Conclusions

1. That allegations of unlawful restraint at Russells Hall Hospital that appeared in the national media in January 2014 demanded a response from Dudley Safeguarding Adults and Children Boards.

2. Issues arising from the Dudley Safeguarding Children Board Section 11 Audit return by Dudley Group NHS Foundation Trust and areas for consideration highlighted in the Stoke Safeguarding Adults Peer Review were quite rightly built into the terms of reference of a pan board reassurance exercise.

3. That liaison with the CQC and Dudley CCG who conducted their own investigations into the allegations was necessary in order to ensure a coordinated approach which both covered all aspects of concern and avoided duplicity.

4. That all concerns have been effectively investigated. West Midlands Police has conducted a comprehensive investigation and concluded that criminal thresholds were not met.

5. That assurance has been gained in respect of compliance with Deprivation of Liberty requirements. The DoLs lead from Dudley Metropolitan Borough Council has ensured that applications are made in an appropriate, timely manner when someone is deprived of their liberty in their best interests to provide necessary care and support.

6. The wider issue of patient safety is confirmed.

7. That confidence in the process of holding the Dudley Group NHS Foundation Trust to account can be gained from the wide ranging extent of review activity. This includes

    - The Pan Safeguarding Board Reassurance Group findings
    - A comprehensive criminal investigation into allegations of unlawful restraint conducted by West Midlands Police
    - A CQC inspection
    - A Dudley CCG investigation
    - An extensive internal investigation commissioned by the Chief Executive of the Dudley Group NHS Foundation Trust

8. That despite the bottom line finding that no evidence of unlawful restraint was found, learning opportunities in respect of training, policy and process were established.

This is entirely to be expected, indeed if no such opportunities had been found the quality of the review would have been in serious doubt

9. The Dudley Group NHS Foundation Trust has cooperated fully throughout and acted with openness and transparency

Recommendations

1. That this report is ratified by all members of the Pan Board Reassurance Group
2. That all members of the Pan Board Reassurance Group satisfy themselves that no further enquiries are necessary. Once this is agreed then the review is formally deemed to be concluded
3. That the Independent Chair of both Safeguarding Boards meet with the board representative from the Dudley Group NHS Foundation Trust to review the status of all recommended points of action / learning opportunities for the Trust and the respective boards receive formal update at a future board meeting
4. That further assurance is required in respect of the action required of other agencies and partnerships to support DGNHSFT. Included are:
    - Delayed Transfers of Care – that all partners work together to improve the experience of all patients requiring quality transfers of care
    - CAMHS – it is recognised that there are challenges across the country with provision of CAMHS tier four services which has a consequential impact locally. We look forward to the national review by NHS England however in the interim partners should undertake a task and finish review of Tier 3 and Tier 4 operation and access
    - Dementia – The Health and Well Being Board should be encouraged to review the current dementia strategy across the health and social care economy
5. That a summary document be drawn from the main body of the report. This summary document should achieve the optimum balance between maximisation of transparency and minimisation of potential for breach of confidentiality
6. That the summary document be circulated to all members of both Dudley Safeguarding Boards who in turn circulate as necessary within their organisation
7. That the summary document be circulated to elected representatives and other stakeholders
8. That subsequent to the above circulation, the summary report is posted on the Safeguarding Board's website
9. That a revised media strategy be drawn up in readiness for the website publication