

Safeguarding in the Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority?

Final Report – March 2012

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Independent Safeguarding Authority

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Executive Summary

The Independent Safeguarding Authority (ISA) was created under the Safeguarding Vulnerable Groups Act (2006) to make independent, well-informed and considered decisions on whether to bar people from working with vulnerable adults and/or children. The Safeguarding Vulnerable Groups Act (SVGA) 2006 and Safeguarding Vulnerable Groups (Northern Ireland) Order (SGVO) 2007, place a duty on employers of people working with children or vulnerable adults to make a referral to the ISA in certain circumstances. Following a structured decision-making process, the ISA can make a 'discretionary' barring decision¹.

This research was undertaken to specifically explore:

- the **behaviours** demonstrated by the referred individuals that lead to their referral;
- the **circumstances** in terms of relationships, culture and policy within which the harm occurred and was reported; and
- **actions** taken by the employer leading up to and in response to those behaviours.

Findings from vulnerable adult cases

Behaviours

- The numbers of behaviours associated with abuse of vulnerable adults varied considerably within the cases reviewed for the study. At a broad level, persons were referred for financial abuse on the basis of singular behavioural types, but other forms of abuse tended to be more complex, and routinely included secondary behavioural types. Physical and emotional abuse often co-presented. The findings illustrate the varying motivations and patterns of behaviour underlying safeguarding cases.
- Some discernible differences were found between one-off incidents in the workplace – those arising from “opportunism” or a poor response to a stressful situation, and multiple incidents of a more systematic or compulsive nature. There was no clear correlation between the nature of the incidents and the decision to bar. A barring decision was made in both one-off and multiple behaviour cases where the behaviour was of a more serious nature.
- Some possible warning signs for employers include where there is over familiarity with the person being cared for, alongside signs of stress or discomfort experienced by the vulnerable adult. In financial abuse cases, the signs potentially include employees being preoccupied with their money problems, combined with secretive or unsupervised handling of financial documents.
- A small proportion (9 cases) of reported persons had previous criminal convictions, although these did not relate directly to the safeguarding issue. Wider

¹ All individuals over 18 who have committed specified sexual offences and other violent offences are placed on the barred list automatically. For some 'auto-bar' offences a person is permitted to make representations to the ISA as to why they should be removed from the barred list(s).

conduct or behavioural problems at work, including carelessness, breaches of policy, attitudinal problems or emotional detachment, and persistent non-attendance were all commonly present in cases where abuse took place.

Circumstances

- Abuse occurred in a diverse range of environments, with the full spectrum of abuse being evident in care home settings. This reinforces that all regulated activities are subject to safeguarding issues, despite there being particular issues for residential settings.
- The 'carer / service user' relationship was by far the most common among vulnerable adult abuse cases, although a small proportion involved managers or supervisors.
- The analysis suggested that a lack of experience was a contributory factor for abuse occurring in the workplace, but it was unclear as to whether this related to competency issues or mismatches in suitability for caring roles.
- Organisational culture and policy issues in the workplace were strongly implicated across the types of abuse. Low levels of training and supervision and poor financial accounting procedures were commonly found, along with allegations of "bullying" and stressful working conditions.

Employer actions

- It was not always possible to establish the suitability of the employers' actions in response to warning signs, without having full access to disciplinary documents, or indeed whether these signs were always known to the employer prior to the investigation. Examples of appropriate responses, where these were documented, included the provision of disciplinary procedures, final warnings and counselling, or extended probationary periods.
- Whilst some isolated examples of overly zealous referrals to the ISA were found, on the whole it is clear that prompt employer action greatly assists ISA decision-making; enabling the early removal of the referred person from the workforce before further harm occurs where appropriate. There is some evidence to suggest a need for increased joined up working between employers and regulatory agencies, to ensure the ISA is provided with a complete picture of the circumstances of the case and supporting information.

Findings from children's cases

Behaviour

- Evidence from the case files suggests that employers in the children's sector will rarely witness isolated one-off incidents of abuse against children, although this occurrence is not unknown. More likely is a pattern of repeated or multiple incidents or behaviour. Across the sexual abuse cases, the multiple incidents of behaviour often demonstrated a clear correlation with known grooming behaviour. Viewed in

isolation these incidents would not often meet the threshold for removal from regulated activity, but taken together they reveal a pattern of behaviour indicative of future risk of harm and unsuitability.

- For an employer, recognising this developing risk can be very difficult, in part because sexual grooming can be quite subtle but also as it may occur outside of the workplace. Employers must therefore be alert for any signs they do see, and create an environment for work colleagues, parents or friends to disclose any concerns that they may have.
- A number of other warning signs were identified from the case examples. These were not necessarily strictly related to the type of abuse that manifested, and some may appear as poor performance or unsuitability to role. Previous criminal convictions offer potential warning signs. Isolated examples in the case review of timely checks not being undertaken reinforced this risk and the need for employers to be vigilant.

Circumstances

- Abuse of children can occur in a wide range of settings, but in the sample of cases, school environments were a common feature. This is not to say that all the abuse occurred on school premises, but this environment facilitated contact with the victim. The 'teacher/pupil' relationship was by far the most common among the children's cases reviewed, but there were examples of abuse committed across a number of roles, including those without direct or routine contact with children.
- The review of children's cases highlighted examples where staff new to the sector, particularly those with more limited work experience, may need additional supervision and guidance. While qualifications can prepare staff to an extent the examples drawn from the case files illustrated that additional support may be needed to deal with the challenges and boundaries that need to be set in caring for children. More experienced staff equally may need support at particular points or in response to developments in the sector or society that change established ways of communicating or interacting with children (e.g. social networking).
- On the basis of the evidence in the children's case sample, it was not always the case that abuse was a consequence of inadequate safeguarding policies and procedures. There were several examples, particularly involving school staff, where referred individuals had been in receipt of relevant training or had explicitly been given guidance following earlier behaviour. There is some evidence, however, that employers' working practices may have provided opportunities for abuse to go undetected or for the risk not to have been identified earlier. Specifically, there were case examples involving the lack of supervision and training offered to temporary staff or the culture within a school setting in respect of unclear boundaries amongst staff and older students.

Employer actions

- In reviewing 100 children's cases, it is clear that those employers who are referring to the ISA are broadly following appropriate processes prior to referral. There was clear evidence of immediate removal of individuals from regulated activity where the nature of the allegation requires it and the ensuing investigation and disciplinary response supports that course of action.
- Appropriate involvement of other agencies in the response to abuse was evident. Early notification and involvement of LADOs and other local safeguarding structures and the active involvement of employers in multi-agency safeguarding strategy meetings was observed in line with best practice.
- In the main, referrals to the ISA are made appropriately in terms of their timing and relevance of content. Most employers are referring at the conclusion of investigations and disciplinary activity which provides adequate supporting information to inform ISA decision making, given the absence of specific investigative powers held by the ISA. There is room for improvement, however, in terms of the provision of multiple referrals to the ISA in line with the duty placed on employers and regulatory agencies to pass on relevant information held by all parties.

Key Action/Learning Points

Based on the research, the following actions should be taken by employers and the wider sector to ensure the on-going safeguarding and minimisation of risk of harm to children and vulnerable adults:

- Any 'warning signs' of potential abuse or risk should be effectively disseminated to staff at all levels within an organisation, through their core training and professional development.
- Employers should continue to implement appropriate systems to record concerns or instances of poor conduct and provide support, where there is felt to be a risk of escalation of this poor performance behaviour into abuse.
- Employers should raise awareness and create an environment that allows for concerns about alleged abuse to be raised via all available channels, including work colleagues, parents or friends. Employers should equip employees to be vigilant at all levels within an organisation, and have clear procedures for whistle-blowing.
- Subject to eligibility, pre-employment checks (including criminal records checks) should be carried out by employers when an individual is first offered employment in regulated activity to minimise any risk and bring safeguarding benefits. It is good practice for employers to update these at regular intervals for employees already in the workforce.
- Employers should pursue the best practice approach of early notification of LADOs and involvement of statutory safeguarding teams in the response to alleged abuse

where appropriate.

- Employers and statutory/regulatory organisations need to increase collaboration in submitting referrals to the ISA, for example, through the submission of joint referrals. These joined-up approaches can assist with providing a more complete picture of the background and circumstances of the case upon which ISA decisions are based.

1.0 Introduction

This report presents findings from research commissioned by the Independent Safeguarding Authority (ISA) on the issue of safeguarding in the workplace.

1.1 The role of the ISA

The Bichard Inquiry, arising from the Soham murders in 2002, questioned the approaches, mechanisms and processes that employers used to recruit people to volunteer and work with children and vulnerable adults. One of the recommendations of the Inquiry was the establishment of a single agency with the responsibility for preventing unsuitable people from working with children and vulnerable adults. The ISA was duly created to fulfil this role in England, Wales and Northern Ireland² following the Safeguarding Vulnerable Groups Act (2006) and Safeguarding Vulnerable Groups (Northern Ireland) Order (SVGO) 2007. The ISA replaces previous arrangements under the Protection of Children Act (PoCA), the Protection of Vulnerable Adults (PoVA) scheme, List 99 and Disqualification Orders.

The role of the ISA is to make independent, well-informed and considered decisions on whether to bar people from working with vulnerable adults and / or children. Previously, this decision making power was held by the Secretary of State. These decisions are recorded through the maintenance of two lists; one detailing those individuals barred from engaging in regulated activity with children, and the other listing those barred from engaging in regulated activity³ with vulnerable adults.

1.1.1 Auto-bar and discretionary referrals decision making process

All individuals over 18 who are convicted / cautioned for specified sexual and other serious violent offences are placed on the barred list automatically. This process covers the most serious offences against children and vulnerable adults - known as 'autobar' offences - and indicates that an individual poses a significant risk of harm to children or vulnerable adults. For some 'auto-bar' offences, a person is permitted to make representations to the ISA as to why they should be removed from the barred list(s). In 2010/2011, 13,663 people were barred through the auto-bar process (ISA, 2011).

Additionally, referrals are made to the ISA when an employer or an organisation has concerns, typically within a workplace, that a worker/volunteer has caused harm or poses a future risk of harm to children or vulnerable adults. Following a structured decision-making process, the ISA can make a 'discretionary' barring decision.

² In Scotland, the Bichard Inquiry resulted in the Protection of Vulnerable Groups (Scotland) Act 2007 which set up a similar authority for Scotland – The Central Barring Unit, which forms part of Disclosure Scotland..

³ Regulated activity is defined in the SVGA 2006 (in summary) as:

- Any activity of a specified nature which involves contact with children or vulnerable adults frequently, intensively or overnight (including teaching, training, care, supervision, transportation, treatment etc.)
- Any activity allowing contact with children or vulnerable adults in a specified place frequently or intensively
- Fostering/childcare
- Any activity that involves people in certain defined positions of responsibility (e.g. school governors and trustees of certain charities)

The Safeguarding Vulnerable Groups Act (SVGA) 2006 and Safeguarding Vulnerable Groups (Northern Ireland) Order (SGVO) 2007, place a duty on employers of people working with children or vulnerable adults to make a referral to the ISA in certain circumstances. This is when an employer has removed a person from working with children or vulnerable adults (or would have if the person had not left or resigned.) because the person has:

- been cautioned or convicted for a relevant offence; or
- engaged in relevant conduct in relation to children and/or vulnerable adults (i.e. an action or inaction (neglect) that has harmed a child or vulnerable adult or put them at risk of harm); or
- the 'Harm Test' is satisfied for children and/or vulnerable adults. (i.e. there has been no relevant conduct (no action or inaction) but a risk of harm to a child or vulnerable adult still exists).

In these circumstances, the employer or regulatory body must make a referral to the ISA. It is these discretionary cases which are examined in this research. The range of organisations that are required to make referrals include:

- Regulated activity providers
- Personnel suppliers
- Local authorities
- Education and Library Boards
- Health and Social Care (HSC) bodies
- Keepers of Registers named in the legislation; and
- Supervisory authorities named in the legislation.

ISA guidance outlines the anticipated process for a referral, including the expected activity undertaken by employers upon being made aware of the abuse or risk of harm. This process is now summarised (overleaf).

- A regulated activity provider removes an individual from regulated activity (often suspended without prejudice) due to relevant conduct, risk of harm or receiving a caution or conviction for a relevant offence (or the person has resigned or left that post in circumstances where they may have been removed).
- The regulated activity provider follows their agreed local safeguarding and disciplinary procedures (this is separate from the duty to refer to the ISA). This may also involve consulting with a relevant governing body or professional association.
- The regulated activity provider consults their Local Authority Designated Officer (LADO) or Health and Social Care Trust Designated Officer if appropriate.
- The regulated activity provider undertakes an initial investigation to establish facts and gather evidence such as witness statements and documentation relating to the disciplinary process.

- If following initial investigation or evidence gathering the regulated activity provider thinks that there may have been relevant conduct or there is a risk of harm, they make a referral to the ISA using the ISA Referral Form after consulting the ISA Referral Guidance. The completed and signed ISA Referral Form and supporting evidence and documents are posted to the ISA.

Following a referral, a structured five-stage decision making process is followed by ISA caseworkers, supported by expert Board members who have a range of experience and knowledge in the field of safeguarding. ISA caseworkers consider all information available on the individual provided by the referring organisation, external parties and, if needed, from the referred individual (representations) as well as the circumstances of the concerns. Caseworkers have no direct investigative powers but can request existing information from a number of agencies.

An informed decision is made as to whether the referred person poses a risk of harm to children or vulnerable adults. Subsequently, a decision is made as to whether it is appropriate and proportionate to bar a person from working with a vulnerable group or groups because of the ongoing risk of harm. Between January and December 2011, some 5,009 referrals were processed⁴, resulting in 476 “discretionary” barring decisions. This represents a very small proportion of the total workforce covered by the SVGA.⁵

1.2 Study aims and scope

The ISA recognises that it has a role to play in informing its partners and stakeholders about those who are referred and the harm or risks of harm they pose to vulnerable people. In addition, the ISA recognises the need to use this case knowledge to inform current and future policy and support Government decision-making in relation to safeguarding. This is particularly important as the process delivered by the ISA has a much wider remit than previous provisions, affecting a greater number and range of workers and professions. The length of bar available under the ISA process also differs from previous arrangements.

The case files collated through the ISA decision-making process represent a significant data set and a substantial bank of knowledge and information. Prior to this study, little or no qualitative research had been undertaken to fully explore and understand any emerging themes or lessons, nor their implications for better and safer employment practices.

Specifically, the objectives of this study were to explore:

- the **behaviours** demonstrated by the referred individuals that led to their referral;
- the **circumstances** in terms of relationships, culture and policy within which the harm occurred and was reported; and
- **actions** taken by the employer leading up to and in response to those behaviours.

⁴ Internal ISA data, supplied in February 2012.

⁵ A study by the Children’s Workforce Development Council estimates a total of at least 2.68 million paid employees across the children and young people’s workforce. The adult social care workforce is estimated to be 1.75 million (Skills for Care, 2011)

A number of additional research questions were identified to be answered through the research, with findings to be presented separately in relation to vulnerable adults and children's cases:

- **Research question 1:** What key indicators can be identified from case data that highlight a developing level of risk from an individual?
- **Research question 2:** What behaviours or circumstances have been witnessed by work colleagues, supervisors, friends and family that raised the first warning signs of potential harm?
- **Research question 3:** At what level of behaviour was a referral made? In what scale of scenarios could this have been done sooner or improved in other ways?
- **Research question 4:** At what point was a decision made to make a referral? On the basis of known information, should the referral have been made earlier? Did the referral contain appropriate and detailed information?
- **Research question 5:** What can be learned about the places where harm occurs? Are there different lessons for employers in the children and vulnerable adults workforces?
- **Research question 6:** What good practice can be identified about responding to allegations and concerns and making a referral to the ISA? How could other organisations implement this practice?

1.3 Methodology

This report draws on the findings from a qualitative analysis of 200 case files from employer referrals, which were concluded in 2011. The findings from this case file review were triangulated with other relevant research findings where appropriate, including a profiling exercise by the ISA of a larger sample of referred cases.

1.3.1 Case file sampling

The aim of the case file analysis was to gather qualitative information on lessons learned from referrals from workplace settings. As such, the sample of case files was drawn from cases referred to the ISA rather than auto-bar cases.

Between January and December 2011, the ISA dealt with 5009 discretionary cases. Vulnerable adult referrals made up 69% of the total cases referred to and barred by the ISA, while referrals about children made up for 31% of the total cases that resulted in a bar.

Table 1.1 Profile of ISA Discretionary Cases

| Barred List | Discretionary Cases | | | | AUTOBAR Cases | |
|-------------------------------|---------------------|-------------|--------------|-------------|------------------|------------|
| | Barred | % of Total | Not Barred | % of Total | No added to list | % of Total |
| Children’s List | 135 | 28% | 1,408 | 31% | 12,219* | |
| Adults’ List | 341 | 72% | 3,125 | 69% | 11,730* | |
| TOTAL | 476 | 100% | 4,533 | 100% | 12,240 | |
| <i>No added to both Lists</i> | 72 | 15% | | | 11,709 | 95% |

Source: ISA Discretionary Case Data (January-December 2011)

An initial qualitative analysis was first completed by the ISA on over 650 discretionary barred cases drawn from the total population, based on the following characteristics of each case:

- The primary victim group (vulnerable adult’s or children).
- The primary type of abuse⁶

The volume of cases resulting in a bar was then considered against the number of referrals received and concluded at each stage of the ISA five-stage decision making process (refer to Section 1.1.1 above). Cases where relevant conduct or regulated activity was not proven were not considered for selection in the research sample.

Based on this analysis, a purposive approach was used to select a sample of cases for analysis. The focus of the analysis was principally qualitative. As such, the sampling approach did not seek to select a fully representative sample of all cases received by the ISA. Key considerations in the sampling included the following:

- Given the need to report findings separately for vulnerable adults and children, a decision was made to select 100 cases in respect of each vulnerable group.
- Across all cases referred to the ISA, those that end in a barring decision is a relatively small proportion. Given the focus of the research on behaviour, circumstances and employer action, cases resulting in a barred decision were over-sampled.
- Over-sampling of certain categories of abuse type was undertaken, to boost the available sample for the analysis.
- Finally, the focus on good practice in referrals made by employers necessitated a more purposive sampling approach.

Table 1.2 overleaf outlines the final sample profile.

⁶ Many cases potentially include multiple types of abuse and this was examined in the analysis. For the purpose of sampling, the primary alleged abuse type was used.

Table 1.2 Research sample (by primary alleged harm) Sample profile

| | | Financial | Sexual | Physical | Neglect | Emotional | |
|-----------------|-------------------|-----------|-----------|-----------|-----------|-----------|------------|
| Adults | Barred | 33 | 5 | 5 | 2 | 3 | |
| | Not barred | 14 | 4 | 6 | 15 | 13 | |
| | | 47 | 9 | 11 | 17 | 16 | 100 |
| Children | Barred | - | 37 | 8 | - | 2 | |
| | Not barred | - | 21 | 19 | 6 | 7 | |
| | | - | 58 | 27 | 6 | 9 | 100 |

1.3.2 The analysis approach

The analysis was based on the hard copy case file documents, comprising the ISA case work and decision-making documentation and the supporting evidence submitted by referring parties and requested from other relevant organisations. Given the format (in hard copy) and sensitivity of the data, the first stage of the analysis required researchers to work on site at ISA premises to extract data for subsequent analysis. A data extraction tool was used to ensure consistent data was collected for all cases.

Following redaction of any identifying or personal data, a second stage of analysis occurred off site, involving subsequent coding and analysis against the key themes and research questions.

1.3.3 Study scope and data limitations

The study design was qualitative in nature to allow in-depth examination of the behaviours of those referred and the quality of referrals made. The purposive sampling approach, therefore, prevents the presentation of quantitative findings, but an indication of scale is provided where appropriate (including suitable caveats). The evidence presented in this report is intended to be illustrative of the cases received by the ISA. It is not possible to make robust generalisations from these findings about cases received by the ISA as a whole due to the purposive sampling approach adopted.

1.4 Structure of the report

The remainder of this report presents the key findings from the research. It summarises the findings in relation to vulnerable adults and children’s cases before drawing conclusions across all cases. The report contains three main sections which address the research questions outlined above:

- **Section 2** provides an overview of the findings in relation to vulnerable adult cases.
- **Section 3** summarises the findings for children’s cases; and,
- **Section 4** provides conclusions and recommendations.

Further information is provided in appendices, which includes a Glossary (Annex 1); details of Prescribed Information for Regulated Activity Providers (Annex 2), and a list of References for the other (external) studies cited within the report (Annex 3).

2.0 Findings from Vulnerable Adult Cases

Section 59 of the Safeguarding Vulnerable Groups Act 2006 defines explicitly a person who is considered as a vulnerable adult. For reference, this briefly means, any person aged 18 years or over who may be unable to take care of themselves, or protect themselves from harm or from being exploited. This may be because they have a mental health problem, a disability, a sensory impairment, are old and frail, or have some form of illness. This current study examined 100 referrals concerning vulnerable adults to examine the behaviours, settings and circumstances of the alleged harmful behaviour and the actions taken by employers in response.

2.1 Behavioural analysis

A key objective of this study was to understand the behaviours exhibited by the referred individuals in the workplace leading to their referral. The following sections examine the behaviours evident in the cases reviewed, covering the types and patterns of behaviour that led to a referral and/or barring decision and the warning signs available to employers.

2.1.1 Types and patterns of behaviour

The qualitative case study considered the following profile of primary abuse types in cases involving vulnerable adults:

Table 2.1 Abuse types in vulnerable adult cases

| | Number of cases in sample |
|------------------|---------------------------|
| Financial | 47% |
| Neglect | 17% |
| Emotional | 16% |
| Physical | 11% |
| Sexual | 9% |

The SVGA/SVGO legislation places a duty on employers to refer following the removal of an individual from regulated activity. There was evidence from the case files of referrals largely being made on the basis of incidents which on the surface represent a single type of relevant behaviour. This was most commonly seen in financial abuse cases where the referred person had stolen or dishonestly received money from a vulnerable adult and this was the main issue in the referral.

The case files included examples ranging from the theft of petty cash to the value of £10 to more systematic abuse where £50,000 was dishonestly accessed. Referrals to the ISA concerning financial abuse go beyond instances involving cash. There were examples in the case files of theft of jewellery, fraudulent use of service users' bank

details to purchase items, and the setting up of payment for services. In other cases the behaviour included use of a service users' telephone (without permission) or alleged theft of food from a service user's fridge.

The high level of financial abuse behaviour evident in the sample of cases referred to the ISA reflects research elsewhere. An assessment by the Social Care Institute for Excellence (2011) suggests that financial abuse is the second most common type of abuse experienced by the elderly in the UK. An estimated 86,500 (1%) of people aged 66 and over were subjected to financial abuse over a 12-month period.

Across many types of abuse, however, there was evidence of secondary behaviour types alongside or underlying the primary abuse type. Evidence in the case files suggested that a secondary behaviour type can often be inferred from the circumstances of the case. For example, although the majority of referrals for financial abuse cases were made on the basis of a single behaviour type, the subsequent review sometimes uncovered other potentially relevant behaviours. There were clear examples where the referred individuals had received money using a degree of coercion, deceit or emotional blackmail, which could also be said to have involved emotional abuse. In one case, a carer providing home care told a service user repeated stories of her difficult financial situation, which prevented her flying back to her native country to see ill relatives. The service user provided a cheque to pay for flights which was not used for this purpose.

More than one type of behaviour was most clearly evident in cases where physical abuse was identified as the principle abuse type. Of the 11 physical abuse cases reviewed, seven exhibited other abuse types. The most common combination was physical and emotional abuse. Examples included verbal abuse occurring in the build up to the physical violence. In one example, a referred individual had repeatedly shouted at and verbally abused care home residents, whilst forcibly manoeuvring them, which had resulted in bruising and other types of injury. Similarly, neglect cases commonly featured inadequate supervision of service users, which resulted in physical harm to service users arising from accidents, injury and discomfort or emotional abuse through likely feelings of abandonment.

Additional analysis centred on the patterns of behaviour evident in the cases; differentiating between one-off acts of abuse and multiple or repeated instances. Table 2.2 below, identifies the number of 'one-off' as well as repeated or multiple abuse cases by type of behaviour reported.

Table 2.2 Frequency of abuse in vulnerable adult cases

| | One-off | Multiple/repeated |
|------------------|---------|-------------------|
| Financial | 10 | 37 |
| Neglect | 12 | 5 |
| Physical | 7 | 4 |
| Emotional | 9 | 7 |
| Sexual | 2 | 7 |

One-off incidents and the common characteristics of the cases in which they were seen across these different abuse types is summarised below:

Table 2.3 Common characteristics of abuse cases involving "one off" incidents, by type of abuse

| Type of abuse | Common characteristics | Case example |
|------------------|--|--|
| Financial | Opportunistic theft by individuals who did not routinely have access to the service user's finances. | A domiciliary care worker, who delivered care in the home, stole a small amount of money (£20) on one occasion. |
| Neglect | Failure to adequately supervise or check on service users. | A service user resident in a care home was left in a chair overnight until the morning shift came on duty. |
| Physical | The use of excessive force or a physical act in an attempt to obtain compliance. | A referred individual grabbed a service user's hands and pulled her roughly to get her to stand. |
| Emotional | Use of inappropriate language or raised tone of voice to service users or degrading/humiliating comments made about service users. | A residential care worker took photographs of two service users, uploaded them onto Facebook accompanied by degrading comment. |
| Sexual | Sexual assault of care home resident or failure to prevent sexual assault between service users. Abuse of position by a medical professional | A doctor sexually assaulted a young adult patient. |

Examples of repeated patterns of behaviour observed across the different abuse categories included:

Table 2.4 Common characteristics of abuse cases involving "repeated or multiple" incidents, by type of abuse

| Type of abuse | Common characteristics | Case example |
|------------------|--|---|
| Financial | Several incidents or regular unauthorised use of service users cash cards/cheques or thefts from the safe in a care home or supported living setting. These cases were characterised by the perpetrators being directly responsible for the financial affairs of the people they care for. | A manager of a supported living facility for individuals with learning difficulties had taken funds to the sum of £25,000 from up to six vulnerable adults. |
| Neglect | Behavioural actions over a longer period of time which suggested an inability or unwillingness of referred individuals to offer adequate care on a number of occasions. | A registered mental health nurse on several occasions, failed to follow correct procedure when administering medications, and on other occasions failed to administer medications in a timely manner. |
| Physical | Repeated rough handling of service users rather than repeated behaviour that could be classed as 'violence'. | A carer in a day-care setting roughly handled various service users on a regular basis. |
| Emotional | Recurrent instances of inappropriate tone or language being used by the referred person. | A care worker at a home for individuals with learning difficulties used abusive and inappropriate language towards a service user over a two year period. |
| Sexual | Health professionals establishing consensual and long-term intimate/sexual relationships with patients, thus blurring professional boundaries or repeated sexual assaults. | A doctor inappropriately and indecently touched the breasts of three female patients without their consent during consultations. |

In the cases involving multiple or repeated abusive behaviour, a distinction can be made between longstanding abuse against a *single victim* and patterns of abusive behaviour perpetrated against *multiple victims*. Of the 100 adult cases reviewed, 26 were

characterised by repeated abuse against one victim, with 19 of these cases involving financial abuse, whilst 36 cases involved a longstanding pattern of behaviour against multiple victims. In cases involving multiple victims, 18 were financial abuse cases, 6 were sexual, 5 were emotional, 4 were neglect and 3 were physical.

Another related issue to multiple or repeated instances of abuse is the escalation or developing risk in terms of increasing seriousness or a risk of harm to a greater number of vulnerable adults. This is now further considered.

2.1.2 Developing risk/escalation

It is important for employers and referring organisations to consider the likelihood of escalation and increasing risk in making decisions on when to refer to the ISA.

As reported above, the case file review found examples of repeated or multiple incidents of similar or related behaviour of the same relative intensity. Evidence of escalation was, however, found in cases where behaviours increased in seriousness, resulting in greater harm to the same individual vulnerable adult. A distinction was evident in the case files between:

- Escalation of a single abuse type (e.g. greater frequency or intensity of physical or sexual abuse or higher amount of money being stolen in financial cases)
Examples across the different abuse types included:
 - Physical abuse: incidents of overly physical manual handling and manoeuvring of several residents in a residential care home for people with learning disabilities, escalating to eventual slapping and hitting.
 - Financial abuse: A home carer not returning small change to a service user after purchasing items on their behalf, which escalated to unauthorised withdrawal of cash on a number of occasions using the service user's bank cards.
- Escalation from one type of abuse to another (e.g. emotional/verbal becoming physical):
 - A care home manager was reported to be verbally abusive to residents, and on several occasions slapped the hands of residents. This case also included allegations of neglect by the manager failing to implement staffing policies (e.g. CRB checks on employees), which put service users at risk.

Analysis of the outcome of cases characterised by developing seriousness in the behaviour suggests that they typically did result in a bar. However, a barring decision was made in both one-off and multiple behaviour cases where the behaviour was of a more serious nature so escalation alone is not the only factor underlying barring decisions.

2.1.3 Warning Signs

The analysis considered the possible 'warning signs' that were exhibited by an individual leading up to the behaviour that led to a referral, relating to their wider

attitudes, behaviours, or personal history. Where one-off behaviour was demonstrated, on the whole, there were few warning signs evident. This was to be expected given the behaviour was often out of character and appeared to result from a short period of stress or anxiety. This was particularly evident in cases of neglect or emotional abuse.

The review of case files identified some recurring warning signs which serve as potential signs for employers as to when they may need to offer greater supervision or improved training. Whilst some of these signs applied across different categories of abuse, there was evidence of others being distinctive to certain categories of abuse within the sample of cases analysed. Table 2.5 below provides an illustration.

| Table 2.5 Possible warning signs in vulnerable adult cases, by type of abuse |
|--|
| Financial <ul style="list-style-type: none">• Individuals talking about money worries to other colleagues or management, seeking advances in their pay or requesting overtime• Previous convictions for theft, fraud, eliciting money• Failure to complete documentation and protocols regarding the handling of money• Portrayal of a close personal relationship with the victim |
| Physical <ul style="list-style-type: none">• Victim exhibiting outward signs of stress and discomfort in the presence of the referred person• Emotional manipulation• Low level acts of physicality occurring in front of colleagues, other service users and even family members |
| Sexual <ul style="list-style-type: none">• Portrayal of a close personal relationship with the victim• Over-familiarity with the victim• Victim exhibiting outward signs of stress and discomfort• A staff member having difficulty in facilitating relationships with others |

There were nine cases where the referred person had a **previous criminal conviction**, which might have provided a warning sign. It is not possible to ascertain completely the extent to which employers had knowledge of these convictions, as case files did not always include full details of the checks undertaken. They often appeared on case file as a result of the PNC check undertaken by the ISA through the information gathering process.

There is no obligation for an individual to declare spent and unspent convictions under the Rehabilitation of Offenders Act 1974 if applying to work with vulnerable adults and children. An employer however, has the right to request disclosure of previous convictions when recruiting into certain identified roles. There was some evidence of voluntary disclosure, for example, in one case where a driving conviction was declared on an individual's application form. However there was also evidence of concealment. A specific example, being deliberate deceit by an individual, giving a false name in their application which emerged following a later conviction for theft. A CRB check had been

undertaken by the employer in this case, but as the individual had used an alias, previous convictions were not revealed.

In the remaining cases, no conclusions can be drawn about the appropriateness of employers' pre-employment checks and specifically whether CRB checks were undertaken. Evidence does show some correlation between the nature of the conviction and the type of abuse for which the individual was referred. This included several individuals who committed financial abuse following a history of previous convictions for dishonesty offences including shoplifting and fraud. The implication is that timely CRB checks undertaken prior to the individual starting employment could provide warning signs at an earlier stage.

Background occurrences of **professional misconduct** or **inappropriate behaviour** in the workplace were also recurrent in many of the cases analysed for the research study. Occasionally, these behaviours related directly to the incident of abuse, and might have provided a warning sign had further information been available to the employer at the time. In one example, a manager of a care home barred for theft of service users' monies had a previous warning about not following financial policy and procedure. At this time, unspecified mitigating circumstances led to demotion and warning rather than dismissal.

More commonly, however, the conduct at work related to poor practice in the delivery of the individual's job role or non-compliance with other aspects of policy, which highlight potential examples of poor safeguarding practice. Some of the examples from the case files included the following:

- Unsafe or careless working practices - a residential care home manager who was eventually barred for neglect had previously been warned for the unsecure and unsafe storage of medication. The findings from an inspection concluded that "*the home is disorganised and not maintained*".
- Breaches of policy – a referred person who committed financial abuse whilst employed as a night time home carer had been warned previously about bringing ironing into work. In another case, an individual had previously been disciplined in relation to dress code and wearing of headphones at work.
- Attitude issues - a residential care worker had previously raised their voice with colleagues, and shown insensitivity when serving food to residents.
- Non-attendance – an individual had been previously warned about leaving shifts early.

These examples occurred across the abuse types, with the exception of sexual abuse. Whilst these forms of non-compliance or misconduct would have been unlikely to give rise to a concern about possible abuse in their own right, they do serve to illustrate wider patterns of behaviour that might serve as a warning signal, when considered in conjunction with other circumstances.

Without full access to previous disciplinary documents, it is difficult to comment on suitability of the employer's action in response to these warning signs, and indeed if all of them were known. In at least one example, this previous behaviour was discovered only as a result of the investigation into the current suspected incident of abuse, when

colleagues were interviewed. Examples of appropriate responses included the provision of disciplinary action, final warnings and support in the form of counselling, or an extended probationary period. There were also isolated examples of disciplinary action taken whilst with a previous employer, including one neglect case where the referred person fell asleep on duty.

The examples considered for the analysis also highlight the difficulties presented for employers when the warning signs are not exhibited by the individual within their working environment, and would not therefore be observed directly. This highlights the need for partnership working within the sector and vigilance on the part of the public may also be needed to flag any concerns with appropriate agencies such as local safeguarding structures.

2.1.4 Barring decisions

It was apparent that a barring decision was made in both one-off and multiple behaviour cases where the behaviour was of a more serious nature. This included where there was evidence of actual harm to a service user, manipulation, or where there was more systematic or deceitful behaviour. In contrast, a decision not to bar was made where there was no evidence of actual harm to service users or there was no risk of future harm. It is notable that financial abuse cases would generally seem to have been more clear-cut in determining relevant conduct and harm, with a decision to bar in over two thirds of cases (33 out of 47).

Of the 62 cases involving multiple or repeated behaviour, 69% resulted in a bar compared to only 13% of the 38 cases involving one-off behaviours, suggesting some correlation between the nature of the behaviour and barring decision. However, this does not take account of other case specific considerations that resulted in the final decision to bar.

Table 2.6 illustrates some of the common characteristics of cases where a bar / no bar decision was made for each of the types of abuse, including brief examples. Whilst the table provides a useful illustration of the decision-making factors affecting the decision to bar, the results should be taken in their rightful context. In practice, the final barring decision was influenced by the specific circumstances of individual cases, as we go on to consider next within this chapter.

Table 2.6 Common characteristics of cases resulting in a bar / no bar decision, by type of abuse

| Abuse Type | Barring decision – outcome | |
|---------------------|--|---|
| | Bar | No bar |
| 1. Financial | <p>Characteristics</p> <ul style="list-style-type: none"> • Where larger amounts of cash or more valuable items were involved. • Where there was evidence of manipulation to access finances, or obvious deceit in covering tracks. <p>Examples</p> <ul style="list-style-type: none"> • Theft of large amounts of cash on more than one occasion; cash machine withdrawals, falsifying cheques. • Manipulating service users to set up joint account to give referred person access, or emotional manipulation – frequent mention of personal financial difficulties • Deceit - Intercepting bank statements, destroying receipts to cover tracks. Falsifying financial records. | <p>Characteristics</p> <ul style="list-style-type: none"> • Where behaviour involved low amount of cash or other items with a low monetary value, with theft or dishonesty occurring on few occasions. <p>Examples</p> <ul style="list-style-type: none"> • Use of service user's telephone while delivering in home care support. • Not returning exact or full change to service user after buying small items e.g. newspapers or chocolate bars. • Eating food from the fridge of service user while on duty delivering home care. |
| 2. Physical | <p>Characteristics</p> <ul style="list-style-type: none"> • Where behaviour is violent, resulting in injury or posing a serious risk of harm. <p>Examples</p> <ul style="list-style-type: none"> • Manhandling of a service user, use of excessive force to transport/manoeuvre users or to control behaviour. | <p>Characteristics</p> <ul style="list-style-type: none"> • Where behaviour does not include obvious violence, or present a risk of actual injury. • Short one-off instances of inappropriate physical handling. <p>Examples</p> <ul style="list-style-type: none"> • A care home worker observed by a colleague to have left a cloth over the face of the resident for several |

| Abuse Type | Barring decision – outcome | |
|---------------------|---|---|
| | Bar | No bar |
| | | minutes while washing the resident until it was removed when colleague intervened. |
| 3. Neglect | <p>Characteristics</p> <ul style="list-style-type: none"> Where service user at risk or experienced actual harm / serious acts of omission. <p>Examples</p> <ul style="list-style-type: none"> Failure to call for medical assistance to a residential care home resident, including one example where a service user was observed to fall through the window by a carer, but no assistance was called. Examples of incorrect administering of medication. | <p>Characteristics</p> <ul style="list-style-type: none"> Characterised by acts of omission but at a low level: <p>Examples</p> <ul style="list-style-type: none"> Carer falling asleep on duty or doing own ironing while on duty as a night time carer for a service user. |
| 4. Sexual | <p>Characteristics</p> <ul style="list-style-type: none"> Where sexual assault occurred. <p>Examples</p> <ul style="list-style-type: none"> Sexual assault of female patient and inappropriate touching of another female patient. The victim was vulnerable and was being treated for depression, referred person exploiting position. | <p>Characteristics</p> <ul style="list-style-type: none"> Cases involving consensual relationships. <p>Examples</p> <ul style="list-style-type: none"> A doctor engaged in a consensual relationship with a patient, whilst also treating her husband and then sought to conceal their actions from colleagues. |
| 5. Emotional | <p>Characteristics</p> <ul style="list-style-type: none"> Verbal abuse occurred with other abuse type e.g. physical. Multiple incidences. | <p>Characteristics</p> <ul style="list-style-type: none"> One-off incident involving an ill-considered, inappropriate response. |

| Abuse Type | Barring decision – outcome | |
|------------|---|--|
| | Bar | No bar |
| | <p>Examples</p> <ul style="list-style-type: none"> Referred person using inappropriate, derogatory language to service users. Also physical abuse involving the slapping of patients. | <p>Examples</p> <ul style="list-style-type: none"> Referred person swore at a patient who subsequently complained. Referred person denied swearing directly at the patient, but admitted swearing in the vicinity of the patient and work colleagues. One-off incident resulting from alleged verbal abuse from the patient. |

2.2 Circumstances

Having outlined the patterns and trends in behaviour, both within and between abuse types, it is important to identify the workplace circumstances and environments within which the abuse occurred. Lessons can be learned accordingly, to minimise the occurrence of abuse in the workplace.

2.2.1 Where the abuse takes place

Reflecting the profile of cases received by the ISA in respect of vulnerable adults, the following settings were represented in the sample of 100 cases examined:

Table 2.7 Settings where abuse took place

| Setting | Number of cases |
|-----------------------|-----------------|
| Residential care home | 43 |
| Home care | 31 |
| Medical settings | 13 |
| Supported Living | 10 |
| Other | 3 |

The small sample sizes for different categories of abuse type prevent a robust analysis in respect of settings but notable trends are evident:

- Just over half of the financial abuse behaviour (24 cases) occurred in home care settings. This was most likely due to individuals having greater access to financial assets, and opportunities for theft due to more limited supervision or more limited likelihood to be working alongside colleagues. Residential care homes were also a key setting for financial abuse (18 cases).
- Sexual abuse was the most common type amongst the cases in a medical setting (13 cases in this category), reflecting the common characteristics of these cases involving relationships between a medical professional and patient.
- All neglect cases occurred in residential or home care settings.
- The cases in a supported living setting or residential care involved common examples of physical and emotional abuse. As reported elsewhere this is likely explained as staff in residential settings often work in a much more intense fashion and for more extended periods with people who tend to have a greater level of need or may have more extreme forms of behaviour that is challenging (Hussain et al, 2009).

There was one case that involved behaviour that occurred in a purely domestic setting and did not directly involve vulnerable adults. This included domestic abuse which resulted in a referral to the ISA due to an individual's employment in the adult workforce.

Overall, there were fewer referrals from the medical setting than would perhaps be expected given the presence of vulnerable adults (particularly elderly) in this setting, and the overall size of the workforce. Analysis completed by Phair (2011) on the volume

of ISA referrals received from the NHS in comparison to internal NHS case data also identified a low referral rate. A number of potential factors are suggested in this research which may account for the low level of referrals from this sector, including difficulties in distinguishing between harm caused by a clinical error and harm caused because of other factors, and the development of a 'no blame' culture (Phair, 2011). However, if certain conditions are met, there is a statutory requirement to refer to the ISA.

2.2.2 Nature of relationship between referred person and victim

Given that just under three quarters of the abuse cases that were reviewed occurred within a residential care home or domiciliary home care setting, it follows that the overall 'carer/service user' relationship was by far the most common among adult cases of abuse.

It is interesting, however, to look more closely at the role of the referred person to distinguish the extent to which the referred person had actual care responsibilities:

- In the 73 cases where the referred person worked in a residential or home care setting, the majority (64 cases) did indeed involve individuals undertaking a front line role which predominantly comprised caring responsibilities.
- There were, however, 8 cases where the referred person undertook a managerial role and thus did not have direct caring responsibilities.
- There were a further 3 cases where the referred person undertook a supervisory role, so caring responsibilities were part of their role but not the whole of their role.

Those in managerial or supervisory roles were commonly referred for financial abuse (9 of the 11 cases). This is of course reflective of financial abuse as the most common type of abuse referred to the ISA for vulnerable adults overall, but also the managerial responsibility would typically involve sole or common access to the financial affairs of service users providing opportunities for financial abuse.

The remaining two cases involved neglect, these cases concerned neglect as a result of not ensuring policies and procedures were followed rather than abuse committed directly against a service user.

2.2.3 Experience

The degree of experience of the referred person was also explored through the study, over-and-above their specific caring role and competencies.

Just under a quarter of cases (21) involved individuals who had been in their current job role for less than one year when a referral was made, and six of these individuals had no experience in the sector before their current role. A third again had no more than three years' experience in the sector. However, there were no particular trends for the type of abuse perpetrated by inexperienced employees, with a mix of financial (10), emotional (5), neglect (3) and sexual abuse (1). Broadly equal proportions of bar / no bar decisions were made for these referred individuals, which further suggests that inexperience is not a strong predictor of risk of abuse in its own right.

At the other end of the spectrum, in around one third of cases (37), the referred individual had over 10 years' experience in their current role. Again all of the abuse types were represented. The majority were repeat or multiple instances, with only five one-off incidents, none of which resulted in a bar. These trends illustrates that the level of experience and number of years in employment with an unblemished record or without incident were factors taken into account by the ISA as part of the barring decision.

Other aspects of the referred person's employment status were also explored, but again no particular trends were apparent within the sample. For example, the permanency of the job role did not appear to be a particular factor. In only one example did the job role / title suggest a temporary position: "*Casual Night Assistant*". As there was just one such case, it is not possible to reach robust conclusions as to whether this temporary role meant increased risk due to unfamiliarity with procedures. Limited work experience in the UK was suggested in a further example ("care experience in native country"). No further details were provided to assess which country and therefore how far removed from the UK standards their experience might be.

2.2.4 Working practices

As the case file review examined abuse that occurred in the workplace, it is important to consider whether the policies, procedures or protocols of employers are contributing towards the perpetration of abuse against vulnerable adults.

These issues emerged in the case files through employers' investigations and in the representations⁷ submitted to the ISA by referred individuals where a 'minded to bar' decision was reached. A note of caution must be issued with regard to the latter source, therefore, given that representations will inevitably tend to portray working conditions in a negative light.

The **level of training and / or qualifications** of the referred person were not always apparent from the referral forms or the supporting case evidence. In 22 cases the level of training or induction received by the individual was not documented and no conclusions could be drawn. Some level of information about training was documented in all other cases. This varied significantly, from formal training resulting in a qualification (e.g. NVQ) to more generic inductions and briefings, and covered a range of professional areas including safeguarding, elder abuse, and manual handling. On the whole, there was no specific evidence to suggest a shortfall in the level of training for referred individuals, although the specific timescales for when this training was undertaken could not be ascertained from the case files, meaning that it is not possible to assess the quality of continuous professional development.

There were examples of referred persons criticising the level of training received, whether it be during induction or 'on the job' training. For example, there were two cases involving the alleged inadequate administering of medication, where the referred

⁷ "Representations" form part of the ISA process. This is the opportunity for the referred person to present their side of the story. Subsequently, a decision is made as to whether it is appropriate and proportionate to bar a person from working with a vulnerable group or groups because of the ongoing risk of harm. Representations can also be submitted in relation to the majority of Autobar offences.

persons had not been trained in the new protocols for recording information, which it was alleged, had contributed to the wrong medication being provided. As part of one of the same cases, questions were raised about the supervision of staff members during their probationary period, specifically, why probationary staff were not being shadowed, and whether this lack of supervision resulted in failures in the duty of care. These accounts must be approached with caution, as representations are likely to carry some inherent negative bias towards the employer, given their function in allowing the referred person to contest the grounds for barring.

There is some evidence that **employers' regulatory and working practices** may have provided opportunities for abuse to go undetected, based on the information from the case review. Some of the main areas of potential weakness include the following:

- **Financial irregularities** – A lack of systematic checks on financial transactions was a potential feature of some cases, along with incomplete financial record-keeping and poor levels of data security. It is perhaps interesting to note that employers commonly became aware of financial abuse because family members or banks identified irregularities. In one case, a manager of a residential care home had sole access to financial record sheets.
- **Lone working** – this was found to be a potential risk area, and especially so for newer employees when combined with a lack of support and supervision from the employer. In one such example the referred person had given an incorrect medication dose. In another case no training was provided in reading new medical charts, whilst in a further example the referred person had been undertaking lone working in delivering home care during their probationary period.
- **Allegations of bullying** - in one financial abuse case the referred person reported having been bullied and tormented within the workplace, which ultimately led to him becoming “very ill”. Mental illness was later claimed by the referred person to be an extenuating factor in an incident of theft.
- **Poor line management and supervision** – excessive work pressures and a lack of supervision were claimed as factors within a case involving multiple examples of mismanagement in a care home, which in turn resulted in emotional abuse and neglect. Staff were reported to be working 60 hours per week on a regular basis within this setting.

There were also examples of abuse cases characterised by managers failing to implement and abide by the protocols and policies established by their employers, and instead choosing to take administrative and supervisory short-cuts to minimise workload. Most common among these cases were managers failing to carry out the necessary service user and staff checks required of their role. One representative case involved a service user being left in their chair overnight following a catalogue of failures, including inappropriate staff handovers and the lack of regular spot checks every two hours through the night. During the disciplinary process, the referred person and colleagues stated it was a regular occurrence for the supervisory responsibilities of managerial staff to be shared among staff members on the night shift. This often took

the form of less senior staff being responsible for all service user checks on a particular floor, together with the completion of associated documentary records.

Other clear evidence existed of referred persons not complying with procedures / policies, including those in relation to safe keeping and cash handling. In one case, for example, an employee left the care home premises with a vulnerable adult to withdraw cash, leaving other residents unsupervised. The full details of the organisational culture were not available for these cases but it suggests that the existence of relevant policies and procedures on working practices needs to be combined with robust implementation.

Isolated examples were also found, where the referral to the ISA may have been made too early and the incident could have been satisfactorily addressed by the employer. The factors involved would seem to have been over zealousness in referring before the circumstances were established, or a misunderstanding of the ISA's role. For example, in one case a carer was dismissed and referred to the ISA for shouting at a care home resident. It was subsequently found that the incident occurred because the resident was about to injure themselves and the carer shouted to alert their attention. The referral to the ISA resulted in a decision not to bar.

Encouragingly, the potentially relevant behaviours were reported by colleagues or other staff members in the vast majority of cases analysed for the study. This is clearly an important way in which safeguarding issues become known to the employer, and one that employers should continue to facilitate through a supportive environment / whistle blowing policies. Other local agencies also played an important role, illustrating the importance of a partnership approach. Examples included abuse reported to police under the Notifiable Occupations Scheme, or discovered as a result of routine or unannounced audit or inspections by the Local Authority, CSCI or Regulation 26 visit (under Care Homes Regulations 2001)

2.2.5 Mitigating Circumstances

A further important aspect of cases considered by the ISA are the mitigating circumstances presented at the representations (reps) stage of the barring process. As might be expected, referred persons sometimes placed a heavy emphasis on such circumstances and these should be approached with caution due to the risk of exaggeration or false accounts.

The **personal circumstances** of the referred person featured in a number of representations. These related to the following:

- **Mental wellbeing** – depression, stress or a nervous breakdown were cited in a number of emotional and physical abuse cases, where the referred person had felt unable to deal with the pressures of their job at the time when the incident took place.
- **Economic hardship** – financial abuse was sometimes explained by way of personal or family debts that had got out of control and led to the referred person taking desperate action, including acts of stealing for family members.

- **Personal relationships** – referred persons themselves being the subject of abuse, such as in the case of a violent relationship, and a further case where the referred person cited the fact that they themselves had been attacked the week before as a reason for carrying a knife in the workplace
- **Coercion** – influence of others on their own behaviour.

The issue of **provocation** was also identified. This arose from the difficult behaviour of some service users, and in one instance from the alleged racist abuse that resulted in a referred person swearing at a service user. Considered in isolation, it was not always clear the extent to which these circumstances had been exacerbated by poor workplace regulation or lack of supervision.

2.3 Employer action

This section examines the responses of employers to the acts of abuse against vulnerable adults and the relative effectiveness and quality of their referrals to the ISA.

In reviewing 100 adult cases, variations appear between how employers investigated potential harm, and the types of disciplinary procedures that were put into effect. More often than not, however, thorough and structured investigation and disciplinary activity resulted in the immediate removal of individuals from regulated activity, where it was appropriate to do so.

2.3.1 Immediate response

In almost all cases reviewed, positively, the employer took immediate action upon being informed by a colleague or witness of the abuse occurring. Of the 100 individuals referred, 66 were suspended before any investigative work had taken place on the part of the employer. In 50 of these cases, the suspension occurred within 24 hours of the abuse coming to light, with the remainder within one week. Critically, this ensures that no subsequent harm occurs. In the majority of other cases (31 of the remaining 34 cases), a suspension was subsequently made but occurred two weeks or more after the abuse came to light. In the main, these were financial abuse cases. There were isolated cases where suspension did not occur immediately or within two weeks:

- In one case, the referred person (a support worker in a supported living setting) was moved to administrative duties, although a subsequent complaint (by an unspecified party) resulted in suspension one month later.
- In a further case, in a prison setting, the victim was moved from the work area where the referred person also worked. Again, a suspension occurred following an initial investigation within six weeks of the incident.
- In the remaining case, an immediate dismissal occurred, seemingly with limited investigation.

Analysis of the immediate employer response by type of setting and/or sector did not reveal any particular trends in terms of whether private or public sector employers responded any more effectively to the identification of abuse.

2.3.2 Investigating abuse

Internal investigations are evident in the vast majority of cases. There were isolated examples where internal investigations were not implemented if the referred individual received a formal caution or criminal conviction for the alleged abuse. When internal investigatory procedures were implemented, it was usually the responsibility of one or two staff members to collate the information and convene meetings and interviews. In the majority of cases, internal investigations were instigated within a matter of days of the allegations being made and over half were concluded within 3 months. A small minority were concluded in a matter of days. These tended to be financial abuses cases where there was irrefutable evidence or admittance of guilt.

2.3.3 Involving other agencies

Established processes for safeguarding vulnerable adults, as reflected in the ISA guidance for employers, encourages employers to inform or consult Local Authority Designated Officer (LADO) (For Children) or Health and Social Care Trust Designated Officer (for adults) if appropriate. The LADO is intended to oversee multi-agency responses to safeguarding concerns. The case file review identified 45 cases where the local authority safeguarding team was referenced. It is not possible to say whether in the remaining cases there was no involvement of this team. It could be the case that supporting evidence did not contain references, so this figure could be higher. Nonetheless, there is potential for greater involvement and employers should make it clearer and more explicit in their submissions to the ISA where safeguarding teams have been involved. Given the absence of investigative powers on the part of the ISA, a reference to the involvement of a local safeguarding team allows requests to be made for supporting information from this agency to assist in the decision making process.

Where references to safeguarding teams were made in the case files, it was difficult to determine the exact nature of their involvement. In some cases, employers informed this team but it was not possible to establish any subsequent activity. Where alleged abuse was of a low level, this may not have necessitated further involvement by the safeguarding team. In other examples, there was clearer evidence of safeguarding strategy meetings being convened and in some cases follow up meetings being undertaken as the investigative and disciplinary procedures were pursued.

It is encouraging, however, that the local authority safeguarding teams were typically involved early in the process. In the examples considered, this involvement occurred typically within 48 hours of the behaviour/incident coming to the employers' attention. However, there was no strong evidence that involvement of local authority safeguarding teams led to a better quality referral in the first instance in terms of provision of supporting information. There were common examples of the ISA making requests for additional information, typically the minutes of strategy meetings. However, being able to access these documents, albeit after a request has to be made, has the potential to provide a more complete picture of the case by allowing triangulation of evidence presented from other sources.

Case example – Involving other agencies

Following an allegation of financial abuse by a home care worker, the employer informed the local authority safeguarding team the day after the abuse came to light. A multi-agency adult safeguarding strategy meeting was convened within two weeks of being informed.

The initial meeting discussed the employers' investigation, including the support required for the victim to be interviewed, and actions to ensure other service users cared for by the referred person were supported. Over a six month period while the investigation and disciplinary process was undertaken, two further meetings were held.

On a similar theme, there was evidence in 16 cases of the employer informing regulatory bodies of the incident or behaviour. In all cases, the specific body involved or informed was appropriate to the setting and job role of the individual perpetrator of the abuse. Common examples included referrals to the Care Quality Commission or General Medical Council.

The other key agency commonly involved in the cases reviewed was the police. Employers appeared to appropriately involve the police in many cases and police representatives were evident as participating in multi-agency safeguarding strategy meetings. The circumstances of the case dictated an employer's timing for involving the police and their role. Two typologies were evident:

- Immediate notification of the police, with their taking the lead for investigating the abuse: and,
- Employer internal investigation started or completed, with later involvement of police as facts of case or potential criminal activity emerged.

2.3.4 Referring to the ISA

The vast majority of referrals were received from the referred person's employer, in line with the duties of employers under the ISA process. Of the 100 cases, 71 of the referrals were received directly from the employer. Reflecting the profile of settings in which abuse occurred, the majority of employers were social care providers but there were examples of referrals received from local authorities, the Police and the Prison Service:

Table 2.8 Profile of Referral Organisations

| Employers | Number of Referrals | | Number of Referrals |
|------------------------------|---------------------|---------------------|---------------------|
| Residential Care Home | 34 | Housing Association | 4 |
| Employment Agency | 15 | Mental Health Trust | 3 |
| Domiciliary Home Care Agency | 14 | Police | 1 |
| Local Authority | 7 | Prison Service | 1 |

| | | | |
|--------------------------|---|------------------------|---|
| Healthcare Company | 7 | Voluntary Organisation | 1 |
| Regulatory Bodies | | | |
| General Medical Council | 9 | Social Care Council | 7 |

If all agencies strictly followed the legislation, a referral should be made by the employer and regulatory body and/or statutory agency. The ISA encourages referrals made by the employer with the support of registered bodies or vice versa with relevant supporting evidence provided by both agencies. Alternatively the process does allow for multiple referrals to be made about an individual, which are brought together through the decision making process

Both approaches ensure that the ISA is provided with a complete picture of the circumstances of the case and the background of the individual being referred. This is necessary as relevant information to inform the ISA's decision may be held across several agencies.

Of the 100 vulnerable adult cases reviewed, only 3 cases resulted in a multiple referral, evidenced by a referral form or letter returned by more than one agency. These cases were residential care homes supported by additional referrals from the Care Council in Wales, a national care agency and a community care company. A further 40 cases, however, can be characterised as a joint referral as they demonstrated provision of information from more than one agency at the time of the initial referral.

In contrast, there were cases where the ISA had to subsequently request several pieces of information from a statutory agency which suggests that joint referrals had not been made. These cases and the lack of clear multiple referrals on specific cases suggest that some employers or registered bodies are not aware of and/or are not fulfilling their duty to the ISA.

2.3.4.1 *Timing of Referrals*

The ISA guidance recommends that referrals are made when sufficient evidence has been gathered as part of investigations to support an employer's decision to withdraw permission for an individual to engage in regulated or controlled activity. The ISA does not have the legislative power to engage actively in investigative work and as such relies almost entirely on the information collated and provided by the referring organisation and additional external agencies. Positively, in the vast majority of cases examined, referrals are made at the conclusion of formal internal investigations and disciplinary procedures, which facilitated the ISA access to the necessary documentation. In eight cases, either police or internal investigations were on-going, and the initial referral lacked key documentation. The referral did, however, reference this ongoing action so ISA caseworkers were simply able to request this evidence.

Conversely, delayed referrals following dismissal/resignation/termination of contract are a concern, as the perpetrators of abuse can move into different regulated employment, providing them with the opportunity to continue their abusive behaviour with new victims and within a new environment. Analysis here focused on the timescales for the referral following the conclusion of disciplinary procedures rather than the timescales from the

notification of abuse. In the main, timely referrals are being made with only isolated examples of cases where the referrals did not occur within one month of dismissal of the individual who committed the abuse. A review of case files identified only one significantly delayed referral due to an apparent administrative error but also potential evidence of employers not fulfilling their duty to refer. In this case a referral was made six months after an individual had been dismissed.

2.3.4.2 *Quality of Referrals*

The ISA guidance requests that referrals are made using the supplied referral form. In the sample of cases there was a proportion where this form was not used. While there was no evidence that non-use of the referral form impacted negatively on the provision of supporting information and the ability of ISA caseworkers to make decisions, some additional contextual information that is captured through the structured nature of the form is unavailable for ISA caseworkers.

Analysis of referral quality focused initially on completion of the referral form. There were a number of instances of the referral form being incomplete. Information pertaining to the training and employment history of the referred individual was commonly missing. This information is important to allow corroboration or rebuttal of any representations made by the referred person.

In only 20% of cases was a clear chronology of events present, and it was often difficult to identify the chronology of events where this section of the form was not completed. One example of a financial abuse case from a Health Care Agency provided only sketchy details of the offence, with no indication of the period of offending or the number of occasions the referred person withdrew money from the victim's account. This information had to be sought from the employer by the ISA caseworker.

The second aspect of quality is the timely provision of appropriate supporting information. Given the ISA's absence of investigative powers, the provision of supporting information is vital to allow robust decision-making. A list of prescribed information is provided in the referral form as a prompt for referring organisations (see Annex Two for the full list). There were examples of cases containing gaps in the supporting documentation at the time of the initial referral. Common examples included the lack of strategy meeting minutes or witness interviews, or by missing external investigative information from the Police and local authorities.

In contrast, a small number of referrals were characterised by the provision of too much information. While in the main, the ISA welcomes complete supporting information, there were isolated examples which raised potential data protection concerns given the amount of personal information provided. In one example a referral from a local authority HR team provided the ISA with the entire personnel file of an individual which potentially represented a breach of data protection. In one other case, copies were provided of all email correspondence relating to the investigation and disciplinary process. This data proved to be of limited relevance to the ISA decision making process.

2.4 Learning points

Behaviours

- The numbers of behaviours associated with abuse of vulnerable adults varied considerably within the cases reviewed for the study. At a broad level, persons were referred for financial abuse on the basis of singular behavioural types, but other forms of abuse tended to be more complex, and routinely included secondary behavioural types. Physical and emotional abuse often co-presented. The findings illustrate the varying motivations and patterns of behaviour underlying safeguarding cases.
- Where single, one-off behaviour was demonstrated, on the whole, there were few warning signs. This was to be expected given the behaviour was often out of character and appeared to result from a short period of stress or anxiety. In other cases, the warning signs became increasingly apparent. It is important for employers and partner organisations to consider the likelihood of potential escalation in the severity of incidents when implementing their own disciplinary process and deciding how and when to refer to the ISA.
- Some possible warning signs for employers include where there is over familiarity with the person being cared for, alongside signs of stress or discomfort on the part of the service user. In financial abuse cases, the signs potentially include employees being preoccupied with their money problems, combined with secretive or unsupervised handling of financial documents.

► Action Point: Employers should raise awareness of safeguarding issues, warning signs and referral routes through staff's core training and professional development. An environment should be created that allows for concerns to be raised via all available channels, including work colleagues, families or friends.

- Some discernible differences were found between one-off incidents in the workplace – those arising from “opportunism” or a poor response to a stressful situation, and multiple incidents of a more systematic or compulsive nature. The sexual abuse cases each included multiple incidents.

► Action Point: Different strategies might be needed to manage the risk of systematic abusers. This might include ensuring that there is effective regulation and supervision of employees to minimise the likelihood that episodes of abuse go unnoticed.

- A proportion of reported persons had previous criminal convictions, although these did not always relate obviously to the safeguarding issue. Wider conduct or behavioural problems at work, including carelessness, breaches of policy, attitudinal problems or emotional detachment, and persistent non-attendance were all commonly present in cases where abuse took place.

► **Action Point: Subject to eligibility, pre-employment checks (including criminal records checks) should be carried out by employers when an individual is first offered employment in regulated activity. A thorough assessment as part of the recruitment process could potentially also prevent a mismatch in the competences or personal qualities that are required for the role. It also suggests that probationary practices have a role to play in identifying unsuitability for a role at an earlier stage, before abuse can occur.**

Circumstances

- Abuse occurred in a diverse range of environments, On the whole, a broadly similar profile of abuse types was evident in the two main settings – residential care homes and domiciliary home care amongst the cases reviewed. This reinforces the importance of effective safeguarding in all regulated settings.
- The overall ‘carer / service user’ relationship was by far the most common among adult cases of abuse, although not all incidences took place directly between front line caring staff and service users. A small proportion involved managers or supervisors.

► **Action Point: Employers should equip employees to be vigilant at all levels within an organisation, and have clear procedures for whistle-blowing.**

- The analysis showed that a lack of experience was a potential contributory factor for abuse occurring in the workplace, but there was mixed evidence as to whether this related to competency issues and mismatches in suitability for caring roles, or simply reflected the likelihood that abuse would occur and be detected in the early stages of working for a new employer. This again reinforces the need for thorough background checks and close supervision and support during initial induction.
- Culture and policy issues in the workplace were strongly implicated across the types of abuse. Low levels of training and supervision and poor financial accounting procedures were commonly found, along with allegations of “bullying” and stressful conditions.

► **Action Point: Employers have a role to play in ensuring that staff are competent, skilled and appropriate for their working role, and that opportunities for abuse are minimised through effective recruitment, regulation and training.**

Employer actions

- It was not always possible to establish the suitability of the employers' actions in response to warning signs, without having full access to disciplinary documents. Examples of appropriate responses, where these were documented, included the provision of disciplinary procedures, final warnings and counselling, or extended probationary periods. On the whole, it is clear that prompt employer action greatly assists with timely barring decisions and thereby removing the reported person before further harm occurs.
- The examples considered for the analysis highlight the difficulties presented for employers when the warning signs and/or relevant conduct are not exhibited by the individual within their working environment, and would not therefore be observed directly.

► **Action Point: Partnership working is needed within the sector as well as vigilance on the part of the public to flag any concerns with appropriate agencies.**

3.0 Findings from Children Cases

This section reports the findings from a review of 100 referrals, which aimed to examine the behaviours, settings and circumstances of the abuse against children, and the actions taken by employers in response.

3.1 Behavioural Analysis

3.1.1 Types and patterns of behaviour

Of the children's cases reviewed, the majority of cases (more than half of the sample of 100 children's cases reviewed) related to alleged sexual abuse. Just over a quarter related to physical abuse, and a smaller number of cases related to emotional abuse and neglect.

Table 3.1 Profile of abuse types in children cases

| | Sample cases |
|------------------|--------------|
| Sexual | 58% |
| Physical | 27% |
| Emotional | 9% |
| Neglect | 6% |

This differs from the profile of cases referred to children's social care services, which subsequently result in children becoming the subject of a child protection plan. Neglect (42.5%) is the most common initial category of abuse under which children became the subject of a child protection plan. This is followed by emotional abuse (27.3%). Physical and sexual abuse cases accounted for 13% and 5.4% respectively (Department for Education, 2011)⁸.

The review of the ISA case files demonstrated that cases involving abuse against children in the workplace commonly involved multiple behaviour types. This was explicitly detailed in the referral and accompanying evidence in 35% of cases. In a further 20% of cases, a secondary behaviour type could be inferred from the circumstances of the case. There were common examples of physical abuse, where verbal/emotional abuse in the form of threats or abusive language preceded the instance of violence triggering the referral. In sexual abuse cases, grooming behaviour was commonly evident involving a degree of emotional manipulation.

Across all the cases reviewed, just over three quarters involved repeated or multiple instances of allegedly harmful or abusive behaviour, with the remaining third of cases relating to one-off acts.

⁸ 11.7% are 'multiple' categorisations. Department for Education (2011) *Characteristics of children in need in England, 2010-11*, final. London: DfE

Table 3.2 Frequency of abuse in children cases

| | One-off | Multiple/repeated |
|------------------|---------|-------------------|
| Sexual | 6 | 52 |
| Physical | 13 | 14 |
| Emotional | 0 | 9 |
| Neglect | 4 | 2 |

The one-off cases concerning alleged physical abuse commonly involved rough or physical handling of young children, or a physical response such as a slap or push to challenging behaviour by an older child. Where one-off incidents were of a sexual nature, these cases typically involved sexualised language or gestures being made in front of children.

The small number of one-off neglect abuse cases typically involved acts of omission. Examples included a foster carer not disclosing full knowledge of an incident involving the ex-partner of a pregnant teenage mother in her care, and a midday supervisor at a primary school not reporting an incident observed in the playground. While these referrals were characterised by a one-off incident, there was sometimes evidence on the case records indicating unprofessional or inappropriate manner on more than one previous occasion. This could potentially serve as a warning sign for employers.

The findings from the case file review suggest that employers are more likely to be dealing with multiple or repeated instances of behaviour that require a referral to the ISA. The size of the sample of cases involving sexual and physical abuse allowed some common features and examples to be identified:

- **Sexual abuse** cases commonly exhibited multiple instances or repeated behaviours. This included accessing child pornography on more than one occasion; being in possession of a quantity of images or repeated assaults, or instances where individuals had incited children to engage in sexual activity. There were examples of cases of repeated behaviour dating back over a significant number of years, and typically involving a number of victims.

Other sexual abuse cases involved prolonged or repeated abuse but involved only one victim. These cases were characterised by inappropriate relationships between an adult male in their 20’s and a teenage girl between the ages of 14-17. Across the sexual abuse cases, abuse were preceded and sustained by evident grooming behaviour.

- **Physical abuse** cases highlighted examples of repeated rough or inappropriate handling of children in response to a child's behaviour. This included, for example, pushing a child's shoulders to make them sit down, and taking a toy from a child who was banging it and hitting them with it on the head. Physical abuse cases also included examples involving physical violence in a domestic setting, where there was concern that a child was at risk.

3.1.2 Developing risk/escalation

It is important for employers to be aware of developing risk or escalation in behaviour; to ensure action is taken at an appropriate point, and to prevent further harm occurring to children.

The clearest examples of escalation or developing risk were evident in the cases reviewed involving sexual abuse. This was particularly the case where there was evidence of grooming behaviour such as:

- Developing close relationships characterised by time spent with the victim, communication outside of the usual setting for contact, and special treatment;
- Unnecessary or inappropriate physical contact, such as hugging, tickling or play-fighting;
- Failure to maintain appropriate professional boundaries and disclosing personal issues to a child;
- Private communication through letters, texts or social media that became increasingly sexualised.

For an employer, recognising this developing risk can be very difficult; in part because sexual grooming can be quite subtle, but also as it may occur outside of the workplace.

Other, more isolated examples of escalation or developing risk were evidenced in physical abuse cases. Patterns of escalation in terms of seriousness were evident in eight cases. Typically, manual or physical handling escalated to incidents of violence, although there were also several incidences where verbal abuse was followed by a violent/physical incident.

Across both of these types of abuse there were examples where colleagues or other children had witnessed previous incidents or behaviour, but had not alerted the employer. Their knowledge of the behaviour typically only emerged during the investigation phase. While recognising that the relevance of this behaviour may only become known in hindsight, the evidence from the study highlights the importance of creating an environment for colleagues, parents, friends or children to disclose any concerns that they may have. This involves setting acceptable standards of behaviour or a code of conduct that all are aware of; implementation of formal whistle-blowing policies, and creating a culture where adults and children are confident to raise concerns.

3.1.3 Warning signs

The analysis considered the possible warning signs that were exhibited by an individual leading up to the behaviour that prompted the referral. Given the predominance of sexual abuse cases in the sample of children's cases, many of the warning signs that employers noted were in fact common features of grooming behaviour and as such are reported also as signs of escalation as detailed above.

In cases of other types of alleged abuse, there was evidence of warning signs that employers may have seen within the workplace, although again some activity may

occur outside of that particular setting. These warning signs did not always relate specifically to the type of abuse for which the referral was made, but were more characteristic of general poor performance or professional misconduct. Across a number of cases, overstepping the boundaries expected of an adult working in the children's workforce was a feature. Examples included:

- Engaging in unnecessary or inappropriate physical contact with children; and,
- Excessive or unnecessary social communication with children outside of the work setting.

Other professional conduct warning signs were evident, such as general poor performance as a teacher, poor attendance or high levels of sick leave. Attitudinal or personality dimensions were highlighted across a number of cases. In a case in a fostering setting, which resulted in a referral for neglect, the approval process noted the couple in question had a preference for unconventional parenting approaches and were found to be difficult to work with. With hindsight, it is of course easy to highlight these issues and in other circumstances these attitudes may not result in any subsequent abuse. Vigilance on the part of employers is nonetheless needed. Employers should implement appropriate systems to record concerns or instances of poor conduct and provide support where there is felt to be a risk of escalation of this poor performance to abusive behaviour.

Previous criminal convictions offer a potential warning sign to employers to take into account. In the sample of 100 cases, only seven cases involved individuals with previous convictions. While this is a relatively small number of cases, the following examples serve to illustrate the role of timely pre-employment checks.

In one case, a CRB check was completed for a referred individual after they were offered a midday supervisor role subject to CRB checks. This check revealed a conviction for child cruelty 18 years previously, which had not been disclosed by the employee. The job offer was withdrawn and a referral made to the ISA resulting in a decision to bar.

There were other isolated examples, however, where timely checks were not undertaken by employers to uncover this background:

- In one case, a midday supervisor in a secondary school was found to have had a previous sexual relationship with a 14 year old boy. This was discovered when the employer asked for a CRB check 12 months after the individual was recruited. While in this case no further abuse was alleged to have occurred, there was a potential risk in the 12 month period before the check was undertaken.
- In another case, an individual did not disclose previous convictions for assault, which were discovered three years after the individual started a job in a school, when the employer sought to update their records.

These examples clearly demonstrate the need for pre-employment checks to be completed before an individual starts working in regulated activity with a new employer to minimise any risk. It is good practice to update these at regular intervals for employees already in the workforce.

3.1.4 Barring decisions

In cases involving children, a barring decision was made in both one-off and multiple behaviour cases where the behaviour was of a more serious nature. Table 3.3 overleaf provides illustrative examples. The table is intended only to provide an illustration of the decision-making factors affecting the decision to bar; the results should be taken in their rightful context. In practice, the final barring decision was influenced by the specific circumstances of individual cases.

Table 3.3 Common characteristics of cases resulting in a bar / no bar decision, by type of abuse

| Abuse Type | Barring decision – outcome | |
|-----------------|---|---|
| | Bar | No bar |
| Sexual | <p>Characteristics</p> <ul style="list-style-type: none"> • Where sexual assault or sexual abuse occurred. • Where convictions for possession of child pornography. <p>Examples</p> <ul style="list-style-type: none"> • A secondary school teacher who groomed two female pupils and entered a sexual relationship with a pupil when she reached the age of 16. | <p>Characteristics</p> <ul style="list-style-type: none"> • Where behaviour occurred historically (30+ years) and current risk was lower due to frailty of referred individual or lack of evidence that behaviour has been repeated more recently. • Where there was a lack of intent in viewing child pornography i.e. an individual was not aware of the content, had not kept it for any length of time and the numbers of images was very low. <p>Example</p> <ul style="list-style-type: none"> • A school ICT manager was not barred, as evidence suggested that the single image on a school network was related to tests on the system to ensure inappropriate content was not accessed by pupils. |
| Physical | <p>Characteristics</p> <ul style="list-style-type: none"> • Where behaviour was violent in nature and was witnessed by colleagues or others. <p>Example</p> <ul style="list-style-type: none"> • A foster carer who hit a foster child in his care, witnessed by other children. | <p>Characteristics</p> <ul style="list-style-type: none"> • Where assaults could not be substantiated on a balance of probabilities. • Inappropriate physical contact where no harm occurred to children. <p>Examples</p> <ul style="list-style-type: none"> • A lunchtime supervisor in a primary school who repeatedly sat children on his knee or carried them on shoulders. • A nursery teacher was believed to have slapped a 5 year old child in her care. Following ISA information gathering, CCTV footage showed that the incident had not happened as initially reported. |

3.2 Circumstances

Having outlined the patterns and trends in behaviour, both within and between abuse types, it is important additionally to identify the workplace circumstances and environments within which the abuse occurred. Lessons can be learned accordingly, to minimise the occurrence of abuse.

3.2.1 Where the abuse takes place, and relationships involved

Table 3.4 overleaf shows a breakdown of the workforce settings in which different forms of alleged abuse in the children's case sample took place, and the role of the referred individual in relation to the victim. Key findings and the implications for the children's workforce are discussed below.

School environments were a feature of 38 cases reviewed. This is not to say all the abuse occurred on school premises, but this environment was instrumental to the referred person meeting the victim or facilitating on going contact. Some 24 referred individuals were teaching staff with direct contact and responsibility for children. This included three individuals in a managerial role but with including teaching or pastoral care responsibilities.

Reflecting the predominance of sexual abuse cases involving teenage pupils, the majority of referred individuals and instances of abuse occurred in a secondary school setting (20 cases). In all but 3 of these cases, the victims were pupils who were taught by or attended the school where the referred person worked providing an opportunity for employers to be vigilant about the behaviour of their staff. The three other cases involved teaching staff, but the abuse or behaviour occurred outside their own school setting and did not involve victims known to the referred individual through their employment. Specifically, two involved images of child pornography, whilst another involved a sexual assault on a bus against a child unknown to the referred person.

Across the cases of all types of abuse linked to an education setting, in 14 cases the abuse occurred in the context of individuals' role as a non-teaching member of the school staff. These roles included midday supervisors, chaplains, a learning mentor, school nurse, IT manager, science technician, learning support assistant and a caretaker. Employers must therefore be vigilant of all individuals who deliver a role within their school community. A degree of collaborative working may be required where these individuals are not employed directly by the school but deliver contracted services. Organisations delivering contracted services need to be made aware of school safeguarding issues and encouraged to highlight any concerns that come to their attention as the direct employer.

Table 3.4 Setting where children's abuse takes place

| Setting | Role in relation to the victim(s) | Sexual | Physical | Emotional | Neglect | Number of cases |
|---|-----------------------------------|--------|----------|-----------|---------|-----------------|
| Education | Teacher | 20 | 2 | 1 | 1 | 24 |
| | Non-teaching school staff | 8 | 5 | 1 | - | 14 |
| Youth sector | Youth worker | 4 | 1 | 1 | - | 6 |
| Early years | Nursery worker | 1 | 4 | - | - | 5 |
| Faith setting | Clergyman | 5 | - | - | - | 5 |
| Care based in referred individual's home | Childminder | - | 1 | - | - | 1 |
| | Foster carer | 1 | 3 | - | 1 | 5 |
| Medical setting | Paramedic | 2 | - | - | - | 2 |
| Other care settings | Residential care worker | - | 1 | - | 1 | 2 |
| | Secure unit staff | - | 3 | - | - | 3 |
| | Other | 2 | - | - | - | 2 |
| Other⁹ | Range of roles | 15 | 7 | 6 | 3 | 31 |
| Total | - | 58 | 27 | 9 | 6 | 100 |

⁹ This category includes cases where the abuse occurred in a domestic setting, there is relevance here as the referred person worked in the children's workforce in some capacity.

All cases occurring in the **youth work** setting involved individuals in voluntary positions supporting young people aged 14-18. Positively, in most of these cases, it appears that appropriate checks on volunteers were undertaken as would be done with any paid employee. There were no obvious warning signs in terms of previous convictions or behaviour that were not picked up. In one case, however, no checks were undertaken locally by the leaders of a voluntary group who appeared to know the referred individual personally. This example reinforces the call for employers to follow best practice in their recruitment processes, including timely and periodic updating of criminal record checks.

There were examples where abusive behaviour occurred in a domestic or family setting, but implicated the children's workforce because of the referred individual's professional role within this sector. For example, four cases involved **foster care relationships** and the physical or sexual abuse of children being cared for. In two cases physical abuse was committed against foster children and in both cases there appears to have been concerns raised about the foster carers' behaviour during the approval process. It is not clear from the case file why this decision was overturned and whether any conflict occurred with processes outlined in the Fostering Services regulations, 2011. This may well be an isolated example set against the estimated 48,000 children looked after in fostering arrangements (Department for Education, 2011)¹⁰.

3.2.2 Age, experience and training

Issues of age and relative inexperience were most obviously seen in the cases in an early years setting. In all cases, the referred individuals had less than three years' experience and in three cases less than 12 months experience. These latter cases all involved individuals under the age of 21. It is not unexpected that this sector attracts younger workers, given the availability of vocational courses at colleges and these cases represent isolated examples given the overall size of the workforce. However, these cases illustrate the need for employers to adopt rigorous selection processes, provide induction as well as ongoing supervision and support to individuals on entry to the workforce or while hosting student placements (two cases). Colleges likewise need to continue to cover safeguarding issues as a key element of their delivery of vocational courses.

Other entry level jobs in the workforce, such as midday supervisors and classroom assistants, were featured in referrals to the ISA (8 cases). There was, however, a more mixed profile of experience and age evident from the individuals referred in these positions suggesting the issues at play were most likely more individualised than just age and experience

In contrast, amongst those cases involving teaching staff, it was more common to involve individuals with an established teaching history and career. In fact, the average age of the referred individual in these cases was 43, and most had at least several years' experience in the teaching industry, up to 30 years in some cases. These findings highlight the potential need and importance for employers to establish a code of

¹⁰ Biehal and Parry's (2010) review of the research evidence found that only two UK studies (Nixon and Verity, 1996; Triseliotis *et al.*, 2000) have reported on the annual incidence of allegations and confirmed maltreatment in foster care. These found that 3.5-4 per cent of foster carers were the subject of allegations in a single year; less than one per cent of allegations were confirmed.

conduct for staff as well as implement a programme of ongoing or refresher training on safeguarding issues.

Working Together to Safeguard Children (2010) requires employers to ensure that their staff are appropriately trained and that those in contact or working with children and young people and/or with adults who are parents or carers have a mandatory induction, which includes familiarisation with their child protection responsibilities and the policies and procedures to be followed if they have concerns about a child's safety or welfare (sec. 4.7). The level of training and / or qualifications of those referred to the ISA was not always apparent from the referral forms or the supporting case evidence. Some level of information about training was documented in 56 cases. This varied significantly, from formal training resulting in a qualification (e.g. NVQ in Health and Social Care or teacher training qualifications) to more generic inductions and briefings.

On the basis of the evidence in the children's case sample, it was not always the case that abuse was a consequence of inadequate safeguarding training. There were several examples, particularly involving school staff, where referred individuals had been in receipt of relevant training or had explicitly been given guidance following earlier behaviour. Child protection training was mentioned in 29 cases, although the specific content and timescales for delivery of this training could not be established.

One area notably absent from the training records, given the predominance of cases in a school setting, was any specific reference to training or guidance on the use of *social media*. Given the relatively recent development of this media, there may be a need for employers to establish more focused policies and provide guidance to staff on its appropriate use.

3.2.3 Working practices

There is some evidence that employers' working practices may have provided opportunities for abuse to go undetected or for the risk not to have been identified earlier, based on the information from the case review.

- As reported above, there were isolated examples of CRB checks after employment had started.
- The supervision and training offered to temporary staff emerged as an issue. In one case a supply teacher reported not having received any safeguarding training.
- The culture within a school setting in respect of a lack of boundaries amongst staff and older students was evident in one case. A referred individual highlighted loose social boundaries between staff and pupils in the sixth form as a factor in his own disregard for boundaries.
- In a case involving a learning mentor, their inappropriate relationship with a pupil was attributed in part to the school providing inadequate pastoral support for pupils. Learning mentors were relied on to provide links with the families of pupils in difficult personal circumstances, rather than being able to refer these pupils to formal support mechanisms within the school.

3.3 Employer Action

In reviewing 100 children's cases, it is clear that those employers who are referring to the ISA are broadly following appropriate processes, with clear evidence of immediate removal of individuals from regulated activity where the nature of the allegation requires it, and following investigation and disciplinary activity. There is evidence, however, that the specific procedures and the associated timescales for employer action varied.

3.3.1 Immediate response

In just under two thirds of cases (60), there was evidence of positive action by an employer to safeguard the children involved:

- In 33 of the 100 children's cases reviewed, the employer acted immediately (within 24 hours) to suspend the referred person as a first course of action, upon becoming aware of alleged abusive behaviour.
- In 14 other cases, the employer first investigated the matter and then acted to suspend the referred person having determined more about the circumstances surrounding the behaviour. The timescales for this investigative process varied, taking between two days and two weeks.
- In four cases, a referred individual took other leave from work, where they might otherwise have been suspended – in these circumstances, the absence of the employee alleviated the employer's concern in dealing with the employee's continued role.
- In all five cases involving a foster care arrangement, the children involved were immediately removed and placed in alternative care arrangements.

There were four cases where the immediate action of the employer was removal of an individual from normal duties. All of these cases involved physical or emotional abuse, which occurred in stressful circumstances or as a result of a degree of provocation. Removing the individual was deemed to be seen appropriate to minimise their contact with children and any subsequent risk of harm. In the remaining third of cases, it was not possible to ascertain from the case files the nature or timescales of employer activity.

In just under half of the cases (49) there was positive evidence of the involvement of local authority safeguarding teams:

- In 25 of these cases, the LADO was notified as one of the first actions taken by an employer; demonstrating best practice in the involvement of statutory teams. However, it was not always possible to determine the exact nature of their involvement from the information in the case files. Where alleged abuse was of a low level, this may not have necessitated further involvement by the safeguarding team following the initial notification.
- In 14 examples, there was clearer evidence of safeguarding strategy meetings being convened to discuss the case. Actions resulting from these meetings focused on appropriate activity taken to safeguard victims; to provide appropriate support, or to co-ordinate the investigation (see below).

- In seven of these cases, there was evidence of best practice, with strategy meetings held on more than one occasion to provide ongoing co-ordination of the investigation.

3.3.2 Investigation and disciplinary activity

Investigations were evident in the vast majority of cases but a number of different models of investigation were pursued. The nature of the allegation appeared to dictate the progress of investigation:

- Where the incident did not immediately appear to be a criminal activity, investigations led by a member of senior management from the referring organisation were conducted in the first instance.
- In other cases, internal investigations were suspended or not pursued pending the outcome of police led investigations, which was fed back to the employer directly through safeguarding strategy meetings.
- In one case, an independent investigator was appointed to conduct an investigation and interview witnesses.
- Investigations were also undertaken by Regulatory Bodies. These tended to involve an inquiry into the referred person's conduct, following by proceedings to consider whether their name should be erased from the professional register. Such investigations were often undertaken, independently of and following an employer's internal investigation.

The timing and format of disciplinary action that followed these investigations varied somewhat depending on the lead organisation. In the main, employers appeared to be operating a robust disciplinary process. A good practice feature within some examples was that the employer offered continued contact and sources of support for the suspended employee:

In two cases, employers set up formal investigations and disciplinary processes, which were not pursued to conclusion as the individual resigned prior to a final disciplinary hearing taking place. In two further cases where this situation occurred, the employer concluded the disciplinary procedures in the absence of the referred party, in order that a full record of concerns leading up to dismissal could be recorded and made a subsequent referral to the ISA. This was appropriate action in line with ISA guidance, to ensure any substantiated concerns about an individual are lodged in case of any subsequent applications to work in the sector.

In cases involving voluntary organisations, there were examples where referred individuals had their membership de-registered, were dismissed without a disciplinary hearing or a substantive investigation of the alleged abusive behaviour. This may reflect the more limited resources that voluntary sector organisations can give to the development and implementation of disciplinary protocols.

It was not always possible to establish the specific timescale for the conclusion of investigation and disciplinary processes. Where this data was available, the wide variety prevents robust conclusions being drawn. There were several examples where investigations took a period of several months and, in one case, a year to conclude.

While the extreme example here was partly due to police involvement during which time the internal investigation was suspended; nonetheless the time taken is significant.

One emerging trend is the lack of capacity for schools to pursue quick investigations. Examples existed, however, where joint work with local authority safeguarding teams appeared to speed up the process. In these cases the LADO led investigations or chaired regular safeguarding strategy meetings, which maintained case progression.

3.3.3 Referring to the ISA

3.3.3.1 Profile of referral organisations

Reflecting the overall profile of referring organisations, most of the referrals for children's cases in the sample were made by the referred party's employer (76 out of the sample of 100). The highest number of referrals within the sample was made by Local Authorities (22). Schools were also prominent sources of referrals; mostly in their capacity as employer. These cases accounted for 20 of the referrals; with a further three cases being referred by Further Education colleges. The following table summarises the whole sample of cases by referring party.

Table 3.5 Referring organisations in children’s cases

| Employers | Number of Referrals | | Number of Referrals |
|--------------------------|---------------------|---|---------------------|
| Local Authority | 22 | Care provider/ agency | 3 |
| School | 20 | Prison Service (YOI/ Secure Training Centre) | 2 |
| Foster Service/ Agency | 5 | Teaching Agency | 2 |
| Faith organisations | 5 | Employer (other) | 2 |
| Voluntary Organisation | 5 | Ambulance Trust | 1 |
| Colleges | 4 | Charity | 1 |
| Nursery | 4 | | |
| Regulatory Bodies | Number of Referrals | | |
| General Teaching Council | 3 | National Governing Sports Body | 1 |
| General Medical Council | 1 | Health Professions Council | 1 |
| Ofsted | 1 | | |
| Other Referring Bodies | Number of Referrals | | Number of Referrals |
| Police | 6 | Historic review of previously referred cases (Department for Education) | 3 |

| | | | |
|-------------------------------------|---|-----------------|---|
| Local Safeguarding Children's Board | 3 | Education Board | 2 |
| DCSF | 3 | | |

As reported earlier in relation to vulnerable adult cases, if all agencies strictly followed the legislation, a referral should be made by the employer and regulatory body and/or statutory agency. Alternatively, referrals should be made by the employer with the support of registered bodies, or vice versa with relevant supporting evidence provided by all organisations to ensure that the ISA is provided with a complete picture of the circumstances of the case. For example, in the case of a teacher, a Local Authority HR team may hold employment records for an individual, while the school will hold information about the specific incident and subsequent investigation. The prescribed list of supporting information provided within the ISA referral documentation (see annex Two) suggests information from both agencies would be required, particularly in light of the absence of investigative powers on the part of the ISA.

In the children's cases reviewed, there was only one multiple referral where a case file included a separate referral from a regulatory body and an employer. More common were joint referrals characterised by the provision of supporting information from more than one agency within a single referral. In 24 of the children's cases, however, there was a need for the ISA to request information from a different agency to that which made the referral to inform their decision making. Availability of information at the time of the referral could be a factor. However, isolated examples suggest room for improvement in collaborative referrals. One case included an explicit reference in the referral form for the ISA to contact the Local Authority to access supporting information on the series of strategy meetings that occurred in relation to the case.

3.3.3.2 *Timing of Referrals*

A positive finding to emerge from the children's case file review is that the majority of referrals were timely and in accordance with the statutory requirement. There were only two instances where the referral could be considered as 'late', but these examples were both characterised by delay in responding to previous instances of abuse. For example, a referral following inappropriate behaviour from a teacher towards a pupil was only made after a third incident had been witnessed by pupils and parents and investigated by the school. It could be argued that disciplinary action and subsequent formal referral should have taken place following the previous allegations to minimise the risk of harm to other pupils.

3.3.3.3 *Quality of Referrals*

The referral guidance issued by the ISA requests that sufficient evidence of relevant conduct¹¹ or risk of harm to a child is provided when making the referral. The specific referral form used by employers to refer individuals to the ISA also includes details of the prescribed documents to be provided, if available, to facilitate timely and robust decisions given the absence of investigative powers held by the ISA.

¹¹ The SVGA 2006 defines relevant conduct as that which endangers or is likely to endanger a child or vulnerable adult.

The case file review identified clear examples of good quality referrals, which were characterised by the provision of comprehensive information that correlated with a detailed chronology of events outlined in the referral form. In addition, there were a handful of multiple or joint referrals that illustrated positive working relationships and communication between employers and external bodies, such as local authorities and regulatory bodies. Through the submission of joint referrals, the case against the referred person was stronger and facilitated a clear decision from the ISA as the referral was more complete in the supporting evidence provided. In contrast, some items of supporting information were missing in 15% of the sample cases. Documents commonly omitted included witness statements and strategy group meeting minutes, which subsequently had to be requested by ISA case workers and resulted in delay.

3.4 Learning points

Behaviour

- Employers could witness isolated one-off incidents of abuse against children or a pattern of repeated or multiple incidents of behaviour, although some of this behaviour (particularly in the case of sexual abuse) may occur outside of the workplace setting. Viewed in isolation, these incidents would not necessarily meet the threshold for removal from regulated activity but taken together they reveal a pattern of behaviour that would meet that threshold.

▶ Action Point: Employers must create an environment for colleagues, parents or friends to disclose any concerns that they may have about individuals. This includes setting acceptable standards of behaviour/code of conduct, implementation of formal whistle-blowing policies, and creating a culture where concerns can be raised confidentially.

- A number of warning signs may be evident, these will not necessarily be strictly related to the type of abuse that will manifest and some may appear as poor performance or unsuitability to role.

▶ Action Point: Employers should implement appropriate systems to record concerns or instances of poor conduct and provide support where there is felt to be a risk of escalation of this poor performance behaviour into abuse.

- One of the potential warning signs is previous criminal convictions, demonstrating the need for routine checks.

▶ Action Point: Regardless of organisation or the role being filled, appropriate criminal record checks should be completed before an individual starts working for a new employer in regulated activity to minimise any risk. It is good practice to update these periodically.

Circumstances

- Abuse involving children can occur in a wide range of settings. Likewise, abuse can be committed by staff across a number of roles, including those without direct or routine contact with children.
- Staff new to the sector, particularly those with more limited work experience, may need additional supervision and guidance. Qualifications can prepare staff to an extent but additional support may be needed to deal with the challenges and boundaries that need to be set in caring for children.

▶ **Action Point: Where employers oversee or engage with individuals not in their direct employment, either through contracted services or temporary/supply staff checks should be made as to the completion of appropriate safeguarding training.**

- It is noted that more experienced staff equally may need support at particular points or in response to developments in the sector or society that change established ways of communicating or interacting with children.

▶ **Action Point: It is important for employers to implement a programme of ongoing or refresher training on safeguarding issues or implement related policies. Given the relatively recent development of social media, there may be a need for employers to establish more focused policies and provide guidance to staff on its appropriate use.**

Actions

- Investigative models should respond to the nature of the allegation but following the specified procedures outlined in Working Together to Safeguard Children (Department for Education, 2010).
- Partnership working with local multi-agency safeguarding structures, the police or regulatory bodies where appropriate typically supports effective safeguarding of victims and subsequent action in investigating and reporting abuse.

▶ **Action Point: Employers should continue best practice approach of early notification of LADOs and involvement of statutory safeguarding teams in the response to alleged abuse where appropriate.**

▶ **Action Point: Employers and statutory/regulatory organisations need to continue and increase collaboration in submitting referrals to the ISA thus providing a complete picture of the background and circumstances of the case on which the ISA can make an informed decision.**

4.0 Conclusions

The findings in relation to cases involving children or vulnerable adults have thus far been presented separately within the report. In the following chapter, a summary of trends to emerge from the research from across the adult and children's workforce is presented. The findings here are considered in terms of behaviour, circumstances and employer action. We have also cross-referenced to the core research questions for the study, although these questions are implicated to an extent under each of the three strands.

4.1 Behaviour

The type of abuse that was the subject of referrals to the ISA from the vulnerable adult and children's workforce showed some distinct profiles. Financial abuse cases predominated for vulnerable adult cases (47% in the sample of cases reviewed for this research). In the referrals from the children's sector, sexual abuse cases were most common (58% in the sample) and financial abuse non-existent. Given this distinct difference in abuse types by sector, some caution is needed with any subsequent comparisons. Any differences noted could be due to the nature of the abuse perpetrated rather than any other features of the workforce or sector.

In examining the findings specifically in relation to **research question 1** (*key indicators that highlight a developing level of risk from an individual*) and **research question 2** (*behaviours or circumstances that raised the first warning signs of potential harm*) a number of conclusions can be drawn:

Developing risk was witnessed both within and outside of the workplace for both vulnerable adult and children cases. The key indicators of developing risk were, however, distinct to the types of abuse evident within each sector. Evidence of developing risk in financial abuse cases, for example, was in the main behaviour or concerns closely related to that specific abuse type, such as the theft of smaller amounts of money. In sexual abuse cases involving children, the behaviour indicative of developing risk was more varied. The main characteristic was grooming behaviour such as inappropriate physical contact or degrees of emotional manipulation. A challenge facing employers is that the behaviours leading up to sexual abuse of children are often subtle and manipulative. As such, they may not occur solely or commonly in the workplace. Employers and work colleagues need training to recognise these warning signs.

Across both children and vulnerable adult cases, indicators of developing risk in physical or emotional abuse cases are largely similar. The case file review identified examples of rough physical handling, inappropriate language or raised tone of voice as behaviour types exhibited by individuals who were subsequently referred to the ISA.

A common indicator of developing risk or warning sign across all case types was the degree of professional misconduct and inappropriate behaviour in the workplace. In vulnerable adult cases, however, there appears to be stronger evidence of these signs, with the individual demonstrating wider problems of poor self-control and self-

management that were not always directly related to the safeguarding issue that subsequently emerged.

Research questions 3 and 4 *focused on the timing of referrals and their content.*

Across both sectors; there were examples where gaps in information about the individual's history prevented the risk of abuse from being detected earlier. This had the consequence of delaying referrals until behaviours became more pronounced. In the main, employers were undertaking appropriate checks of criminal convictions and performance in other roles but there were isolated examples of slow take up of pre-employment criminal record checks and some deliberate with-holding of information by employees. Compounding this issue was the fact that a fair proportion of referred persons had a low level of professional experience, and a limited employment history against which to check for previous warning signs within a workplace setting.

Across sectors, a key challenge for the employer often related to a lack of completeness of information about the individual's actions, including where behaviours were not exhibited in the workplace, were consciously hidden by the individual, seemed irrelevant, or were observed separately by colleagues without making the association with potential abuse. Here, the need for staff awareness of the possible signs of abuse, clearer lines for reporting and supportive employer attitudes and policies for reporting concerns emerged as being key areas for employers to consider.

4.2 Circumstances

Research question 5 focused on the lessons to be learned about the *places where harm occurs*. Additional trends were also established through the research in terms of other factors in the circumstances of cases.

As would be expected, the settings within which abuse takes place were fairly distinct across vulnerable adult and children cases. In vulnerable adult cases, residential care home and domiciliary home care were common settings (71%) while school environments (38%) predominated in children's cases. On the whole, children's cases demonstrated a wider range of workplace settings within which abuse takes place.

Common across both sectors, however, were a small number of cases involving domestic abuse, which took place outside of a workplace setting. Likewise referrals from medical settings were few for both vulnerable adults and children, suggesting work needs to continue to be done by the ISA to ensure appropriate referrals are received from this sector where the behaviour meets the criteria for referral.

Across both sectors, abuse was most commonly perpetrated by individuals with more direct or 'front line' contact with children, but employers should note that those in more senior or managerial positions with less contact do also exhibit abusive behaviour. In the children's sector in particular, there appeared to be a wider range of job roles represented in the cases referred. In assessing risk, employers, particularly in a school setting, need to be mindful of the full range of employees who may come into contact with children.

There was clear evidence that aspects of organisational culture and working practices may have provided opportunities for abuse to go undetected. This was particularly the case with some forms of financial and physical abuse in adult cases, where a lack of professional experience and supervision were identified.

On the whole, appropriate qualifications or training were observed to have been delivered in the workplace across both sectors. What did not emerge strongly across either sector was evidence of the currency or regularity of training. This suggests a potential need for employers to ensure ongoing refresher training where appropriate, as developments occur in the sector or working practices emerge. One example of a potential gap was evident in children's cases in respect of online communication and the use of social media, which was a common feature of grooming behaviour in sexual abuse cases.

Within both workforces, clear examples were found where individuals were obviously mismatched with the personal and professional qualities needed for the job. This was particularly illustrated by caring occupations in the vulnerable adult sector, but was also demonstrated to a lesser extent in cases in the early years setting. Emerging across both sectors was a need for better staff selection as well as improved induction, training and supervision for new entrants to the workforce. More common to vulnerable adult cases were employees who were poorly equipped to deal satisfactorily with stressful situations presented by service users in their care.

4.3 Employer action

Findings in relation to **research question 6** focus on a number of aspects of *employer actions* in response to becoming aware of the behaviour or alleged abuse including good practice in referrals to the ISA.

It was clear from the cases reviewed that, on the whole, those employers that refer from across both sectors are responding appropriately to abusive behaviour in the workplace. There was clear evidence of immediate action to remove individuals from regulated activity to prevent further harm and of structured investigation and disciplinary activity.

Investigative models and the time to complete investigations varied but on the whole employers were appropriately investigating abusive behaviour. Capacity to undertake timely investigations is perhaps more of an issue for employers in the children's workforce. For example, school investigations on average took longer to complete, and there were some potential isolated issues with capacity and knowledge of voluntary sector organisations.

Across both sectors, appropriate involvement of other agencies in the response to abuse was evident. Early notification and involvement of LADOs and other local safeguarding structures and the active involvement of employers in multi-agency safeguarding strategy meetings was observed in line with best practice.

Of the cases, examined, most employers referred at the conclusion of investigations and disciplinary activity which provides adequate supporting information to inform ISA decision making given the absence of specific investigative powers held by the ISA.

There is room for improvement, however, in terms of the provision of joint referrals in line with the duty placed on employers and regulatory agencies to make referrals to the ISA.

There was mixed evidence from the case review that employers are complying with requirements in terms of full completion of the referral form. On the whole, the supporting information provided by employers is broadly appropriate and complying with the prescribed information. Where information is missing and additional requests for information were made by the ISA, this tended to be for documents which are not generated or held by the employer directly (e.g. strategy meeting minutes.). The examples also suggest that in isolated cases, the provision of too much information such as the whole personnel file of an individual may be perceived to conflict with data protection regulations.

Some good practice in referrals evident within the sample, but this was by no means the norm, and the research suggest that further work is needed to raise awareness of good practice criteria with employers from both sectors. Where good practice examples were found, they were characterised by detailed and organised referral forms that include clear evidence of the relevant conduct and a detailed chronology of events and of the relevant internal and external investigations. Good referrals also provided access to clear investigatory notes and commonly reflected the quality of the internal investigatory and disciplinary procedures of the referring organisation. The table below summarises the core characteristics of a good referral:

Table 4.1 Good practice in referrals

| Core components of a good quality referral |
|--|
| <ul style="list-style-type: none"> • Referral form sent within a reasonable timeframe that balances the need for a swift response with the need for sufficient documentary and supporting evidence; • Time taken to accurately complete the referral form resulting in limited gaps and recognition of any gaps, if present; • The presence of a clear chronology detailing the sequence of events from the initial notification of the alleged abuse through to the final outcome, be it dismissal, suspension or return to work; • The sending of only relevant information to facilitate the decision making process of the ISA; • Inclusion of an accurate, dated training and supervision record; • Submission of all elements of the investigative and disciplinary processes, including interviews, strategy meetings, formal written and electronic correspondence, employment information, and references; • Details and documentation pertaining to external investigations from the Police or other agencies; • Evidence of multi-agency and collaborative working. |

It was outside the scope of this research to assess the number of employers that do not refer when required. Moreover, while there were some isolated examples of joint referrals, this is an area for further exploration.

4.4 Key Action/Learning Points

The overall aim of the research was to identify key lessons learnt emerging from a review of ISA case files. The following points highlight areas of potential action on the part of employers to ensure the ongoing safeguarding and minimisation of risk of harm to children and vulnerable adults.

Vulnerable Adults Sector:

- It is important that 'warning signs' of potential abuse or risk are effectively disseminated to staff at all levels within an organisation through their core training and professional development.
- Probationary practices should continue to be used to identify unsuitability for a role at an earlier stage, before abuse can occur.
- Employers should continue to ensure that staff are competent, skilled and appropriate for their working role, and that opportunities for abuse to occur are minimised through effective regulation and training.

Children's Sector

- Where employers oversee or engage with individuals not in their direct employment, either through contracted services or temporary/supply staff checks should be made as to the completion of appropriate safeguarding training.
- It is important for employers to implement a programme of ongoing or refresher training on safeguarding issues or implement related policies.
- Given the relatively recent development of social media, there may be a need for employers to establish more focused policies and provide guidance to staff on its appropriate use.
- Employers should continue the best practice approach of early notification of LADOs and involvement of statutory safeguarding teams in the response to alleged abuse where appropriate.

Both sectors

- Employers should continue to implement appropriate systems to record concerns or instances of poor conduct and provide support where there is felt to be a risk of escalation of this poor performance into abusive behaviour.
- Employers should raise awareness and create an environment that allows for concerns about alleged abuse to be raised via all available channels, including work colleagues, parents or friends. Employers should equip employees to be vigilant at all levels within an organisation, and have clear procedures for whistleblowing.
- Regardless of organisation or the role being filled appropriate pre-employment checks should be completed before an individual starts working in regulated activity to minimise any safeguarding risks. It is good practice to update these at regular intervals for individuals currently in the workforce.
- Employers and statutory/regulatory organisations need to continue and increase collaboration in submitting referrals to the ISA through the provision of multiple or joint referrals thus providing a complete picture of the background and circumstances of the case on which the ISA can make an informed decision.

Annex 1: Glossary

Definitions of Abuse Types

| Type of harm to children | Meaning | Examples |
|--------------------------|---|---|
| Emotional | Action or inaction by others that causes mental anguish | Emotional harm is the emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. It may involve children witnessing aggressive, violent or harmful behaviour such as domestic violence. Some level of emotional harm is involved in all types of ill-treatment of a child, though it may occur alone. Grooming, harassment, inappropriate emotional involvement. |
| Physical | Any intentional physical contact that results in discomfort, pain or injury | Physical harm may involve assaults including hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen syndrome by proxy. Supply drugs to children. Inappropriate/unauthorised methods of restraint. |
| Sexual | Any form of sexual activity with a child under the age of consent | Sexual harm involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways. Downloading child pornography. Taking indecent photographs of children. Sexualised texting. |

| Type of harm to children | Meaning | Examples |
|--------------------------|--|---|
| Verbal | Any remark or comment by others that causes distress | Demeaning, disrespectful, humiliating, racist, sexist or sarcastic comments. Excessive or unwanted familiarity, shouting, swearing, name calling. |
| Neglect | Failure to identify and/or meet care needs | Neglect is the failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. |

| Type of harm to Vulnerable adults | Meaning | |
|-----------------------------------|--|--|
| Emotional | Action or inaction by others that causes mental anguish | Inflexible regimes and lack of choice. Mocking, coercing, denying privacy, threatening behaviour, bullying, intimidation, harassment, deliberate isolation, deprivation, manipulation. |
| Sexual | Coercion or force to take part in sexual acts | Inappropriate touching. Causing bruising or injury to the anal, genital or abdominal area. Transmission of STD, inappropriate relationships |
| Financial | Usually associated with the misuse of money, valuables or property | Unauthorised withdrawals from vulnerable adult's account, theft, fraud, exploitation, pressure in connection with wills or inheritance. |
| Physical | Any physical action or inaction that results in discomfort, pain or injury | Hitting, slapping, pushing, shaking, bruising, failing to treat sores or wounds, under or overuse of medication, un-prescribed or inappropriate medication, use of restraint or inappropriate restraint, inappropriate sanctions. |
| Neglect | Failure to identify and/or meet care needs | Untreated weight loss, failing to administer reasonable care resulting in pressure sores or uncharacteristic problems with continence. Poor hygiene, soiled clothes not changed, insufficient food or drink, ignoring resident's requests, unmet social or care needs. |

Source: *Guidance Notes for the Barring Decision Making Process, ISA, February 2009*

Annex Two: Prescribed Information for Regulated Activity Providers

Prescribed Information for Regulated Activity Providers

Section 35 of the Safeguarding Vulnerable Groups Act (SVGA) 2006 and Section 37 of Safeguarding Vulnerable Groups (Northern Ireland) Order (SVGO) 2007 sets out the duty for a Regulated Activity Provider (RAP) to refer prescribed information to the Independent Safeguarding Authority (ISA) in certain circumstances.

Section 37 of the SVGA and section 39 of the SVGO place a duty on a RAP to provide prescribed information on request to do so by the ISA.

The information to be provided in a referral or on request is outlined in the Schedule to:

- The Safeguarding Vulnerable Groups Act 2006 (Prescribed Information) Regulations 2008 (No. 3265 of 2008); and
- The Safeguarding Vulnerable Groups (Prescribed Information) Regulations (Northern Ireland) 2009 (No. 40 of 2009).

The information required is as follows, although all information requirements do not apply to all referring parties:

Paragraph 1 requires the provision of personal information about the person being referred namely:

- a) full name and title;
- b) any other name or names by which the person may be known e.g. maiden name, aliases;
- c) date of birth;
- d) national insurance number;
- e) gender;
- f) last known address (including postcode);

Paragraph 2 requires a description of the regulated or controlled activity that the person is, or was, engaged in.

Paragraph 3 requires information as to whether or not the person is included in a register maintained by a keeper of a register or a supervisory authority.

Paragraph 4 requires information or documents in relation to the person's employment including application for employment, job description, qualifications, relevant training, whether they are still employed or not.

Paragraph 5 requires information relating to the persons conduct, (including copies of relevant documents):

- a) a summary of the conduct including details of the setting and location in which such conduct occurred;
- b) details of any harm suffered by any child or vulnerable adult resulting from or arising from the conduct or any risk of harm that a child or vulnerable adult was, or may have been, exposed to as a result of such conduct;
- c) the following details of any child or vulnerable adult referred to above;

- I. the name and date of birth of the child or vulnerable adult;
 - II. details of the relationship between the person and the child or vulnerable adult;
 - III. information relating to the vulnerability of the child or vulnerable adult that may be relevant to ISA's consideration of whether to include or remove the person in or from a barred list including any emotional, behavioural, medical or physical condition;
- d) whether the person has accepted responsibility for or admitted the conduct or any part of it;
 - e) any explanation offered by the person for the conduct or any remorse or insight demonstrated by the person in relation to the conduct;
 - f) any information other than that relating to the person's conduct which is likely to, or may, be relevant in considering whether the person should be included in or removed from a barred list including information relating to any previous offences, allegations, incidents, behaviour or other acts or omissions.

Paragraph 6 requires information relating to the reason why the referring party considers that the harm test is satisfied in relation to the person (if referring on the basis of satisfying the harm test).

Paragraph 7 requires details of any investigation undertaken in relation to the person's conduct.

Paragraph 8 requires details of any disciplinary proceedings or measures taken, or to be taken in relation to the person's conduct.

Paragraph 9 requires details of any other proceedings before any court, tribunal or any other person taken or to be taken in relation to the person's conduct including the outcome of any such proceedings.

Paragraph 10 requires details of any action taken, or to be taken, by the person referring or providing information under the Act to the ISA in relation to the person's conduct including whether or not the matter has been referred to the police or to any other person.

Annex Three: References

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