Learning Disabilities Mortality Review (LeDeR) Programme: Fact Sheet 13

Recognising signs of abuse

Key considerations for reviewers

- Were there any significant changes in behaviour for which there was not a medical or reasonable explanation investigated?
- Are there any signs or indications that the person may have been subject to abuse or neglect?
- Had there been any previous safeguarding concerns raised or being investigated?
- Was there evidence of poor practice within an institution or specific care setting, through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation?

Introduction

People with learning disabilities often require support with areas of their life such as accessing healthcare, decision-making and support with personal hygiene. This can make people with learning disabilities vulnerable to abuse.

In 2011, BBC's Panorama broadcast a programme investigating abuse of people with learning disabilities at Winterbourne View. The programme prompted a CQC review of learning disability services which found almost 50% of hospitals and care homes did not meet national standards[1]. The review of abuse at Winterbourne View highlighted that the regular review of a person's support needs and provision can be a protective factor. Of the people with learning disabilities whose deaths were reviewed by the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013), more than a quarter had not had their support reviewed within the past year, and one in ten had had previous safeguarding concerns investigated. In addition, findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

Current definition

"Failing to act to prevent harm being caused to a person you have responsibility for, or acting in a way that results in harm to a person who legitimately relies on you, both constitute abuse"[2].

Abuse involves the misuse of power and is defined as harm caused to an individual, regardless of intent. Abuse and neglect take many forms. Abuse can be physical, verbal, psychological, sexual, domestic, financial, discriminatory, organisational, institutional, or modern slavery. It can be the result of an act or a failure to act. Abuse can occur in a wide range of settings including in residential centres, hospitals or in a person's own home. It can take place when an adult lives alone or with others.

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[1] Care Quality Commission (2012) Learning disability services inspection programme: National overview. Newcastle upon Tyne: CQC.

[2] SCIE (2011). 'Prevention in Adult Safeguarding'

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Key Principles

There are a number of indicators of abuse or signs that may alert someone to the possibility of abuse occurring. The following may be useful for the LeDeR Programme reviewers to consider.

Relating to the individual

- Was there a significant change in the persons behaviour for which there was not a medical or other reasonable explanation e.g. sudden onset of enuresis, refusal to accept food from some individuals, crying, self-harming, faecal smearing, tearing clothes or possessions, increased or new sexualised behaviours. If these behaviours were recorded but not investigated this would give cause for concern
- Do care staff describe the person in a positive way? Are they able to describe the person's history, personality, relationships, likes and dislikes?
- What contact and communication was there between the person and their friends and family? Was there free movement i.e. family visiting the person freely and at times of their choosing? Were family and friends valued by the staff team?
- Were the person's needs clearly identified in care plans, and were their needs being met?
- If the person demonstrated behaviour that challenged carers, how were these incidents managed, reported and reviewed?
- Did anyone express concerns about emotional, financial or any other types of abuse, and if so, were these reported and followed up?
- Was the person ever a subject of a safeguarding plan as a child or adult?

Relating to the environment

- Was the environment where the person lived clean, warm, personalised? Was equipment (e.g. wheelchairs) well maintained and clean? Was there adequate equipment? Poorly maintained equipment may be an indicator of neglect.

Relating to the provision of care

- How did the care provider work with wider agencies and professionals? Is there evidence of good communication between the professionals e.g. CLDT, GP etc. Did the person have specific protocols to support their needs e.g. feeding, dressing, bathing, teeth-brushing / denture care? Were these understood by all staff and followed? For example, if someone had dysphagia guidelines were these followed by care staff and catering staff?
- How do carers speak and interact with other people for whom they provide support? Be very aware of any sarcasm or dismissal of service users. Are staff respectful of service users' environment and privacy? Do they disclose information appropriately? Be particularly aware of racism and cultural ignorance, and derogatory remarks
- Is the staff team stable? Are agency staff used as a matter of course? If so, in what roles and how are they monitored?
- What training is available for the person/people/staff caring for the person who died? How did they identify their training needs and were they able to request training?

Statutory Responsibilities under the Care Act 2014

- Has consideration been given by the Safeguarding Adults Board as to whether the person's death should be subject to a safeguarding adults' review?
- Has anyone expressed or reported concerns as a whistleblower or under the Duty of Candour?

- Is there a recent CQC report relating to any of the services that supported the individual?

Summary of key points

People with learning disabilities are vulnerable to abuse. When reviewing the death of a person with learning disabilities, follow your gut instincts – if something feels not quite right it is generally because it isn't. Ask questions and if you are still unhappy, discuss this with someone senior to yourself.

Additional sources of information

Department of Health response to Winterbourne View – DH (2012). 'Transforming care: A national response to Winterbourne View Hospital' available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

DH information for Partnership Boards regarding Safeguarding Adults with Learning Disabilities
http://www2.hull.ac.uk/fass/pdf/Safeguarding%20Adults%20Report.pdf

Care Quality Commission (2012) Learning disability services inspection programme: National overview. Newcastle upon Tyne: CQC.

Social Care Institute for Excellence 'Adult Safeguarding Resource'
http://www.scie.org.uk/publications/elearning/adultsafeguarding/resource/2_study_area_3_2.html

SCIE (2014). 'The Care Act 2014: Safeguarding adults' available at
http://www.scie.org.uk/care-act-2014/safeguarding-adults/