POVA referrals – the First 100:

Analysis of the first 100 referrals to the POVA list

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Introduction

Background

As part of the implementation of the Care Standards Act (2000), the Department of Health introduced the Protection of Vulnerable Adults (POVA) list on 26 July 2004, as a complement to the requirement for the development of local multi-agency adult protection policies and procedures, set out in *Not Secrets* (DH, 2000). One of the main requirements of this was that employers would be required to make checks on the POVA list, in addition to the Criminal Records Bureau Check, when employing workers (or providing volunteers) in regular contact with (in care homes) or providing personal care (in their own homes) to vulnerable adults. Furthermore, employers are required to make a referral to the list whenever a worker has been seen to be guilty of misconduct that harmed, or placed vulnerable adults at risk of harm (DH, 2004a). Once an individual's name is placed on the POVA list, that person is not able to work or volunteer with vulnerable adults, until his or her name is removed. Initially, the POVA regulations apply to staff in registered residential establishments or domiciliary agencies and Adult Placement carers. Staff working in NHS and private hospitals and other units providing services to vulnerable adults, such as day care centres, are excluded. The POVA list is being run by the Department for Education and Skills (DfES) on behalf of the Department of Health (DH, 2004a). A similar list exists in relation to children, the POCA (Protection of Children Act, 1999) list.

Introducing the *Practical Guide* (DH, 2004a), the Minister for Community Care linked this development to 'the Government's drive to raise standards across health and social care' (DH, 2004a, p4). The POVA list is part of a general strengthening of the protection of vulnerable adults. Local procedures for adult protection had been required in England, as part of the implementation of *No Secrets* (DH 2000), and the House of Commons Health Select Committee (2004) indicated the extent of progress in elder abuse, but identified the need for further work, deliberation and evidence. POVA may also be viewed in the context of the regulation and professionalisation of the social care sector, where a wide range of more general problems has been identified. It applies in both England and Wales.

Aims

This small study aimed to identify any commonalities and the extent of differences between the first 100 referrals to the POVA list, with an initial exploration of:

- The genesis and contexts of referrals
- The context of the reason(s) for referral
- Stated reasons(s) for referral

- The employment status of the person referred
- What is known about any ‘victim(s)’
- The presence/absence of criminal proceedings
- The risk factors mentioned (if any)
- Any involvement/consultation with other agencies.

Methods

Material relating to the first 100 referrals to the list was provided by the DfES. Information on the following issues was recorded:

- Genesis of referrals
  - Organisation making referral
  - Role of referrer
- Types of referral
  - Reason for referral
  - Period of misconduct
- Characteristics of referred person
  - Age/sex
  - Type of worker
- Actions taken
  - Consequences for workers
  - Involvement of other agencies
- Characteristics of ‘victims’
  - Age/sex
  - Disability

A series of frequencies and cross-tabulations summarising this data is given below and compared with relevant national data, where this exists. In addition to this quantitative data, more extensive notes were taken about the details of each case, in the form of a narrative and more general comments. Common themes were identified and a typology of cases has been devised. These themes are illustrated in a series of fictional scenarios, which include typical features of the 100 referrals. All information has been anonymised in the preparation of this report: no names have been included and no details of actual cases have been used. Since none of the referrals involved volunteers or adult placement staff/carers, we use the term staff and workers when discussing these first referrals.

Findings – Summary statistics

All percentages quoted in the text are based on the whole sample (n=100) unless stated.

Genesis of referrals

Organisations making referral

In order to examine the genesis of referrals, organisations making referrals were categorised and recorded. Table 1 shows a simple breakdown of the numbers of different types of organisations making referrals to POVA.

Table 1: Organisations making referrals

Organisation making referral	No. Refs[#]
Private residential care company	42
Private residential care home	22
Private domiciliary care agency	11
Not-for-profit care home group	5
Social Services Department	5
Not-for-profit domiciliary care agency	4
Private nursing home	3
Supported Housing Association	2
Other*	6
Total	100

[#]NB Numbers = %

Just under two thirds (64%) of referrals were made by private care home companies (42%) and private care homes (22%). About one sixth (15%) of referrals came from independent sector domiciliary care agencies (11% private, 4% Not-for-profit).

*Other organisations consisted of:

- Not-for-profit run residential 'apprenticeship' scheme
- Not-for-profit service running supported housing and day services
- NHS Trust
- NVQ training provider
- Social care employment agency
- Not-for-profit care home

To explore further the genesis of referrals to the POVA list, Table 2 shows a breakdown of provider by sector: this also enables a comparison with data on the social care market in England.

Table 2: Type of service by sector

Sector	Type of service		No. Refs (%)
	Domiciliary (%)	Residential (%)	
Private	14 (74)	66 (81)	80 (80)
Public	1 (5)	5 (6)	6 (6)
Not-for-profit	4 (21)	10 (12)	14 (14)
Total	19 (100)	81 (100)	100 (100)

A greater proportion of referrals, over four fifths (81%), came from residential services. In England and Wales, however, four fifths (80%) of service users were receiving community-based services (DH, 2004b). While this is not an exact comparison, as the referrals concern providers rather than service users, this does suggest a large difference in the contexts of POVA referrals, compared to the social care workforce in England. In terms of sector, of domiciliary care, there is a suggestion that Local Authorities were under-represented in the sample of referring organisations. There was only 1 (5%, n=19) referral from a local authority Home Care service, whereas local authority Home Care services provide support to nearly two fifths (38%) of households receiving domiciliary care in England, and nearly a third (31%) of the domiciliary care contact hours (Health & Social Care Information Centre, 2004).

The vast majority (94%) of referrals came from the independent sector, of which four fifths (80%) were providers operating for profit, and 14% were from the not-for-profit sector. This pattern was repeated in terms of care homes for older people (data not shown in table): almost all (98%, n=46) were run on a for-profit (91%) or not-for-profit (7%) basis. In England, 81% of care homes for older people are operated for profit and 13% are not-for-profit. (source: Sca Analysis of Cross-Section of Pre-Inspection Questionnaires, cited by Eborall, 2003, p. 28.). This suggests a similar pattern in the POVA referrals and the overall picture of the care home sector for older people in England.

The relative size of organizations, in terms of the number of units owned or run managed by organisations, is also a key aspect of the genesis of referrals. A very simple categorisation was developed to indicate whether the provider was operating a single or multi-site service. Table 3 shows the type of service provided broken down by size of organisation

Table 3: Type of service by size of organisation

Size of organisation	Type of service		No. refs (%)
	Domiciliary (%)	Residential (%)	
Multi-site	18 (95)	51 (63)	69 (69)
Single-site	1 (5)	30 (37)	31 (31)
No. referrals	19 (100)	81 (100)	100 (100)

Almost two thirds (63%, n=81) of referrals from care homes were from large providers, operating two or more homes. When considering just care homes for older people, over two thirds (68%, n=50; data not shown) were run by such companies. However, in England, just over a quarter (28%) of care homes for older people are run by large providers (source: Laing & Buisson's Healthcare Market Review 2002-3, cited in Eborall, 2003, p. 29). While the national data defines 'large' organisations as those which run or more three units, making this not a perfect comparison, this finding does make it appear that larger care home companies are over-represented in the sample of providers.

However, the pattern of domiciliary care providers appears to be more similar to the national picture. Almost all (95%) of the domiciliary providers making POVA referrals were categorized as large, being from limited companies, charities or Not-for-profit organisations. In England, 81% of domiciliary providers were limited companies, charities or Not-for-profit organisations (source: Domiciliary Care Providers Study, PSSRU/Nuffield Institute for Health, 2001, cited by Eborall, 2003, p.29).

Role of referrer

Information about the roles of referrers is given below, in Table 4, broken down by size of organisation.

Table 4: Role of referrer by size of organisation

Role of referrer in organisation	Size of organisation		No. Refs (%)
	Multi-site (%)	Single site (%)	
Unit manager	17 (25)	15 (48)	32 (32)
Director of a private company	21 (30)	6 (19)	27 (27)
Other senior manager	14 (20)	3 (10)	17 (17)
Human resources personnel	14 (20)		14 (14)
Proprietor	1 (1)	4 (13)	5 (5)
Administrator		2 (6)	2 (2)
Other role*	2 (3)	1 (3)	3 (3)
No. referrals	69 (100)	31 (100	100 (100)

*Other referrers

- Practitioner
- Investigating manager
- Company representative

Almost all (95%) referrals were made by managers or other senior figures within organisations. About half (49%) of referrals were made by senior managers (directors, area or service managers, and proprietors) and about a third (32%) were made by unit managers. One seventh (14%) of referrals were made by human resources personnel. However unit managers, as opposed to more senior figures, made a quarter (25%, n=69) of referrals from large organisations.

Reason for referral

The types of abuse or harm that formed the reason for referral are shown in Table 5, broken down (separately) by the type of service and gender of staff involved. Many referrals involved more than one type of abuse or harm. Consequently, the numbers of mentions of each type sums to over 100. However the percentages quoted relate to the numbers of referrals (i.e.100)

Table 5: Reason for referral by type of service and by gender of staff

Reason for referral	Type of service		Gender of staff		Total for each reason (%)
	Dom. (%)	Res. (%)	Fem. (%)	Male (%)	
Neglect	6 (32)	27 (33)	24 (36)	9 (26)	33 (33)
Physical	2 (11)	27 (33)	15 (23)	14 (41)	29 (29)
Financial	8 (42)	17 (21)	21 (32)	4 (12)	25 (25)
Verbal	2 (11)	15 (19)	11 (17)	6 (18)	17 (17)
Psychological	2 (11)	14 (17)	10 (15)	6 (18)	16 (16)
Policies	2 (11)	3 (4)	3 (5)	2 (6)	5 (5)
Sexual	3 (17)	1 (1)	2 (3)	2 (6)	4 (4)
Boundaries	2 (11)	2 (2)	3 (5)	1 (3)	4 (4)
Application		4 (5)		4 (12)	4 (4)
Rel. with staff		4 (5)	3 (5)	1 (3)	4 (4)
Other*	2 (11)	7 (9)	5 (8)	4 (12)	9 (9)
Total referrals[#]	18 (100	82 (100)	66 (100)	34 100	100 (100)

[#]Totals do not sum, as referrals concerned more than one type of harm

*Other reasons

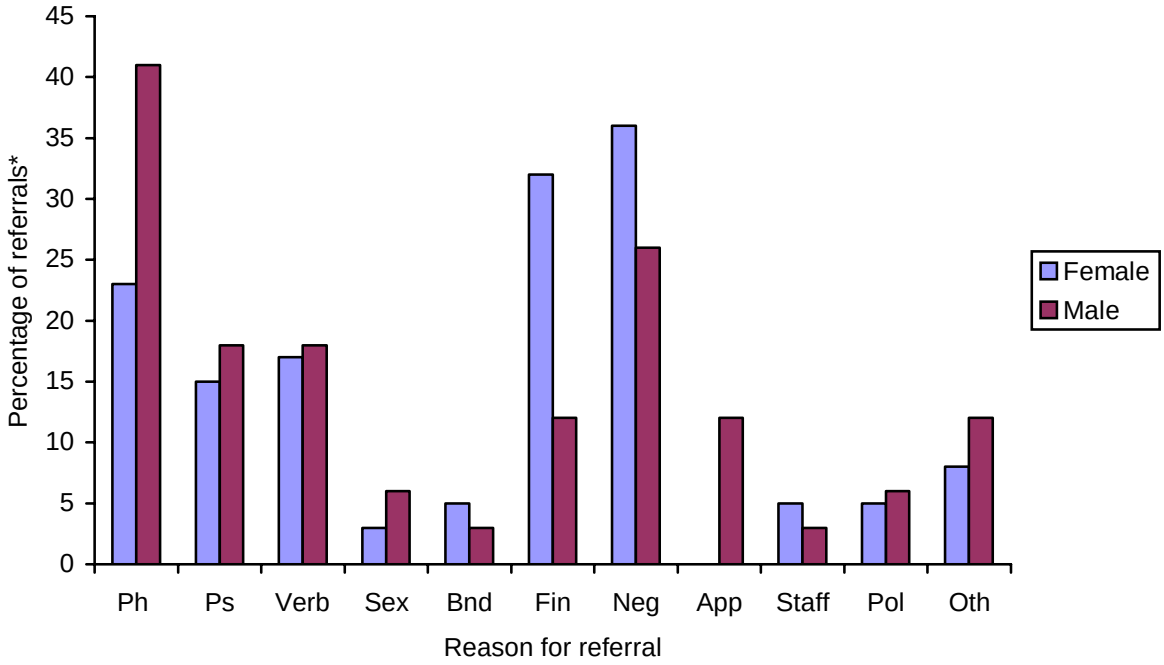
- Breaking confidentiality
- Damage to property
- Discrimination in the workplace
- Failing to report the end of work permit
- Failure to prevent abuse
- Falsifying timesheet
- Poor management skills, general integrity
- Sleeping on duty
- Threatening behaviour
- Working under the influence of drugs and alcohol.

Almost all (85%) referrals involved Neglect (33%), Physical abuse (29%), or Financial abuse (25%). Verbal and psychological abuse were involved in about one third (33%) of referrals (16% and 17% respectively).

An examination of Table 5 suggests that there is more of a likelihood of referrals involving physical (33%, n=82%), psychological (17%, n=82) and verbal abuse (19%, n=82) from residential settings. In contrast, there was more of a likelihood of referrals from domiciliary providers involving financial abuse (42%, n=18).

Male and female staff were found to be involved in different patterns of misconduct. Over two fifths (41%, n=34) of male staff were referred for misconduct involving physical abuse, compared with under a quarter (23%, n=66) of female staff. However, almost one third of female staff (32%, n=65) were referred for financially abusing service users, compared with about one eighth (12%, n=34) of male staff. This is presented graphically in Figure 1.

Figure 1: Reason for referral by sex of worker



*Percentages do not sum to 100%, as referrals concerned more than one type of harm.

Ph – Physical; Ps – Psychological; Verb – Verbal; Sex – Inappropriate sexual behaviour; Bnd – Boundaries; Fin – Financial; Neg – Neglect; ND – Non-disclosure of information on application; Staff – Relationships with staff; Pol – Breach of policies; Oth – Other.

Period of misconduct

While it was clear that many of the referrals concerned a single incident, it was more difficult to work out the period of misconduct in other cases. Consequently, an estimate of the period was made, in terms of the groups shown in Table 6, which gives this information broken down by the size of organisations.

Table 6: Period of misconduct by size of organisation

Period of misconduct	Size of organisation		Total (%)
	Multi-site (%)	Single-site (%)	
Single incident	31 (46)	9 (30)	40 (41)
<3 months	15 (22)	5 (17)	20 (20)
3-6 months	2 (3)	3 (9)	5 (5)
6 months - 1 year	4 (6)	7 (23)	11 (11)
1-2 years	4 (6)	4 (12)	8 (8)
>2 years	6 (8)		6 (6)
N/A and Unknown	7 (10)	3 (9)	10 (10)
Grand Total	69 (100)	31 (100)	100 (100

About two fifths (40%) of referrals were made concerning a single incident, in both residential and domiciliary settings. Furthermore, about three fifths (61%) concerned misconduct that had been taking place for less than three months. Over three quarters (76%) of referrals concerned misconduct that had been taking place for less than one year.

There was very little difference between the periods of misconduct in residential and domiciliary settings or between providers from the private, not-for-profit or public sectors. However, as shown in Table 6, there was some suggestion that misconduct had been taking place for longer periods in single site providers than in larger companies: size of organisation was associated with period of misconduct, which was statistically significant at the 5% level ($\chi^2 = 13.2$, $p<0.05$).

Characteristics of referred person

Age/sex

Table 7 shows information about the ages of referred staff, broken down by gender.

Table 7: Age by gender of referred staff

Age-group	Gender		No. Staff (%)
	Female (%)	Male (%)	
<25	9 (14)	1 (3)	10 (10)
25-34	15 (23)	8 (23)	23 (23)
35-49	21 (31)	14 (41)	35 (35)
50 and over	19 (29)	10 (30)	29 (29)
Unstated	2 (3)	1 (3)	3 (3)
Numbers staff	66	34	100
	Male	Female	Overall
Average age	41	42	41
Maximum age	68	62	68
Minimum age	18	22	18
Standard Deviation	13.3	10.2	12.30

About one third (34%) of referrals concerned male staff, compared with between four fifths and one in twenty of the social care workforce in England:

> *Overall, the social care workforce is at least 80% female, increasing to 95% or more in certain sectors.* Eborall (2003, p 51)

Generally, there were similar percentages of staff in different age groups, compared with the social care workforce in England (source: Analyses of Labour Force Survey, reported In European Care Work Project, 2001, cited by Eborall, 2003, p. 56). Over one third of referred workers (35%) were in the 35-49 age group, which was the most frequent age group; the mean age was 41. Over a quarter (29%) of staff were over 50, which was the next largest group. One in ten (10%) of referrals concerned staff under 25. Very similar percentages of referrals concerned male and female staff in the different age groups, and the variation was highly similar as shown in Table 7.

Type of worker

The roles of staff members referred for placement on the POVA list were examined in order to understand something of the context for referrals; this is shown in Table 8, which also shows sub-totals for frontline practitioners and managers.

Table 8: Types of worker referred

Type of Worker	No. referrals (%)
Residential care/support	63 (63)
Domiciliary care	15 (15)
Day service support worker	1 (1)
Registered nurse	8 (8)
Frontline practitioners (sub-total)	*87 (87)*
Residential care home manager	6 (6)
Residential deputy manager	5 (5)
Support manager	2 (2)
Managers (sub-total)	*13 (13)*
No. referrals	100 (100)

The vast majority (87%) of referrals were of front line workers, care assistants and support workers. Registered nurses working in residential care homes, who were involved in about one twelfth (8%) of referrals, were counted as front line practitioners, although these workers also had some management responsibilities. Very similar percentages of male and female staff in these posts were referred.

Actions taken by employers

What happened as a result of the identification of misconduct was recorded in order give an indication of consequences for staff and the processes involved before referrals are made.

Consequence for staff

The employment positions and the involvement of the police are shown in Table 9.

Table 9: Employment position and police investigation

Employment position	No. Ref	(%)	Police investigation	No. Ref	(%)
Dismissed	70	(70)	No	60	(60)
Suspended	7	(7)	Ongoing	10	(10)
Resigned/retired before July 04	2	(2)	Completed, not charged	14	(14)
Resigned/retired after July 04	12	(12)	Completed, charged	10	(10)
Still working in social care*	6	(6)	Completed, convicted	7	(7)
Contract not renewed	2	(2)			
Moved to non-care position	1	(1)			
No. referrals	100	(100)	No. referrals	100	(100)

*Includes 3 staff members who received written warnings and 3 for whom there was no action taken.

The majority (86%) of workers were longer working in social care at the time of the referral. Over two thirds (70%) of staff had been dismissed, about one seventh (14%) of staff had resigned and two had not had their contracts renewed. A further seven staff involved in these referrals had been suspended. Members of staff involved in all but three of the referrals were working in social care at the time of the misconduct.

The police were involved in two fifths (40%) of referrals. No criminal proceedings were undertaken in 14 of these referrals. However, the police investigations had not been completed in 10 referrals and 10 staff members had been charged, and were awaiting trial or sentence. Seven staff members were convicted, and received the following sentences:

- Two people received prison sentences of one and three years
- One person received a suspended sentence of one year
- One person was fined £250
- Two people received community service sentences, one for 100 hours and the other for two years.
- One person received a caution.

Involvement of other agencies

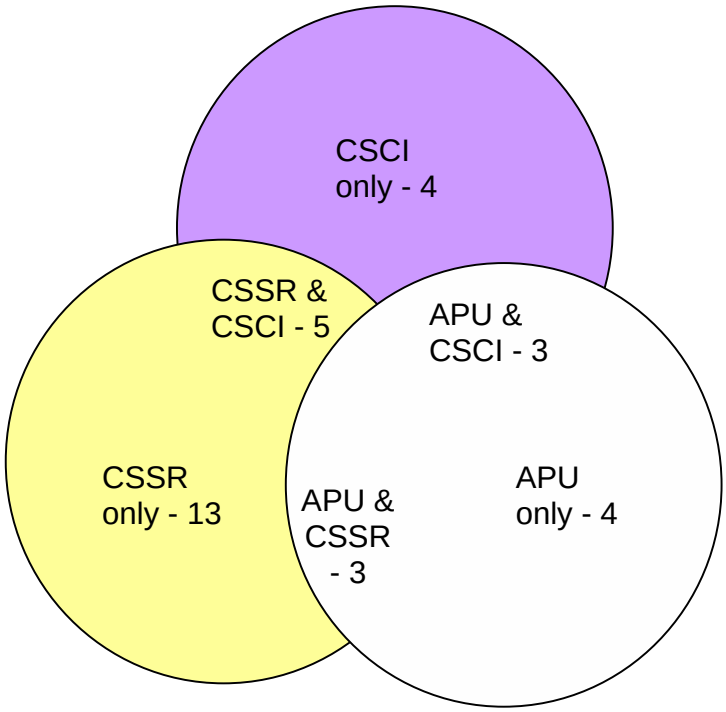
In the information provided by organisations, there was reference to the involvement of three agencies: local Councils with Social Services Responsibility (CSSRs); Multi-Agency Adult Protection Units (APUs) and the Commission for Social Care Inspection (CSCI). Several referrals mentioned more than one agency and this information is given in Table 10.

Table 10: Involvement of other agencies

CSSR		APU		CSCI	
CSSR only	13	APU only	4	CSCI only	4
CSSR and APU	3	APU and CSSR	3	CSCI and CSSR	5
CSSR and CSCI	5	APU and CSCI	3	CSCI and APU	3
Total CSSR	21	Total APU	10	Total CSCI	12
		Total mentioning other agencies			32

About a third (32%) of referrals mentioned contacting one of three other agencies: the local Council with Social Services Responsibility (CSSR – 21 referrals); Adult Protection Unit (APU – 10 referrals); or Commission for Social Care Inspection (CSCI – 12 referrals). About one fifth (21%) of referrals mentioned contact with just one agency: the breakdown of involvement with the three agencies was as shown in Figure 2.

Figure 2 – Other agencies contacted



Characteristics of 'victims'

Information about the age, sex and disability of 'victims' was recorded and is given below, compared with national data where relevant. While 'victims' is a term that is emotive and sometimes inaccurate, it is used here to describe individual service users.

Age/sex

Table 11 shows the age-group (i.e. whether they were over or under 65) of 'victims' broken down by gender, where this is known.

Table 11: Age-group by gender of service users

	Male (%)	Female (%)	Males and females (%)	Unknown (%)	No. refs (%)
>65	13 (41)	23 (68)	21 (66)		57 (57)
18-65	19 (59)	11 (33)	11 (34)	1 (50)	42 (42
Unknown				1 (50)	1 (1)
Grand Total	32 (100)	34 (100)	32 (100)	2 (100)	100 (100)

Younger service users were over-represented in the sample of service users affected by the misconduct involved in the referrals. Just over two fifths (42%) of referrals concerned service users under the age of 65, which compares with just over a quarter (27%) of service users in England and Wales (DH, 2004b). Older

service users were involved in a greater proportion of referrals compared with national figures.

About a third of referrals concerned misconduct towards males (32%), females (33%) and both males and females (32%). There were two referrals where it was not possible to determine the sex or age of service users. People who have not disclosed previous offences could be said to have placed service users at risk and to have deceived their employer. Consequently, for the four referrals in which this was the misconduct, the age group was determined from the registration details of service provider and it was assumed that both males and females would have been involved.

There is some statistically significant association between the age group and sex of service users ($\chi^2 = 6.4$, $p<0.05$). From an examination of Table 11, this suggests that older females are more likely to be 'victims' than younger females and younger males are more likely to be involved than older males.

Disability

The reported disabilities of service users, which were identified in general from the registration information of the organisation making the referral, were combined with the more detailed information provided. Table 12 and Figure 3, overleaf, show the disability of service users involved in referrals, with Table 12 including a comparison with national data.

Table 12: Disability of service users

Disability	POVA referrals (%)	National* (%)
Old age PD	29 (29)	1,062,000 (61)
Old age, MH, Cog imp	28 (28)	107,000 (9)
Learning disabilities (LD)	31 (31)	116,000 (7)
Physical Disabilities (PD	6 (6)	201,000 (12)
Mental Health (MH)	5 (5)	141,000 (8)
Substance Abuse		13,000 (1)
Vulnerable people		11,000 (1)
Unknown	1 (1)	
Total	100 (100)	1,737,000 (100)

*Source: DH, 2004b

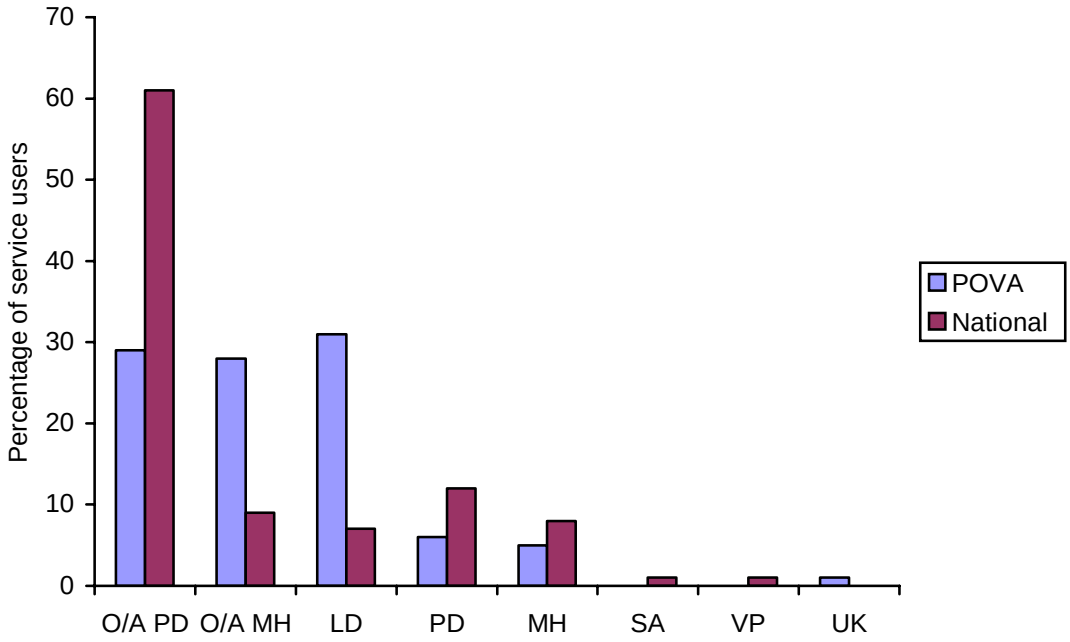
As suggested by the breakdown of gender and age, almost three fifths (57%) of service users were over 65, and this is reflected in the breakdown of disability. Compared with the national statistics, the sample of referrals over-represented:

- older people with mental health problems or cognitive impairment (28% compared with 9%)
- younger people with learning disabilities (31% compared with 7%)

However the following groups were under-represented:

- older people with disabilities or frailty (29% compared with 61%)
- physically disabled people (6% compared with 12%)

Figure 3: Disability of service users



- O/A PD Frail or disabled older people
- O/A MH Older people with dementia or mental health problems
- LD Younger adults with learning disabilities (including people with learning and physical disabilities and people with learning disabilities and mental health problems)
- PD Younger disabled people,(including people with sensory impairment)
- MH Younger people with mental health problems
- SA Substance abuse
- VP Vulnerable people
- UK Unknown

There may be overlap between the old age-physical disability and old-age mental health categories, so these figures need to be treated with caution

Outcomes of referrals

Immediately upon receipt of a referral, the information is checked and, if necessary extra information is requested: these referrals are designated as 'pre-provisional'. Once the required information has been assembled it is then assessed to identify whether there is a case to answer and the worker's name is provisionally placed on the list (designated 'Provisional'). Employers are not allowed to employ anyone during the nine months allowed for a full investigation and final decision to be made about whether to place a worker's name on the list. Once this decision has been made, the referral is designated as 'Confirmed'. A decision to close a case can be made at any stage, although a record is kept of all referrals: these are designated as 'Closed'. Table 13 shows the status of the referrals considered in this study, as of 17 June 2005.

Table 13: Outcome of referrals

Status	No. refs[#]
Closed	31
Confirmed	8
Provisionally*	49
Pre-Provisional[+]	12
Grand Total	100

[#]NB Totals = %

[+] Includes 5 referrals where information had been checked and about which a decision was being made concerning whether to provisionally place on the list.
* Includes 3 referrals which were 'suspended' because police or other investigations had taken precedence.

Almost three fifths (58%) of referrals were either placed on the list (8%) or provisionally placed on the list (49%). About one third (31%) of referrals were 'closed' meaning that the worker was definitely not placed on the list on the basis of this referral. There were no discernible patterns in these outcomes in terms of:

- age and gender of referred workers
- whether referrals came from care homes or domiciliary care agencies
- whether provider was from the private, not-for-profit or public sectors
- the stated reasons for referral
- period of misconduct
- age and gender of 'victims'.

Findings: Themes and scenarios

All the material included with the referrals was read: each referral was summarised as a 'narrative' and more general comments were made. The following themes were identified through the process of producing and then reading the narratives and comments. In order to illustrate the themes, imaginary scenarios were written, which reflected the issues identified and included

features of several different referrals. Presenting this analysis in this way both makes it possible to condense the data and also ensures confidentiality for employers, services users and staff. This may be seen as a first step towards generating a typology of cases, about which more in-depth analysis would be required to validate and further development.

Themes:

Seriousness of misconduct

Issues arose over interpreting the seriousness of misconduct, in terms of the actual harm suffered, the degree to which it reflected a pattern of behaviour and whether the worker would necessarily present a risk to vulnerable people in all settings. A number of allied factors came out in terms of relationships with staff, which can be seen to add to the potential seriousness of the misconduct and the role of other agencies in judging the seriousness of the misconduct.

- *Response to single incidents*
  A number of cases involved a single incident of misconduct that resulted in dismissal. Some cases of misconduct were so serious that a single incident had led to referral. Furthermore, a single incident sometimes occurred after long periods of minor misconduct that built into a picture of a worker who is seen by managers to be systematically abusing service users.
- *Degree of harm*

  The harm caused by the misconduct involved in the referrals varied considerably, but details of this were not always recorded. In some situations service users were reported not to be visibly hurt or obviously harmed emotionally, although it was felt that the behaviour of staff represented abuse, possibly because of a breach of policies designed to protect service users. However, some service users were seriously physically harmed, or had been psychologically damaged or had had large amounts of money stolen.
- *Role of workers*
  Some managers and nurses were referred because of issues concerning inadequate management or poor clinical judgement. They were referred because of concerns about their consequent suitability for working with vulnerable people in different roles.
- *Relationships with staff*
  In several referrals, other staff members alleged that workers had been bullying or intimidating towards them; often after allegations of abuse to service users had been raised. Where this was evident, it added to the seriousness of the misconduct directed at service users.
- *Role of other agencies*
  In those referrals where CSCI or APUs were involved, there was an interaction between the judgements of the employer and inspectors or staff at

the APU about interpreting the seriousness of misconduct. This sometimes led to changes in the outcome of disciplinary hearings.

Interpreting the significance of events

There was often doubt about the significance of events, which were open to competing interpretations. Such variation in interpretation was one of the difficulties addressed by employers in disciplinary hearings: however, they represent further issues when making decisions about who to refer or place on the POVA list. Several dimensions of interpretation were identified, in terms of the nature of and intentions underlying the behaviour leading to the referral.

- *Mismanagement of money – fraud/theft and abusing trust*
  Poor administrative and recording practice sometimes led to suggestions of financial abuse and there was sometimes a blurring of this dividing line, with workers claiming to have lost receipts or not managed a recording system very well.
- *Skills and abuse*
  Where workers were seen to be neglectful or physically harming service users, there was sometimes a blurred dividing line between poor practice, possibly because of lack of training or workload, and abuse.
- *Abusive workers or dangerous contexts*
  Several referrals raised questions about the quality of the social care providers involved as well as the behaviour of individual workers, particularly where service users are challenging or have very high support needs.
- *Reactions to challenging behaviour*

  Many of the referrals concerned a staff member who reacted to a service user grabbing, hitting or being verbally abusive towards them. Staff claimed to have reacted instinctively or as a result of long periods of working with such challenges. Such responses included tapping on the wrist of someone who had grabbed a worker's wrist, shouting or pushing and hitting service users.
- *Over stepping emotional involvement*

  Engaging in games, banter or joking is an essential part of some types of social care, which involves modelling social interactions, and necessitates striking a difficult balance between managing involvement with service users and maintaining a professional distance. The misconduct involved in several referrals involved workers claiming to have been trying to maintain this sort of balance. Such situations could lead to confusion and distress.
- *Involvement in managing finances*

  Boundaries were also an issue in the degree of practical involvement between workers and service users. Several referrals involved questions about over-involvement with finances, responsibility for collecting pensions or paying bills. When this occurred the dividing line between worker and service

user became blurred, leading at best to confusion and misunderstanding, and at worst to financial abuse.

Establishing the facts of the case

In many referrals staff members denied either that the misconduct had taken place at all or that they had been involved in the situation. This led to the need for an investigation to gather evidence about what happened and who did what. The level of proof and quality of evidence varied across the referrals.

- *Quality of evidence*

  Many of the referrals involved disputes over whether incidents occurred, or workers simply denied that they had been involved. Staff were often dismissed on the basis of one witness statement against another or circumstantial evidence. Service users' testimonies were also used and this added strength to some cases, although complexities arose concerning people with dementia and those who were suspected or known to have a history of making false allegations.

- *Level of proof required*

  In making decisions about whether misconduct had taken place, many of the employers referred to the need only to prove that the events had occurred on the balance of probabilities.

- *Conflicting interpretations*

  Some referrals rested on different interpretations of events. What was seen by witnesses as a swipe or hit was often claimed by workers to have been self-defence and rough handling or was sometimes claimed to be quick action to prevent harm to a service user.

Mitigation

Staff offered a wide variety of factors in mitigation of their behaviour, where this was accepted as having taken place. Issues about intentions and aspects of the working environment or home life were raised, as were claims to be committed to working in social care.

- *Working conditions*

  Many workers' statements included claims of long periods of over work, because of covering for under-staffing situations, which were ignored or denied in the disciplinary proceedings, which focused more on the occurrence or otherwise of the episode of misconduct.

- *Lack of training*

  Staff concerned in referrals were often working with people who present challenges, which frequently involved physical and verbal aggression or had very high support needs. In mitigation, several staff claimed that they had not received training to work with people with these needs.

- *Mental health*

  Several workers also claimed that they had been suffering from periods of high personal stress and mental health problems, such as depression, during the periods leading up to their dismissal. There were also some who directly linked their problems with conditions at work.

- *Intentions*

  Some workers claimed that they never intended to harm service users; this took two forms. Firstly, there were staff who claimed that their behaviour had been part of normal social interaction that was misinterpreted by other staff members or by service users. Secondly, there were those who claimed that they had been trying to help service users but that through accident or mishandling, service users had been harmed or been put at risk. Many of these staff members stressed their overall good relationships with service users and commitment to working in social care.

Scenarios

1. Single reaction to challenging behaviour

While being helped to eat her lunch, a service user spat food at a care assistant, working at a care home for older people, and swore at her, aggressively and loudly. In response to this, the worker wiped the food off her own face, flicked a bit of it at the service user and shouted ‘there, see how you like it!’ A colleague reported this to the management, and this led to the worker’s dismissal. In her defence, she claimed that she had had to help several very challenging service users that morning, because another worker had unexpectedly called in sick. However, the hearing decided that the worker’s actions amounted to verbal and physical abuse, which was gross misconduct and she was dismissed.

Issues raised

- Seriousness of events
  - Degree of harm
  - Response to single incidents
- Interpretation the significance of events
  - Reactions to challenging behaviour
- Mitigation
  - Working conditions
  - Lack of training

Commentary

As the worker admitted that the events took place, there is no question about the evidence. Consequently, interpretation of this scenario rests on the seriousness of this misconduct, a single incident of physical and verbal abuse, in which the dignity of the service user was not respected by the worker. This was seen as behaviour that is not acceptable in working with vulnerable people. However the harm was minor and a response to challenging behaviour although it may have

been frightening to the service user and the other residents. Furthermore, the worker claimed the incident had occurred after a morning when she had had double her usual workload. There is perhaps a question here about whether the worker would have been able to develop more skills in working with people who are challenging, and also about the working conditions of the home involved.

2. Longstanding pattern of bullying and neglectful behaviour

A worker was seen by visiting family members roughly moving a (unrelated) service user from a wheelchair to his bed, and slapping him hard on the arm, when he grabbed the worker's wrist. When the worker saw the relatives, he immediately closed the bedroom door, but they also reported hearing the worker shout 'stop snivelling, it was only a tap' to the service user. A thorough investigation, involving senior managers of the care home chain and the local Multi-Agency Adult Protection Unit, was held after the relatives reported this incident to the home manager. The service user corroborated the relatives' story, and reported other incidents of rough and unkind treatment. Several staff members voiced their longstanding doubts about the worker's practice and attitude towards service users, and also complained of feeling generally intimidated by him themselves. At the disciplinary hearing, the worker denied hitting the service user and shouting, but the company decided that on the balance of probabilities there was enough evidence to dismiss the worker on the grounds of physical abuse. The matter was reported to the police, but in their view there was not enough evidence to secure a conviction.

Themes illustrated

- Establishing that misconduct took place
  - Quality of evidence
- Interpreting the significance of events
  - Skills and abuse
- Seriousness of misconduct
  - Relationships with staff

Commentary

There is little problem in establishing that these events took place: relatives and the service users provided independent corroboration of the events. Interpretation is also fairly clear: the worker clearly was mistreating the service user, both physically and emotionally. Furthermore, the concerns raised by other staff members both about the worker's previous practice and attitude, and also concerning the worker's bullying behaviour towards them, makes the incident of misconduct significant in terms of the suitability of the worker to work in social care.

3. Overstepping professional boundaries

When a new manager started working at a Not-for-profit (charity) sector small group home in which 4 adults with learning disabilities lived, she immediately had

to reprimand a young male member of staff for his approach to a male service user. Although there appeared to be a good relationship between the worker and the service user, the manager was concerned about the level of rivalry about games of pool and the differing fortunes of the football teams each supported. Pool sessions or discussions about the relative merits of each other's teams would often end up in a mock brawl, with 'pretend' punching and general loud rough and tumble. After her initial comments, the worker agreed to tone things down a bit, and the manager reported that he had complied, temporarily. Some weeks later, the worker and service user watched a televised football match between their respective teams, which resulted in the service user's team being relegated. Immediately following the game, the worker had let out a loud cheer and started a football chant, at which the service user initiated what at first seemed like another mock fight. However, as it progressed, the service user hit the worker hard in the stomach, to which he reacted by pushing the service user, making him fall and bruise his leg and arm. The service user was very upset by the incident, and immediately apologised to the worker. He appeared distressed about the incident for several days. On hearing about this, the manager suspended the worker and instigated disciplinary procedures. At the hearing, the worker claimed that his had been an instinctive response, in self-defence, and that he had been taken completely by surprise by the intensity of the service user's reaction. He also claimed not to have received training before starting work in the unit. In response, the group manager referred to the manager's reprimand and indicated that the worker had not maintained a proper relationship with the service user. They felt this amounted to emotional abuse in addition to the fact that the worker had caused actual harm to the service user. However, they were initially going to issue a written warning, but after taking advice from the local Adult Protection Unit, they dismissed the worker.

Themes illustrated

- Relationships and boundaries
  - Overstepping emotional involvement
- Interpreting the significance of events
  - Response to challenging behaviour
- Seriousness of misconduct
  - Degree of harm
  - Role of other agencies
- Mitigation
  - Training
  - Intentions

Commentary

This case raises complex issues relating to what is meant by psychological harm as well as the role of social care for young adults. The worker felt he had a good relationship with the service user, a claim supported by the service user's reaction following the incident and acknowledged by the manager. Furthermore,

the pattern of the relationship may be seen to mimic that between young men generally, which may be seen to be one of the roles of such workers. However there are complexities; the service user's judgement may not be reliable, and serious psychological harm could result, which was also illustrated by the service user's reaction to the incident. This is compounded by the difficulties involved in assessing the worker's claim to good intentions. Also important here is the worker's inexperience and lack of training, which may have influenced his response and the way he managed the relationship with the service user.

4. Capability – financial abuse

When the manager of a care home for older people returned to work after a period of long-term sick leave, she undertook an audit of residents' finances. She discovered discrepancies in the records of two services users' savings accounts, amounting to £300. The deputy manager was responsible for managing service users' money, collecting pensions and issuing money to workers who went shopping with/for service users who had no relatives able or willing to do this. Over the previous year, several different workers had been shopping for the two service users, all of whom were adamant that they had returned from expeditions with receipts and the right amount of change. However, when the receipts were examined, it emerged that they did not tally with the amounts taken from and subsequently returned to the two accounts. At the disciplinary hearing that followed, the deputy manager denied taking any of the money and claimed that she had no idea how the discrepancies had occurred. She described how much stress she had been under over the year, both at home and at work, particularly during the period when the manager had been off work. However, the manager decided that on the balance of probabilities, the deputy manager had been taking the change returned after such trips and she was summarily dismissed for financial abuse and breach of trust.

Themes illustrated

- Establishing misconduct
  - Level of proof
- Seriousness of the misconduct
  - Role of worker
- Interpreting the significance of events
  - Abusive workers or dangerous contexts
  - Mismanagement or fraud
- Mitigation
  - Working conditions
  - Intentions
  - Mental health/stress

Commentary

Establishing what had actually happened to the money was a key aspect of this scenario. There is a great deal of confusion about this because the records were

very unclear. The manager clearly judged that theft had taken place, which was explicitly acknowledged as a decision made 'on the balance of probabilities', a conclusion reached because of the lack of any other explanation. Judging whether this is enough proof to warrant placement on the POVA list may require a further examination of the evidence. If the misconduct was interpreted as poor administration and recording, perhaps a different response would be more appropriate. While this could also be regarded as abuse it might be possible in this instance for the worker to be work with vulnerable people in a less responsible role, in which the management of finances at that level was not required. Also important here is the claim that the working conditions were very difficult: the worker's claim to have been under a great deal of stress, due to a lack of support and a need to work long hours to cover the home. It is not possible to come to any conclusion about this from the information as it is provided by and edited by the employers. Some investigation of this aspect may be warranted, given the previously good record of the worker and the need to protect other service users, and there were no records of police involvement, advice, or discussions with CSCI.

5. Theft of money

A service user's son alleged that a home care worker had taken money from the coffee jar that his mother used to keep the £100 he left for his mother every Saturday, which his mother used to pay for the hairdresser and chiropodist, who came to her house, and also pay for the milk delivery. By the following Tuesday, when his mother went to pay for the hairdresser, she found £50 had been taken. The home care worker was the only person who had been working with his mother over the weekend and there had been no other visitors. When challenged about the incident, the worker eventually admitted taking the money, claiming this had been a one-off occurrence. However, the agency had discovered several other service users had not wanted the worker to come to their homes, and there had been a previous accusation that had not been substantiated. She was dismissed and the police were informed, although they felt there was not enough evidence for a conviction.

Themes illustrated

- Establishing misconduct
  - Quality of evidence
- Seriousness of misconduct
  - Degree of harm
- Interpreting the nature of events
  - Distinction between mismanagement of money and fraud/theft and abusing trust

Commentary

This case is much easier to interpret: it was apparently clear that the money was missing and, although circumstantial, strong evidence that the worker had stolen

it. Secondly, the worker admitted the theft, and, although she claimed that it was a first offence, there were suggestions that this may have happened before.

Conclusion

Introduction

A number of issues have been raised by this examination of the first 100 referrals to the POVA list. It is to be remembered that the analysis has been descriptive in nature: consequently, these findings can only be suggestive of areas of further investigation and debate. Setting the development of the POVA list in a wider context may also be of value in this respect and some more general issues are discussed below

Individual decision-making

As a means of reducing harm to vulnerable adults, it is clearly important to ensure that people of general ill-will or those who lack capacity are prevented from working in social care. However, it is also important to balance the focus on individual abusers and episodes of abuse with a wider examination on the quality of social care employment practice, availability of training, working conditions, impact of under-staffing and ongoing nature of stress.

Consequently, it is possible that previous CSCI reports on the provider unit or company may be a valuable addition to the information to be considered in making decisions about referrals. In situations in which a worker claims not to have had training, examination of such records may help provide better evidence. Furthermore, some referrals included evidence about staffing levels at the time of and immediately preceding the incident or periods of misconduct would be useful. Such evidence may help in deciding individual cases, but also identify situations which might give rise to ongoing concern about the safety of service users in those establishments. More generally, no information was provided in terms of ethnicity of staff or service users involved, which not only may be a factor in making decisions but also be valuable in analysing patterns of referrals.

Evidence from service users, their carers or relatives played a part in many of the referrals. Not surprisingly, this took the form of reports of misconduct and its effects, which is a vital aspect of identifying abuse. Ensuring that service users are supported and their reports taken seriously will be a key way of reducing the harm and help in identifying staff who should not be working in social care. However there were also situations in which service users and relatives were indicating their reluctance for workers to continue in employment. This adds a level of complexity for interpretation. It clearly increases the potential seriousness and impact of the misconduct, and rightly should play a part in the disciplinary proceedings. However, the question arises as to how much importance should be given to such views in deciding whether a person should ever work in social care again. There is also the possibility that employers may be very sensitive to

relatives' views, particularly where they think they may remove the service user or cancel the contract. Interpreting these reports and statements needs special care in making decisions about placement on the POVA list.

Looking at the themes and scenarios, there were a number of different types of case, that may need to be considered in different ways. Four major themes were identified: seriousness of misconduct; establishing the facts of the case; interpreting the nature of events; and the mitigation offered by staff. It is possible that these issues could be used to develop a systematic approach to decision-making. However more work would be needed to validate these themes and to examine the links between the themes, types of cases and outcomes of referrals. The need for further work in this analysis is emphasised by the lack of patterns or connections between outcome of referral and the characteristics of staff, service users or contexts.

Implications for the development of the POVA list

Mathew *et al.,* (2002) identified that local authorities implementation of Adult Protection procedures was variable, although most of them have made definite progress in at least some areas. Summer (2004) studied the codes of practice developed by local authorities, and also found a variable picture of progress. While many local authorities had developed genuinely multi-agency policies, and some had consulted widely, large numbers had not extended consultation beyond the statutory sector. Least progress had been made in dissemination of the ideas and the adult protection procedures, which meant that managers and practitioners may not be in the best position to follow procedures and members of the public are likely to be unaware of how to report suspected abuse (Summer, 2004). These findings, and the variable picture that emerged from our reading of the referral information in terms of contact with local APUs and CSCI, suggest that more guidance for employers about the roles of APUs and CSCI in relation to making referrals to the POVA list would be of value.

Several employers mentioned that simultaneous referrals had been made to the Nursing and Midwifery Council (NMC), which has the power to remove nurses from their register, thereby rendering them unable to practise. Employers can make complaints about nurses to the NMC both about unfitness to practise and incompetence to practise (NMC, 2004a;b), which taken together cover similar issues underlying the referrals to the POVA list. Unfitness to practise is defined widely, and includes misconduct and various health conditions, such as drug or alcohol addiction (NMC, 2004b). Competence is conceived more narrowly and covers nurses who make repeated mistakes, or show lack of skill or knowledge. Before a referral the NMC on the grounds of incompetence can be considered, employers need to inform the nurse about the areas identified and show that he or she has not improved their practice despite efforts to identify and remedy the causes (NMC, 2004a).

In our reading of the referrals there appeared sometimes to be a merging of poor skills and abuse, which Fyson *et al.,* (2004) also note as an issue in identifying the abuse of adults with learning disabilities. There was also a relatively high percentage of referrals concerning single incidents. Consequently, there might be an advantage to develop some guidelines which suggest distinct approaches to making referrals in these different circumstances. Where the problem concerns incompetence, it may be necessary, when making referrals, to include information about any attempts to improve the worker's practice. Where this was available, it provided very good evidence to support the referral. For single episodes of misconduct, it is possible that the worker's previous record and other information about the quality of care provided in the establishment would be useful.

Implications for the workforce

There were several interesting patterns suggested by the make-up of referrals. Firstly there was a clear suggestion that males were over-represented in terms of the staff involved in referrals compared with the population of social care staff. Furthermore, males were seen to be more likely to be involved in certain types of misconduct, mainly in the more direct forms of harm, physical, psychological and verbal abuse. Female staff were more likely to be involved in neglect and financial abuse. Staff working in residential establishments were more likely to be referred for more direct types of abuse (physical, verbal and psychological), whereas domiciliary care workers were more likely to be involved in financial abuse. There is room to consider the ways that staff work with people who are challenging, given the role that challenging behaviour played in many of the referrals. Overall this study suggests the potential of examining POVA referrals as a continually useful source of information about recruitment, training, support and supervision of staff.

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