The Protection of Vulnerable Adults List: an investigation of referral patterns and approaches to decision-making

(Summary Report)

Martin Stevens, Shereen Hussein, Stephen Martineau, Jess Harris, Joan Rapaport and Jill Manthorpe

July 2008
Contents

Introduction ............................................................................................................. i
Methodology ......................................................................................................... i
Analysis of referral records.................................................................................... ii
Synthesising (un)suitability..................................................................................... vi
Discussion, conclusions and recommendations ..................................................... xi
Introduction
Since July 2004, employers of social care staff working with vulnerable adults in settings that are registered with the relevant social care inspectorates in England and Wales have been required to refer workers (and volunteers) dismissed for misconduct that harmed vulnerable adults or placed them at risk of harm, to the Protection of Vulnerable adults (POVA) list. Employers are also required to check the list before employing people to work with vulnerable adults. The POVA list is unique to England and Wales. It does not apply to health care settings or social care settings, such as day centres or sheltered housing.

In 2005, the Department of Health commissioned the Social Care Workforce Research Unit to undertake a review of the first 100 referrals to the POVA list. This first POVA study (Stevens and Manthorpe, 2005) confirmed the importance of the Protection of Vulnerable Adults list to many groups and services.

The Department of Health (DH) commissioned the research reported here to assist those with responsibility for the scheme to be confident that their judgements have the support of those affected. The research explored the factors leading to placement on the POVA list by addressing the following research questions:

• What factors are associated with decisions to place referred staff onto the POVA list?
• Are there any commonalities and any differences within a sample of referrals to the POVA list?
• How are decisions being made about whether to place referred staff on the list?

This report summarises this research; a longer research report is available on the Department of Health website.

Methodology
A multi-method approach was adopted for this study. We compared the patterns and associations found in quantitative data with discussions arising in interviews and discussion groups. Two datasets were analysed for the quantitative element of the research. First, data about all referrals to the POVA team were sent to the research team. Second, all the written information accompanying for a sample of 300 referrals was sent to the team and a more detailed set of data was looked at in depth. Three vignettes, or fictional cases, were created, which were used as stimulus material. Interviews were carried out with 18 POVA team members, and discussion groups were held with five managers, three frontline practitioners and 14 older people (who took part in two discussion groups).
Analysis of referral records

This section sets out the results from the quantitative element of the research. General characteristics of referrals are presented first, followed by an analysis of types of abuse, mitigation and finally the status and process of referrals.

Characteristics of referrals

Introduction

In this chapter the data on the characteristics of all referrals and the sample are reported in terms of who is being referred and what services they work in.

Where do referred people work?

The proportion of referrals concerning home care or residential workers appears to match estimated proportions of such staff in the workforce as a whole. Almost four fifths, 39 percent, of referred people were working with people with learning disabilities, which was the most common category, although, almost as commonly, referred people were working in services caring for older frail people (37 percent) and people with mental health problems (34 percent).

The categories used above included many services that were registered for older people. Thus, about nine out of ten, 90 percent, of referrals were made from establishments registered to work with at least some older people.

Who are referred staff?

Men were over-represented in terms of referrals to the POVA list compared with the social care workforce as a whole. However, referred staff had a similar age profile as the whole social care workforce in Great Britain. The proportion of staff from ‘white’ background was 47 percent; this compares to an estimate of 92 percent in the social care workforce. Importantly, this was based on only 30 referrals where this information was available. About two thirds, 67 percent, of referred workers were frontline care staff, such as support workers or care assistants.

What happened before the referral to POVA?

In over three quarters (77 percent) of referrals employers’ investigations had resulted in some form of disciplinary action. Referrals from residential services were more likely to come after completed employers’ investigations (often resulting in disciplinary action) than those from home care services. The most commonly involved organisation in the employers’ investigation process was the Inspectorate, the Commission for Social Care Inspection (CSCI), which was cited in about two thirds, 67 percent, of referrals.

Police investigations had taken place in about half, 51 percent, of the sample of referrals; and in 14 percent, their investigations resulted in a criminal
charge or conviction. Police investigations were more likely to have taken place among referrals of financial or sexual abuse and less likely in respect of neglect, emotional or ‘other’ type of abuse and where the service users involved were categorised as being ‘older frail’.

**Types of abuse**
Staff are referred to POVA if they have caused harm or risk of harm of various kinds (in this study these are referred to as ‘types of abuse’).

What were the reasons for referral?
Physical abuse was the most common cause, involved in about a third, 33 percent, of referred cases. This was followed by around a quarter, 24 percent, of referrals containing an element of financial abuse. Emotional abuse was present in 14 percent of cases, whereas sexual abuse was the cause of referral in six percent of cases.

Comparisons of the types of abuse by group
Staff from residential services, in particular, were significantly more likely (over three times) to be accused of physical abuse, as were frontline care staff when compared to staff without care responsibilities. Younger staff (aged less than 25 years at time of referral) were significantly less likely to be accused of physical abuse than their older colleagues.

Referrals from domiciliary care settings were significantly, nearly six times, more likely to be accused of financial abuse compared with referrals originating from residential services. Managers and deputy managers were also very much more likely (three times), while nurses were significantly less likely (about three times less than frontline staff) to be accused of financial abuse. Referred staff working with older frail service users were also significantly more likely (nearly two and a half times) to be accused of financial abuse. The probability being referred for financial abuse decreased with age (older staff were less likely to be referred for this kind of abuse).

However, the probability of being accused of sexual abuse increased considerably with the age of staff. Staff without care responsibilities and older staff were more likely to be accused of sexual abuse compared with referred workers in other posts. Men were much more (27 times) likely to be accused of sexual abuse than women. Staff working with people with learning disabilities were more likely to be accused of sexual abuse, while those working with people with physical disabilities were less likely.

Emotional abuse was significantly more likely to be reported in residential compared with domiciliary care settings. Frontline care staff were also more likely to be accused of emotional abuse when compared with nurses or managers/deputies. Referred people working with people with mental health problems were more likely to be accused of emotional abuse compared with staff working with other groups of service users.
**Mitigating Factors**

The referral sample included information on whether those referred raised any form of mitigation as well as the exact mitigation claimed.

**Numbers of mitigating factors claimed**

In total, fewer than half of referred members of staff claimed any mitigation to explain or excuse what they had done. More women than men, but few staff who were younger than 25 years provided mitigation.

**Types of mitigation**

Men and women used broadly similar sorts of mitigation with few exceptions. The most cited mitigation was ‘little harm’, followed by ‘previous record’, meaning a previous good work record. Claims that what they had done resulted in little harm to service users or that they had shown remorse were made more by staff aged 50 or over as mitigation compared with younger staff. Staff in the youngest age-group (aged under 35 years) were more likely to cite ‘working conditions’ compared with older staff.

**Type of abuse and mitigation**

Those who were accused of physical abuse were most likely to claim any form of mitigation, while those who were accused of sexual abuse were least likely. Among referrals with some elements of physical abuse, the most commonly cited mitigation factor, was a previous good record at 37 percent followed by claims that little harm had been caused at 34 percent. In relation to referrals due to ‘neglect’ the most cited mitigation was that any harm had been unintentional, at 35 percent. The most commonly used types of mitigation in cases of financial abuse were claims that the staff member had a good previous record and had expressed remorse at 44 percent.

**Response to challenging behaviour**

About nine percent of the sample indicated that their actions were related to challenging behaviour of service users. This claim was most common, 24 percent, by workers accused of physical abuse, followed by those accused of emotional abuse, 16 percent. Men and younger members of staff were also more likely to claim that the misconduct had been due to the challenging behaviour of service users. Frontline care staff (including team leaders and supervisors) had the highest prevalence of this claim. Workers referred from residential services used this claim much more than those from domiciliary care settings.

**How were referrals processed?**

Referrals go through several stages before a final decision is taken about whether to confirm a person on the POVA list.
What happened to referrals?

A large proportion of all referrals, 58 percent, were removed (closed) and the worker was not placed on the list. About seven percent of all referrals were confirmed on the POVA list. Over a quarter, 28 percent, of referrals were provisionally listed while investigations were being completed. The proportion of referred people whose appeal against decisions made by the referrals team was ongoing was negligible at only 0.3 percent. Figure i shows the two thirds, 65 percent of cases (3418 referrals) in which a final decision had been taken either to confirm a referred person on the POVA list or to remove them. Of those referrals where a decision had been taken, about one tenth, 11 percent had been confirmed and almost two thirds, 66 percent, had been removed at the pre-provisional stage.

Figure i Outcomes of completed referrals

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed referrals (3418)</td>
<td>100%</td>
</tr>
<tr>
<td>Closed at pre-provisional (2254)</td>
<td>65.9%</td>
</tr>
<tr>
<td>Closed after provisional listing (539) or other stages (262)</td>
<td>23.4%</td>
</tr>
<tr>
<td>Confirmed</td>
<td>10.6%</td>
</tr>
</tbody>
</table>

Referrals relating to either financial or sexual abuse were significantly more likely to be confirmed than other referrals. No other staff, care provider or service users’ characteristics were significantly associated with the probability of a case to be confirmed when controlling for other variables.

Time taken

The average time taken to reach a decision among all referrals, recorded for 2566 referrals, was 5.8 months. Almost half, 48 percent, of open referrals had been ongoing for at least nine months. In about a fifth, 21 percent of completed referrals, the decision took over nine months. The average time was significantly longer among cases with alleged financial, physical and emotional abuse while significantly lower among cases with alleged sexual or ‘other’ forms of abuse.

Reaching decisions about referrals involving emotional abuse took longest, 7.7 months on average. In relation to job role, referrals involving managers and deputy managers took significantly longer for a decision to be made (mean=7.1 months) while those among staff without care responsibility took significantly shorter period of time (mean=4.1 months).
Synthesising (un)suitability

The second part of the findings focuses on the processes of making decisions to bar referred workers. These findings are based on an analysis of:

- Interviews with 18 POVA team members
- Discussion groups held with five managers, three frontline practitioners and 14 older people (seven in two discussion groups).

These data were analysed in NVivo using elements of grounded theory. A model of the decision-making emerged from the analysis of the interviews and discussion groups.

Contextual influences

Members of the POVA team referred to a number of influences on decisions that did not arise out of individual cases, but were part of the general context for decision making.

Legal aspects of the POVA scheme

The overall legal mandate, the standard of proof that decisions had to satisfy and the appeal process are influential in the decision-making process. The POVA team managers have used POCA (Protection of Children Act scheme) and POVA appeal judgements to inform training and development of the approach to decision making. Several respondents said that an important restriction in terms of the list’s operation was the fact that the POVA team had very limited powers of investigation. Under the legislation, the POVA team has to work to the civil standard of proof, which requires that they are satisfied, **on the balance of probabilities**, about all aspects of referrals. In one respondent’s opinion, the Care Standards Tribunal (CST) applied a more stringent standard of proof than the POVA team employed. Senior members of the POVA team have used the judgements from appeals in relation to decisions to confirm referred people on the POCA list to inform the development of a structured approach to decision-making. Lessons from current appeals are also used in staff training and development.

Nature of POVA scheme

A distinction was often drawn by respondents between the types of misconduct and situations that justified dismissal and those which should result in a referred person being confirmed on the POVA list and so be banned from working in social care. In the interviews with POVA team members, three main, inter-related principles could be discerned: ‘equity’, ‘evidence-base’ and a ‘precautionary’ approach to decision-making, in which the potential for harm to people using services outweighed the possibility of injustice to referred people particularly in difficult judgements. The culture of the different teams within the overall POVA team and the extent to which cases are discussed between team members are important informal aspects of the system.
Where the mitigation claimed by a referred person indicated that it had been impossible to avoid the misconduct because of poor working conditions, CSCI reports were useful additional pieces of evidence. Police investigations, past and present, were crucial factors in the ultimate decision to confirm or otherwise a referred person to the POVA list

**Effects on referred people**

The age and circumstances of the referred person were reported as making a difference to the impact of being listed. In terms of decision-making, the gravity of a decision to confirm someone on the POVA list was another factor driving the focus on evidence and the need to make sure that the penalty fitted the misconduct. A further factor, cited as influencing the effect on workers, was the low status of social care work.

**Undertaking investigations**

Formally, a referral goes through five stages

- **Screening**
  When a referral is received by the POVA team, an initial check is made, usually by administration staff, to check that the referral is from an employer covered by the scheme and contains the right set of information

- **Decision to provisionally list**
  After screening, an initial assessment is made about whether to provisionally list and therefore to bar the referred person while further investigations are being made. This process involves several members of staff at different levels, who check whether the referral meets the basic criteria for involvement in terms of the circumstances and where the level or type of
abuse is felt to raise the possibility of an ultimate assessment of a referred person as unsuitable to work with people in vulnerable situations.

- **Observation stage**
  During this stage, which only takes place after a decision to provisionally list a referred person, further information is sought to help make a final recommendation. At the time of this research, it was at this stage that the referred person could give their point of view and offer any mitigation.

- **Submission to Secretary of State**
  After all investigations have been completed, a final submission is made, recommending that the referred person be confirmed on the POVA list or to close the case without confirmation.

**Evidence**
Evidence was sought both about the misconduct or harm and the overall suitability. However, being limited to a 'paper exercise' was seen as an important restriction and team members reported on the variable quality of evidence received. Some misconduct was in itself judged to be sufficiently grave to warrant confirmation on the list, minimising the need for further consideration of suitability.

**Sources of Evidence**
A range of sources of evidence are typically used, including:
- Disciplinary hearings
- Care plans
- Managers and colleagues of the referred person
- Police investigation and National Identification Service\(^1\) (NIS)
- Patterns of misconduct
- Relatives of the service user
- The service user.

**Interpreting investigations**
Each piece of information uncovered by investigations needed to be interpreted and added to the picture of the referred person as being unsuitable (or not) to work with adults in vulnerable situations.

**Incrimination**
The POVA team’s first task is to establish a causal link between misconduct and harm. Unsurprisingly, physical and sexual abuse were viewed particularly seriously. However, financial abuse was considered problematic in terms of proof and seriousness, often requiring further investigations. However, a

---

\(^1\) A national service run by the Metropolitan Police, used to identify people who have a criminal record
simplistic ranking might easily be disrupted by one or more of the array of variables that made up any one incident.

**Mitigation**

Mitigating factors counting against a decision to confirm a referred person on the POVA list were raised in interviews and discussion groups. It was very common for mitigation factors to be perceived as cumulative, in other words, more weight was often given to a defence based on a range of mitigating factors. However, mitigation was often perceived as constrained by the type of misconduct and level of harm. Two separate but linked types of mitigation are evident: **mitigation for the person** and **mitigation of the misconduct**.

**Mitigation for the person** involves establishing that the referred person has certain general characteristics reducing the likelihood of the person being judged as unsuitable to work with adults in vulnerable situations. Factors identified as **mitigation for the person** are shown in figure ii (overleaf).

**Mitigation of misconduct** involves identifying factors that can explain the immediate conditions surrounding the incident(s), which support a more positive interpretation of the role of the referred person. Figure iii (overleaf) shows the factors that are claimed in **mitigation of misconduct**.

**Figure ii Mitigation for the person**

- Admission of guilt
- Remorse
- Previous good record
- Reaction
- Intentions
- Age of worker
- Ongoing stress/mental health
Synthesising (un)suitable persons
The POVA list is a scheme that makes value and moral judgements about people as being unsuitable to work with adults in vulnerable situations

Emotional reactions
An emotional response to initial information supplied about the referred person shapes the subsequent investigation. Feelings about a referral also play a part in interpretations of evidence.

Moral judgements about unsuitability
Making a judgement that a person should be on the POVA list is a moral assessment of his or her character as someone who is likely to repeat the same, if not worse, harm. The misconduct and person were sometimes characterised as being unacceptable and bad in themselves (a deontological approach). Other responses stressed the perception that a person capable of such actions is likely to repeat them (a consequentialist perspective).

Dimensions of Suitability
A three-way balance was involved between type of misconduct, extent (or risk) of harm and contextual information about the person (person characteristics). Presenting these as two-dimensional balances, illustrates some of the detailed thinking that was described. Three key dimensions were identified:

- Misconduct versus harm: a focus on balancing what the person has done against the level of harm caused.
• Harm versus person: a balance is also struck between the level of harm caused, by whatever means, and overall mitigation for the person.
• Misconduct versus person: comparing the type and severity of misconduct (whatever the level of harm) against other information about the person and the situation.

Building a picture
Unsuitability is not a fixed, objective state, rather, it should be considered as being a picture built from perceptions of the incident, the person and the context. For several respondents, a preliminary process of establishing that a referred person had committed what was alleged and that this had caused harm informs an initial judgement about the possibility of the person being unsuitable. The initial interpretation of the information guides the further information gathering process and subsequent interpretations of the case. A simultaneous process is undertaken of making sure that good evidence is obtained for the event(s), the interpretation of the event(s) and any mitigating factors claimed or unearthed.

Discussion, conclusions and recommendations
In the final part of this summary report, the findings are discussed and conclusions are suggested. A set of recommendations for the development of the POVA list and the new vetting and barring scheme and for social care more widely is presented in the final section.

Discussion
One of the most notable findings is an over-representation of male care workers being referred, implying a possible need for an increase in focus on gender issues in managing and developing the social care workforce. Three further strong patterns were identified:

• residential workers were more likely to be referred because of physical and emotional abuse;
• domiciliary workers were much more likely to be referred for financial abuse;
• almost all referrals regarding sexual abuse concerned male staff.

Each of these findings supports the earlier work on the POVA referrals. Such findings have implications for recruiting, training, supporting and managing care staff. Social care staff from Black and Minority Ethnic (BME) groups face a number of barriers in the workplace and are under-represented in the social care workforce. The very limited information about ethnicity available from the referral data suggests that staff from BME groups may be over-represented in referrals. Therefore, it is imperative that information on ethnicity of referred people is recorded in order to investigate this more thoroughly.
POVA team members and some of the other stakeholders involved in the discussion groups indicated that financial and sexual abuse were easier to interpret than other forms of harm. Such cases were also more likely to be confirmed on the POVA list; decisions about sexual abuse referrals were reached more quickly; and the Police was more likely to be involved in all such cases.

The initial information accompanying referrals influences a developing emotional and moral understanding of the referred person, from which unsuitability (or otherwise) is synthesised. Different perspectives of service users, practitioners and managers may well be of value in developing the approach to decision-making. Further work within the POVA team to help generate common understandings may also be of value, especially for the new vetting and barring scheme. Finally, in terms of the development of the vetting and barring scheme and arising from the ratio of referrals to confirmed persons, guidance on making referrals may need to be changed, to limit the numbers of referrals that currently are removed at the pre-provisional stage. Also of value in this regard would be further information and training for social care managers responsible for making referrals to the POVA list.

Conclusion and recommendations

Conclusion

The research shows a number of patterns in terms of referrals. While the relationship between these findings and patterns of abuse may be queried, these were large effects at a high level of significance. Such findings have implications for recruiting, training, supporting and managing care staff and their regulation through registration.

Decision-making was characterised as an iterative process of information gathering that influences an emotional and moral understanding of the referred person.

Recommendations

• Increasing awareness of gender issues in: the management of day-to-day social care workload allocation; training; and ongoing support for male staff; may help reduce the over representation in referrals.
• Recording an additional set of variables and clarifying others in the information collected on all referrals would greatly facilitate further analyses.
• Variables that should be added include:
  o Ethnicity of referred persons (recording the ethnicity of referred workers would make it possible to investigate further the suggested over-representation of care workers from black and minority ethnic groups referred to the POVA list).
  o Gender of referred persons (recording the gender of workers would make it possible to investigate future patterns of gender balance of
• Service users’ characteristics need to be collected more systematically and using categories that reflect their socio-demographic characteristics and health and care status (such as kinds of disability, age, ethnicity and gender of service users allegedly harmed). Categories such as ‘older frail’ are not very helpful in determining vulnerability or risk factors.
• Police involvement and conclusion (whether a police investigation had taken place and what the outcome was at the time of the referral).
• Mitigation (reasons offered by the referred person to explain or excuse their actions).

- Variables also need to be clarified in the following areas:
  - Staff post: there were many kinds of post included in the database. A categorisation of post, using Skills for Care job categories (in addition to recording the actual job title) would make analysis of trends more straightforward.
  - Type of abuse: in the analysis of the 300 referrals a clear category of ‘Neglect’ was identified, which is not categorised in the full dataset. Over two fifths (43 percent) of referrals were for ‘other’ types of abuse, many of which we categorised as ‘Neglect’. Using a ‘Neglect’ category would make future analyses much more meaningful.
  - Recruiting, training and particularly supervising of staff of different ages may need to be tailored to reflect the different patterns of abuse.
  - Commissioning self-report surveys of service users (or carers) and care staff would provide evidence from different perspectives of the prevalence of such misconduct and interpretations of the harm produced. This would help interpret the patterns of referrals established in this current study.
  - Further research and practice development are necessary to address the risks of adults with learning disabilities to being sexually abused by staff.
  - Having information about the previous work record of staff members submitted with the initial referrals might facilitate the decision-making process, given the emphasis on previous record as a way of judging the (un)suitability of a referred person.
  - Amending the guidelines on the kinds of circumstances that warrant a referral to the POVA list may help reduce the numbers of referrals, which are removed at the pre-provisional stage, freeing up time for consideration of more serious cases.
  - More training and support for managers responsible for making referrals in order may increase the proportion of appropriate referrals, particularly around disciplinary hearings.
  - Developing a strategy to keep abreast of the changing context for social care might enable the POVA team to keep up to date with interpretations of misconduct and mitigation.
  - Ensuring routine sharing of information concerning POVA referrals with regulatory bodies could improve service provision at the level of individual providers and at a more general level. The inspectorate should be informed of referrals to POVA.
• Increasing direct involvement of service users in a dialogue with POVA team members might inform the empathic understanding of the nature of misconduct and harm, which is an essential part of the decision-making process.
• Some form of interaction with frontline practitioners would also be of value in informing the understanding of the POVA team of the experiences of working in social care.
• Increased exchange between social care managers and other personnel responsible for making referrals to the POVA list would also increase the overall understanding of the team.
• The experiences of operating the POVA list should inform the new vetting and barring scheme and the extensions of Care Councils regulation to wider groups of care workers.