BE Safeguarding Adults Review Learning Brief
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Case Summary

Cumbria Safeguarding Adults Board (CSAB) commissioned a Safeguarding Adults Review in response to a number of incidents of serious physical, sexual and emotional abuse to residents of a specialist dementia nursing home in central Cumbria. The abuse was highlighted by a newly appointed member of staff who observed disrespectful and cruel behaviour towards residents by an existing member of staff during her first night shift. The newly appointed worker was 'shadowing' two members of the care staff throughout this shift and on challenging them about their behaviour, was told 'it's just a laugh'.

Later on in the shift, she overheard one of the carers state to the other that she had nearly been caught using her mobile phone on shift by a member of the nursing team and commented that if caught, they may have seen the videos. The carer reported the abuse she had witnessed the next day and resigned.
Safeguarding alerts were reported to Adult Social Care the next day which resulted in a thorough and robust investigation taking place which was led by the Police. Extensive evidence was retrieved from the mobile phones of three members of the care staff who were subsequently arrested and charged with s.44 offences under the Mental Capacity Act and one carer with an additional charge of sexual assault. The investigation identified a number of victims of the abuse within the care home by the three workers. All three care workers were subsequently prosecuted and all received custodial sentences.

The nursing home is now closed.

The review highlighted key themes which are listed below;

- Learning from this review should be included in the safeguarding training of all partner organisations across the sector
- Organisations need to challenge providers when they are not satisfied with the quality of provider led investigations directed under the Safeguarding process.
- There needs to be a clearly defined route of escalation when barriers to progress are experienced.
- A recognition nationally that the previous regulatory methodology needed to be developed.
- A local recognition that quality and contracting processes need to be aligned to enable actions to be taken swiftly when concerns arise.
- There is a need to recognise in individual care reviews that changing patterns of behaviour may be indicative of underlying issues.
- There is a need to develop how we share good practice and evidenced based learning across organisations and professional groups.