Editorial

Bridget Penhale and Margaret Flynn

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Welcome to this fourth issue of the journal for 2021, and over a year in the situation of an apparently unrelenting but evolving (or perhaps mutating!) pandemic. Although media coverage remains preoccupied and focused on the pandemic crisis across the world, in the UK, we have seen continued coverage of safeguarding-related issues and thus provide a round-up of what appears to be some of the most topical of these. Time, perhaps to consider serial deceptions and the necessity of fact-fightback! Less of the halting COVID-19 responses, "moon-shots" or even "oven-ready" Brexit deals, but the impacts of successive torrents of misinformation. So many places to begin and items to chart – so let us return first to the promise of the new year and beyond for a glimpse of the past few months!

We could start with former US President Donald Trump's "election defence fund", which was created to challenge a democratic process. Track onwards to the mayhem of a rampaging mob at the US Capitol on 6 January to an impeachment trial. The climax of this test of accountability and the rule of law was a not guilty verdict; that is, a decision that the former president did not incite insurrection. Maybe that was inevitable as the Republican jurors were witnesses too and did not want to face the ire of voters. But to all would-be presidents, the message is that it will be fine to unleash violence during your outgoing weeks, and you too may escape institutional censure. Yet some hope remains elsewhere – in Warsaw, a court has ordered two historians to apologise to a woman who claimed that her late uncle had been defamed in their Holocaust research [1].

We could reach back to the promises of England's Health and Social Care Act's apparent lift for competition lawyers. The Act introduced a "market", payment by results, the requirement of hospitals to compete and, also by the way, innovation. This is soon to give way to a "duty to collaborate [. . .]" in an ill-timed re-organisation [2], once again with barely a nod at social care.

Perhaps we should settle for applauding the efforts of fact fighters such as Sam Bowman and Stuart Ritchie. Their website, for example, refutes the amplified claims of anti-vaxxers[3] and highlights how stories shift as the assertions and threads of free-speech advocates are deleted.

Although it was known during November 2020 that people with learning disabilities had a higher death rate from COVID-19 than non-learning disabled people [4], do not attempt cardio-pulmonary resuscitation notices are being given to some care home residents, prompting a review by the Care Quality Commission. It would appear that people with learning disabilities are potentially being denied life-saving treatment [5]. Families have expressed frustration that adults with learning disabilities living in communal settings are not vaccinated against COVID-19 as a priority because they may be unable to describe their symptoms if they become ill, for example [6].

The Bank of England's Governor, the former Chief Executive (CE) of the Financial Conduct Authority from 2016 to 2021, has accepted full responsibility for its failings in relation to London Capital and Finance (LC&F). LC&F went into administration in January 2019 [7] and its investors lost £236m. For students of regulation and inspection, there is something familiar about Andrew Bailey's explanation:

> I didn't know about LC&F until pretty much the point it was closed down by the FCA [. . .] The red flags were buried in the 200,000 calls [to FCA's call centre, which included 15 from one person]

> [. . .] there was no proper system for extracting that information [. . .] I wish I had known about it sooner because [. . .] I would have jumped in and got on it sooner [8].

Is the regulators' hierarchy of graduated responses to noncompliance a spent force? Check out BBC Wales' coverage of the recent Operation Jasmine inquests [9] – 16 years after the Gwent Police investigation of deaths in care homes owned by husband and wife GPs. The inquest took almost 2 months as it considered the deaths of six specific residents, with a further death considered separately after conclusion of the first full inquest. For five of the six residents, cause of death was found to have been contributed to by neglect. As this finding is not commonplace within a coronial context, it may be of interest – particularly when considered in the light of the Review report produced by Margaret Flynn in 2016 (Welsh Government, 2016).

There are muted cheers for the new Office for Product Safety and Standards which states: "Our purpose is to make regulation work, so that it protects people and enables businesses to understand their obligations"[10]. Although it will be able to ban unsafe building materials such as the Grenfell Tower's combustible cladding, this is clearly an example of after-the-tragedy remedy. It does not alter the fact that residents' safety was deprioritized as companies such as Kingspan, Celotex and Arconic ignored their own safety results [11].

The Department of Health and Social Care has published proposals for the reform of the Mental Health Act, noting *inter alia:*

"We have seen high profile cases of quality failings in the care of people with a learning disability and autistic people in inpatient settings such as the abuse uncovered at Whorlton Hall in May 2019. Too often people have been detained without sufficient therapeutic input and without their rights being upheld. We propose changes to reduce reliance on inpatient services for people with a learning disability and autistic people and to further ensure the availability of community alternatives [. . .]" [12] As many readers will no doubt note, quite so. However, it will require more than the reform of the MHA to ensure that directors and shareholders invigilate their own corporations and are held accountable for doing so. Credible corporate safeguards are overdue.

It is 10 years since Margaret Flynn and Vic Citarella wrote the Serious Case Review concerning Winterbourne View Hospital, which resulted from the BBC's broadcast of Panorama's "Undercover Care: the abuse exposed". At the time, they had little sense that this obsolescent model of specialist service provision would be so defiantly durable. The broadcast received national news coverage because of the cruelties and distress revealed at a private hospital, which in 2011 was being paid on average £3.5k per patient, per week from NHS coffers. Although it had an annual turnover of £3.7m, the Care Quality Commission's light-touch regulation did not notice that the hospital had strayed far from its mandated purpose of assessment and treatment, or even respond to a whistle-blower's three alerts. Politicians' expressions of horror and promises of "lessons" being learned fell short, regardless of the regret expressed by the hospital's parent company Castlebeck Care (Teesdale) Ltd and armfuls of parallel information-gathering activities by the Care Quality Commission, NHS South of England, South Gloucestershire PCT (Commissioning), the Department of Health and the Equality and Human Rights Commission, for example. However, it was Private Eye's forensic accountants who trumped all in an article, "Passing the Beck" [No.1327, 16–29 November 2012, p. 31]:

> "The company that owns Winterbourne View, Castlebeck, is itself part of a group called CB Care Ltd, which is itself owned, via Jersey, by Swiss-based private equity group, Lydian, backed by a group of Irish billionaires. The process of private equity ownership is that all the money gets whipped out by the bankers and offshore owners as soon as possible. So, while CB Care makes healthy operating profits, these disappear in interest payments, leaving the group with hefty annual losses and [. . .] liabilities exceeding assets by £14m [. . .] The Care Quality Commission confirmed that for private providers there is "no provision to require insurance under the Health

and Social Care Act." So while private equity owners scoop up the profits, it looks like the tax payer could end up having to pay for private care fiascos."

The government promise to transfer 3,000+ patients out of assessment and treatment units by July 2014 could not be kept, primarily because there is no incentive for commercially provided inpatient care to discharge patients and retain empty beds. Concordat commitments, the Transformation Programme, the Winterbourne View Joint Improvement Programme – backed by over £10m – did not halt the continuing registration of such institutions and the fleeting decision-making of commissioners who are typically spared the consequences of their continuing place-hunting. It follows that the scandal did not result in promised change, as even now there remain over 2,000 people in these services. "Assessment and Treatment Units" provide neither credible assessment nor treatment. The use of power and violence with which they are associated entangle and poison the ends sought.

Speaking of poison, who would have imagined that the UK's Post Office (PO) would gift a powerful example of institutional abuse? It was during 1999 that the PO adopted Fujitsu's IT system, despite its Board's "serious doubts" concerning the software's reliability. Under standard contracts, sub-postmasters and mistresses were held liable for financial shortfalls, and the PO began a programme of prosecutions of those concerned. Denial that the software was malfunctioning suited Fujitsu's profitable contract, and the PO transferred all blame to the sub-postmasters/mistresses who were subjected to charges of theft and convictions of false accounting. The PO was uncompromising. It was preparing for separation from Royal Mail and was entirely focussed on halving losses of c£200m.

Things became interesting when the PO dismissed media reports, and the new CE and Chair promised to be "open and transparent". The PO's enforcers were convinced that the IT system was exposing extensive fraud, regardless of a rolling programme of "patches" to fix persistent IT problems. It appeared that the system could not cope with the scale of its problems. The *Justice for Sub-postmasters Alliance* began to acquire traction, and a review of the IT system was commissioned. However, access by reviewers to error logs, for example, was blocked, and PO lawyers quibbled with emergent findings. So far, so familiar and yes, lives were indeed lost during this protracted process.

The CE professed a desire to "get to the bottom" of the matter while proposing mediation rather than compensation for sub-masters/mistresses. This was a single dimension of the denial, which dictated CE's response to the Commons Business Committee. The IT reviewers were sacked. During the inevitable litigation, the PO sought to strike out evidence and resist claims that it had been unfair. However, in May, the judge declared that the PO was guilty of "oppressive behaviour", and the PO sought to recuse him because of "bias". The PO agreed to pay £68m to settle claims, plus costs. Its approach "amounted to the 20th century equivalent of maintaining that the earth is flat"[13], Its treatment of those prosecuted for false accounting and theft nothing short of an institutionally abusive regime with no systems in place to protect those harmed.

This issue of the journal contains five papers covering a wide range of safeguarding topics. The first paper is by Michael Preston-Shoot (University of Bedfordshire) and is a further paper from him about Safeguarding Adults Reviews (SARs) in relation to cases of self-neglect. This useful paper provides an update to the core data set of SARs on self-neglect that has been developed and to analyse these additions to the data set. The core aim of the paper is to examine whether lessons are being learned from the findings and recommendations of an increasing number of reviews that are being undertaken on self-neglect cases. The SARs that have been added to the data set were analysed using the previously developed framework, with a number of findings that were similar to the previous findings on policy and practice and the existing evidence-based model. The fact that some Safeguarding Boards appear to be undertaking additional SARs concerning individuals who self-neglect raises very legitimate questions about whether effective lessons are being learnt from the SAR processes.

The second paper is by Kai Goh and Cathy Andrew (of the University of Canterbury, New Zealand) and reports on a literature review concerning the topics of safety awareness and protection skills for people with disabilities to protect themselves from abuse. In view of the high prevalence of abuse against people with disabilities, various training initiatives on safety awareness have been developed to assist individuals. The central aim of this review was to explore the efficacy of such safety training. A search of relevant electronic databases considered peer-reviewed empirically based evaluations of safety training. Six papers were found that met the criteria that had been developed. Analysis of these papers identified key themes relating to accessibility, the need for differing training approaches for specific types of disability and the learning needs of people with disabilities as well the necessity to contextualise abuse of those with disabilities within the design of training interventions. The key finding from the review was that people with disabilities can benefit from and contribute to training in safety techniques if programmes are adapted to assist participation and meet specific learning needs.

The following paper in the issue is by Jade Scott and colleagues (from the University of Liverpool and King's College, London) and reports on a research study in relation to professional views of how Deprivation of Liberty Safeguards (DoLS) have been operationalised to support individuals who have experienced brain injuries. The study explored the decision-making processes concerning DoLS through the perspectives of health and social care professionals who were working with people with acquired brain injuries (ABI). Twelve professionals were interviewed about their experiences of using or supporting individual decision-making for ABI survivors within the DoLS framework. The data analysis determined three main styles, which appeared to affect decision-making outcomes. These styles are risk averse, risk balancing and risk simplifying, with a number of mediating factors that seemed to lead to some variation in the styles used. A preliminary explanatory framework was developed, together with recommendations for changes to both policy and practice. The authors suggest that these findings may be of relevance to the forthcoming Liberty Protection Safeguards, so these findings may be of interest to those working, or expecting to work, in this area.

Our fourth paper in this issue is a legal paper by Owen O'Sullivan of Northumbria University and the South London and Maudsley NHS Foundation Trust, focusses on issues relating to financial abuse, statutory provision and powers of attorney (both enduring powers of attorney [EPAs] and lasting powers of attorney [LPAs]). This review paper considers the adequacy of existing statutory provision and courts in England and Wales in offering protection to older adults at risk of harm from financial abuse. The specific focus of the paper centres on EPAs/LPAs. The narrative techniques used in the review included a selection of cases: those in which there were significant judgements about the use of powers, a range of issues and extent of commentary about cases. The review identified the shortcomings and potential vulnerabilities of both provisions, which are then contextualised within the broader frame of dealing with and preventing financial abuse of older people. The paper ends with some consideration of other potential areas and scope for reform of existing provisions.

The final paper of the issue is by Avanish Patel of Alliance University Bengaluru (Bangalore, India). This paper reports on a qualitative research study that explored specific challenges faced by older people in a district of Uttar-Pradesh, India. The particular challenges that were examined related to economic and social aspects of life, as well as those relating to health care. The availability of support from social support programmes was also explored through the exploratory qualitative interviews that were undertaken. The findings identified reports of an increasing number of challenges for older people arising from these areas. This led to difficulties for older people and had a major effect on both well-being and reduced social bonds with other family members, as well as with broader society in more general terms. Implications of the findings for the health, safety and well-being of older people are drawn from the findings. Recommendations for changes at policy and service delivery/practice levels are also developed.

As usual, we hope that you will find items of interest in this issue and that some of these will be of use to you for both your safeguarding interests and work. We are always interested to receive contributions to the journal and as the current situation extends would like to invite readers to continue to contribute papers in relation to safeguarding and COVID-19, as well as other aspects of adult safeguarding. If you are potentially interested and wish to discuss this further before working on a submission do get in touch with one of us to discuss. Finally, we hope that everyone is continuing to stay safe and well during these continuing challenging times and look forward to providing future issues of the journal later this year.

Notes

1. www.bbc.co.uk/news/world-europe-55996291 (accessed 18 February 2021).
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