Speaking up for vulnerable adults: What the whistleblowers say

A report from Public Concern at Work, the whistleblowing advice line

April 2011

Speaking up for vulnerable adults: What the whistleblowers say

There were an estimated 1.75 million paid jobs in adult social care in England in 2009.[1] Our ageing population means this figure will inevitably increase. The drive for individuals to have direct payments or personal budgets will also drastically change the landscape of social care.

Year on year we receive the highest percentage of calls to our helpline from the care sector (15%). These cases are often the most harrowing and many involve vulnerable adults. Additionally this is a sector with many workers who may be considered vulnerable due to low pay, low awareness of rights and lack of access to or knowledge of support.

Our research demonstrates that the whistleblowing process is still not as straightforward and as safe as it should be for those in the care sector. Much more can be done to improve the perceptions and experiences of those who speak up in the public interest to protect vulnerable adults. This report examines a variety of issues arising on our helpline: the types of concerns we receive, outcome of concerns, the role of independent advice and the steps which need to be taken to improve the process of whistleblowing in the UK care sector.

Many of our overall calls[2] are about abuse in care and vulnerable people being put at unnecessary risk. Within the care sector itself, over half of the calls we receive are about abuse. The most common concerns being; physical abuse, lack of dignity, neglect, conduct of staff, verbal abuse and medication administered incorrectly or not at all. Queries often relate to how to escalate a concern, advice on personal positions, seeking reassurance, needing support, or dealing with victimisation for raising a concern.

This report highlights that the vast majority of workers in the care sector (80%) have already raised their concern when they call us and over a third of these concerns are initially ignored, mishandled or denied by organisations. This suggests a low awareness of available support. In addition, care workers often do not realise that they are actually "blowing the whistle" until they encounter difficulties when having their concern addressed or are mistreated personally. Most tell us that they wish they had spoken to us prior to taking action. Our advice is designed to avoid conflict and allow the whistleblower to be a good witness by raising a concern in a constructive way.

Frequently, whistleblowers struggle with the lack of feedback from organisations regarding how their concern is being handled, leading workers to raise their concerns externally, or not knowing where to go, when it could have been dealt with internally. The majority of whistleblowers are unaware of their organisation's whistleblowing policy.

[1] Skills for Care, State of the Adult Social Care Workforce 2010.

[2] Many of the workers who call our helpline are support workers or care workers in a residential home or providing care as domiciliary workers directly in an adult's own home. However, we also receive calls from workers across the adult social care spectrum including: social workers, safeguarding teams, volunteers, students, cleaners, doctors, nurses and other professionals. All case studies in this report have had identifiable information removed or changed.

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Essentially there needs to be proactive promotion of best practice in whistleblowing arrangements. This includes training and guidance for managers on how to handle concerns, employers providing feedback when responding to concerns, a greater awareness of rights and zero tolerance for whistleblower victimisation, and clearer guidelines as to how and when to approach relevant authorities.

Significantly, in over half the cases where other staff were aware of a problem, they felt unable or too scared to speak up. The challenge is how to encourage, empower, support and protect every worker who is in a position to speak up to protect the most vulnerable members of society.

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Key statistics

- Since we were established in 1993, we have received over 19,000 calls. In 2001 we developed a database to capture information about the individual caller and their concern. Therefore we have full sets of data for 2002 – 2010. During this period we have advised 13,406 individuals, 7994 of which were classified as public calls, i.e. those with a whistleblowing concern. The remainder are those where the caller is seeking advice about a private matter. 1,180 of our public calls (15%) were from the care sector. This is the highest percentage of calls we receive from any sector. The second largest category is health (13%). All graphs in this report are based on the total number of calls overall or for each sector between 2002 – 2010.

- 1 in 10 of our calls are about abuse in care. This could be from any sector, i.e. care, health, education. However in an examination of whistleblowing claims under the Public Interest Disclosure Act 1998 (PIDA) in a ten year period, only 3% were about abuse.[3] This suggests a low awareness of the law or that such claims are more likely to be settled before they become public.

- In care, 55% of all calls were about abuse. 12% were about public safety, which includes patient safety. To obtain a deeper understanding of what was happening in the care sector, we took a control sample of 100 care cases, randomly selected over 8 years and identified further key themes.

- Of the 100 cases the most common concerns were as follows – physical abuse (27), vulnerable adults not being treated with dignity (21), neglect (17), administering medication (wrong medication, wrongly administered, not administered or thrown away) (15) and verbal abuse (12).

- Where a client had a concern about medication, they were less clear on how to raise the concern or the role of the Care Quality Commission.

- In 40% of all our care cases, concerns were initially ignored or denied by the organisation.

- Most concerns were first raised with a line manager. This is also where most concerns were ignored or mishandled, demonstrating a great need for training and awareness.

- In over half the cases where other staff were aware of issues, the whistleblower was the only witness to come forward.

- In only 8 of the 100 control cases was the whistleblower aware of a whistleblowing policy which they had been able to follow, the majority of these cases required

[3] *Where's whistleblowing now? 10 years of legal protection for whistleblowers*, Public Concern at Work, March 2010

prompting from our advisers.

- 41% of all clients and 40% of clients from the care sector reported no negative impact from raising their concern. This is a better picture than is commonly held in the public mind set.

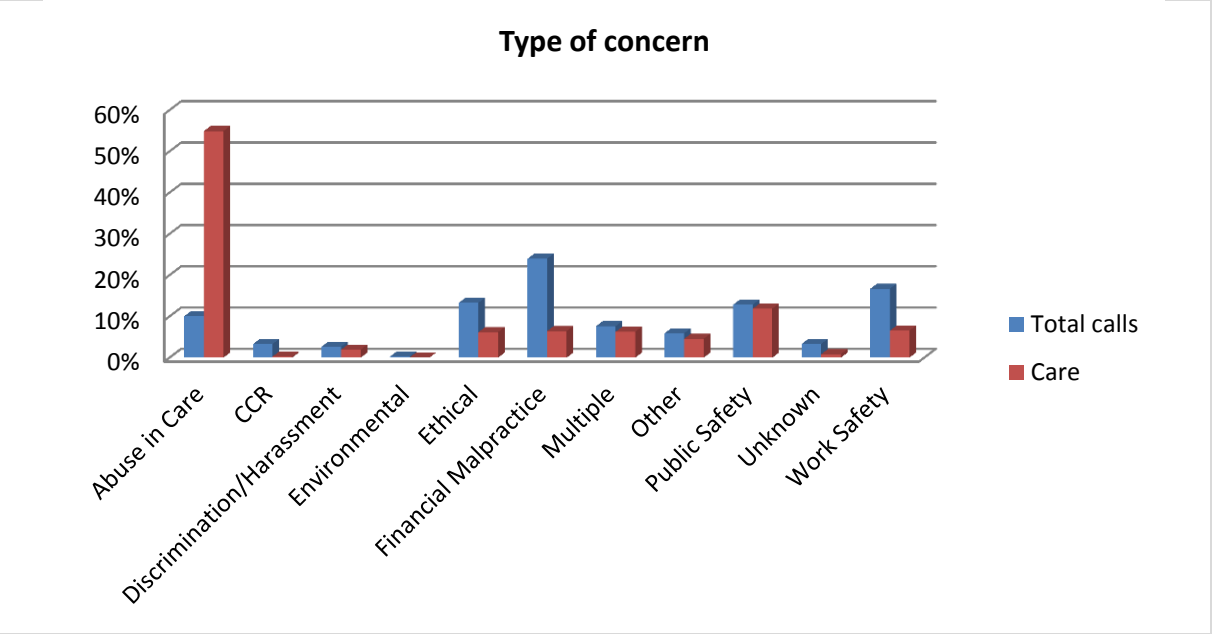
- In the care sector, 6% of individuals had raised their concern with a regulator[4] before they even contacted us. By way of comparison, this is the same in financial services sector, 3% in health and 4% in the charitable sector.

- Overall 75% of people had already raised their concern when they called us. In the care sector this figure increased to 80%. This indicates a low level of awareness of the support available in the sector and/or care workers may not realise they are "blowing the whistle" until they encounter difficulties having their concern addressed or are mistreated personally.

- The most common comment we receive in all our feedback surveys is clients wish they had spoken to one of our advisers before raising their concern. While much work needs to be done to deal with this by raising our profile, all organisations should know how vital it is to promote access to independent advice to their staff, be that from us, a union or elsewhere. However, only 20% of callers from the care sector were unionised – compared with 26% of callers to our helpline overall.

[4] PIDA has a tiered disclosure regime which most readily protects internal disclosures, i.e. to your employer or the responsible person. The second tier of disclosure would be to a regulatory body that is a "prescribed person" under 43F of PIDA. For a disclosure to be protected under 43F the individual must have good faith and reasonably believe "the information disclosed, and any allegation contained in it, are substantially true." In care the most relevant prescribed person is the Care Quality Commission.

Type of concern



Unsurprisingly a large number of calls from the care sector relate to a concern about abuse in care and this was the driving force behind our campaign. This is in comparison to 10% of our calls overall. On analysis of our control sample of 100 cases the types of concern fell into the following categories. Some cases involved multiple concerns.

Type of concern	No. of occurrences
Physical abuse	27
Failure to treat with dignity	21
Neglect	17
Administering medication	15
Conduct of staff	15
Verbal abuse	12
Training of staff	8
Incorrect lifting	7
Financial abuse	6
Understaffing	6
Illegal workers	2
Health and safety of staff	2
Sexual abuse	1

Of the control group we analysed themes and trends of the most frequent concerns to see if the type of concern impacted on how it was handled, how the caller was treated and who was informed.

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Physical abuse

Physical abuse, particularly where there was more than one witness, was in general handled well in comparison with other types of concern. It was also more likely that either the home, the family or the whistleblower informed the relevant team at the local authority or the relevant prescribed person for care (care regulator), commonly the Care Quality Commission (CQC) or the CQC's predecessor, the Commission for Social Care Inspectorate (CSCI). The care regulator was involved in 12 of the 27 cases concerning physical abuse. This is perhaps unsurprising given the seriousness of such a concern, clear signs such as bruising on a victim and a great deal of policy work has occurred in this area that helps workers have a clearer understanding of what to do.

Fred's story

Fred worked at a home for adults with learning disabilities. Fred and two other colleagues witnessed another employee kicking a client in the head when he would not get up. They reported this to their manager who said "oh why is it always you" and took no action. Fred and colleagues immediately took their concern to CSCI. There was a subsequent police investigation and the home suspended many members of staff.

Alice's story

Alice and another colleague witnessed Mark hitting residents, force feeding them and tweaking one resident's nipples. Alice's colleague did not have strong English skills so together they drafted a letter outlining their concerns. The manager reacted angrily and told other staff that Alice had complained. Alice was off sick for two weeks with depression, however on her return she took her concerns to the CQC. They informed the police.

Administering medication

The cases we analysed revealed where an individual was concerned about administering medication (including failure to administer drugs, administering incorrectly or mixing medication between residents) it was far less likely they knew who to speak to. Only three of the 15 cases involved a regulator. Usually there was only one witness in these circumstances and the individuals were unsure who to raise the matter with.

"The cases we analysed revealed where an individual was concerned about administering medication it was far less likely they knew who to speak to"

Asif's story

Asif was a domiciliary worker and was concerned about a change in medication. Previously the pharmacist had sorted the medication into blister packs by date and time, this way staff knew if they were administering the medication correctly and it was clear if a pack had been tampered with. Asif said they were now given the medication in bottles or unmarked packs and were meant to sign and date a chart when it was administered. However the charts were running out and were not always immediately replaced, offering no security for things going wrong. Asif wrote a letter with eight other concerned workers at the agency to the manager, asking for a meeting. The manager had not responded and Asif did not know where else to go and what to do.

Belinda's story

Belinda worked as a staff nurse at a residential home. Belinda was concerned that her colleague Peter, a staff nurse, who was in charge of liaising with the Commission for Social Care Inspection, was breaching the home's drugs policy. The policy stated that all medication left at the end of the month should either be destroyed or returned to the pharmacy. However Peter was keeping the leftover medication in a cabinet drawer to top up supplies if there was a discrepancy or medication was lost. Belinda was worried that the patients were at risk of not receiving medication or an overdose. Belinda was also concerned a local doctor had accepted confirmation of death over the telephone from the manager, without visiting the home. Belinda raised the drugs issue with her manager in confidence who said that what Peter was doing was for the good of the home. The manager then went on to reveal to Peter that Belinda had raised a concern. Belinda submitted a grievance and went off sick with stress. Belinda had contacted the care regulator in the past but had been told they do not deal with employment issues, which Belinda thought covered her current situation, and had not contacted them again as she did not think they would be able to help.

Neglect

From our research we noted neglect is often raised in conjunction with a concern about physical abuse, or was a symptom of financial abuse or financial mismanagement of a home (see below for more information on this). The latter usually resulted in understaffing, failure to meet care plans, failing to equip the home with necessary supplies (particularly in relation to lifting equipment). However as with physical abuse, care workers appeared to have a clearer understanding of what amounts to neglect and were more likely to raise a concern with social services or the regulator. Additionally, where

neglect was a concern, action was taken against wrongdoers more than in any other of our sub categories. While this may in some part be because neglect was often raised in conjunction with other issues, this may also be attributable to the fact that neglect is often visible to all, meaning corroborating witnesses and evidence are easier to find.

Financial abuse

Financial abuse can often lie at the heart of other problems, such as reports about neglect or malnourishment. Our cases reveal that while care workers are clearer about what to do when they witness physical abuse they may not know how to identify financial abuse or where to raise the matter. Financial abuse is often perpetrated by a person acting in a trusted position and they may also have control over the working environment. Further, and as is the case with many forms of abuse, a vulnerable adult may not be aware of the abuse or not wish to challenge the abuse due to embarrassment, lack of capacity, anxiety about their relationship with the abuser, denial or fear of the abuser.

"Financial abuse can often lie at the heart of other problems, such as reports about neglect or malnourishment"

Domiciliary workers and financial abuse

While this may be no more common in or outside a care home, with the drive for more individuals to be put in charge of their own social care budget, a worker may be faced with more complex problems and pathways to raise a matter as a lone worker. A failure to ensure clear pathways in those circumstances may result in damage to the positive impact of the personalisation agenda. A worker engaged with a vulnerable adult in the community may be the only outside contact beyond the family or at all. The challenges in such an environment are likely to be multiple and varied:

- the absence of a management line through which to raise a concern
- the worker's personal position is more at risk if the vulnerable adult is also their employer
- the concern relates to someone close to the vulnerable adult who can effectively shut the individual out of the working environment.

The role of the regulatory authorities and social services is thus likely to be all the more important in this area.

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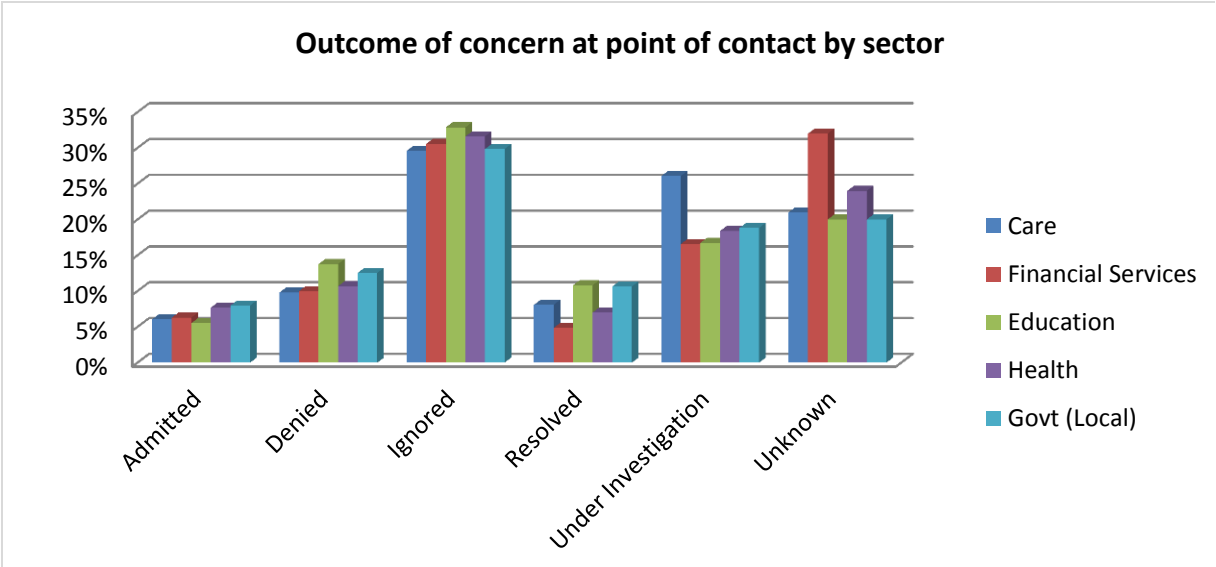
Adam's story

Adam worked for a company that provides care in the community. Adam was worried about a client, Jane, who was mentally disabled and needed a lot of support. Adam said Jane was being neglected as she did not have enough clothes suitable for the cold winter and she was not allowed haircuts or outings. Adam said Jane's mother had been on three expensive holidays in the last year and did not understand why the mother said Jane did not have the money for these things.

Adam went to his contacts at the company and said he was worried about emotional abuse. The company did not look into this concern. Adam returned months later with evidence and was told they were looking into the matter. Having not heard anything for a few months Adam decided to contact social services, who began an investigation and interviewed Adam. Adam was then told he had to attend a disciplinary meeting as the mother had made a complaint about his conduct.

While the employer eventually acknowledged the concern, Adam felt unable to continue working for them given their response and resigned.

Outcome of the concern at point of contact

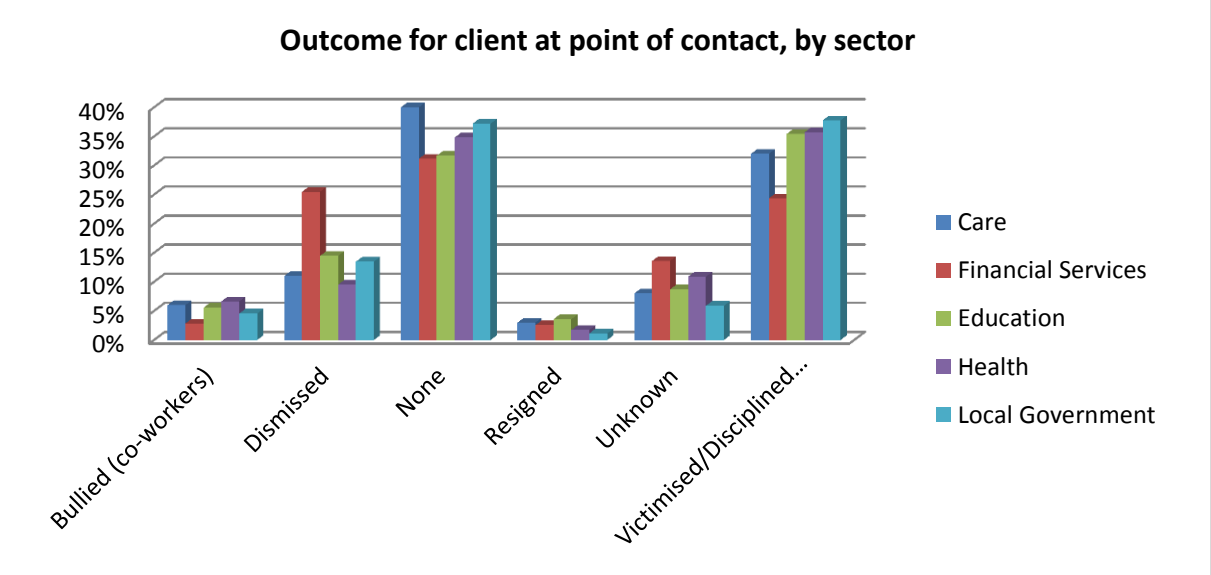


If the caller has already raised their concern we ask them what has happened with the concern so far. In the care sector more concerns are under investigation than in any other sector. Additionally less are ignored and this may be because of the seriousness of the issues involved (abuse/neglect/ financial abuse). Despite the care sector faring no worse, 40% of concerns are still ignored or denied. This is too high.

"A large number of our callers are worried about the lack of feedback"

Our research shows that a large number of callers to our helpline are worried about the lack of feedback. Having taken the difficult step of raising their concern, the lack of feedback from the organisation may lead to a sometimes mistaken view that their concern has been ignored. This may result in an individual taking a concern elsewhere which in turn could result in problems for an ongoing investigation or, worse, build the impression within a workforce that you might raise a concern, only for nothing to be done. This builds a negative culture and jeopardises an organisation's ability to encourage staff to raise a matter internally, at an early stage.

Outcome for client at point of contact



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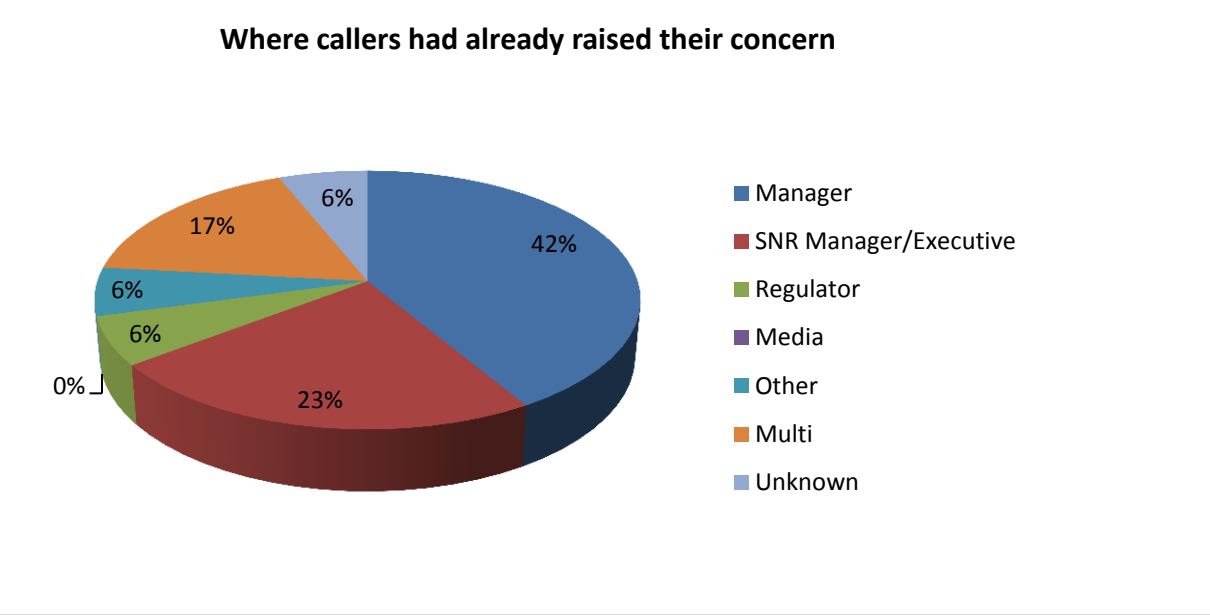
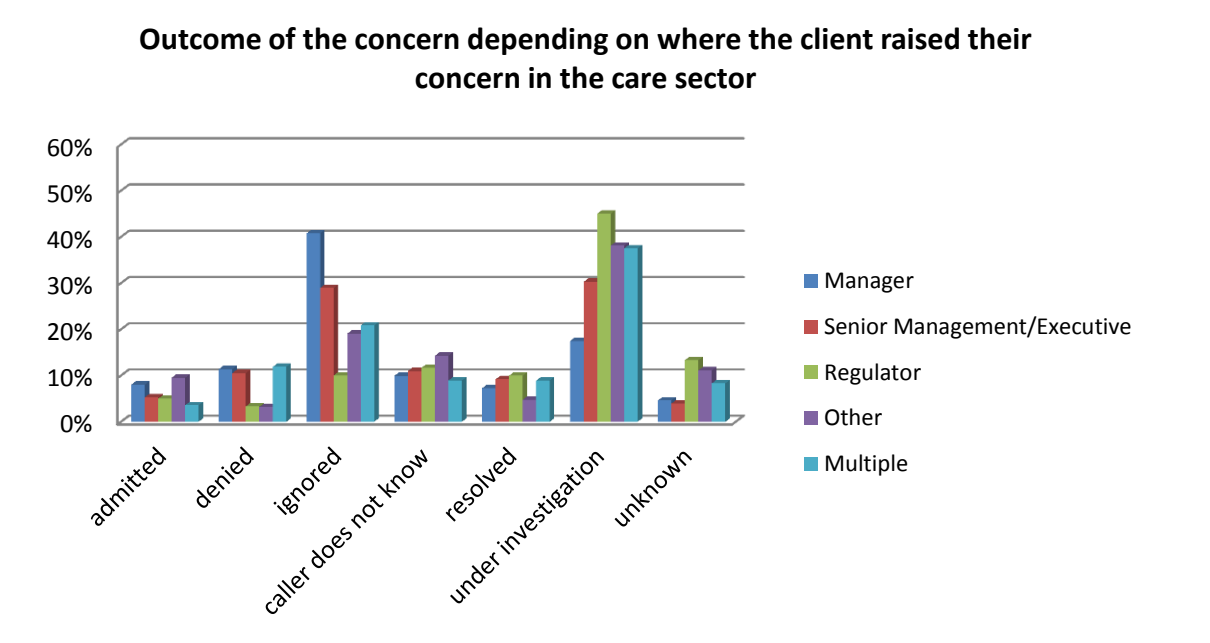
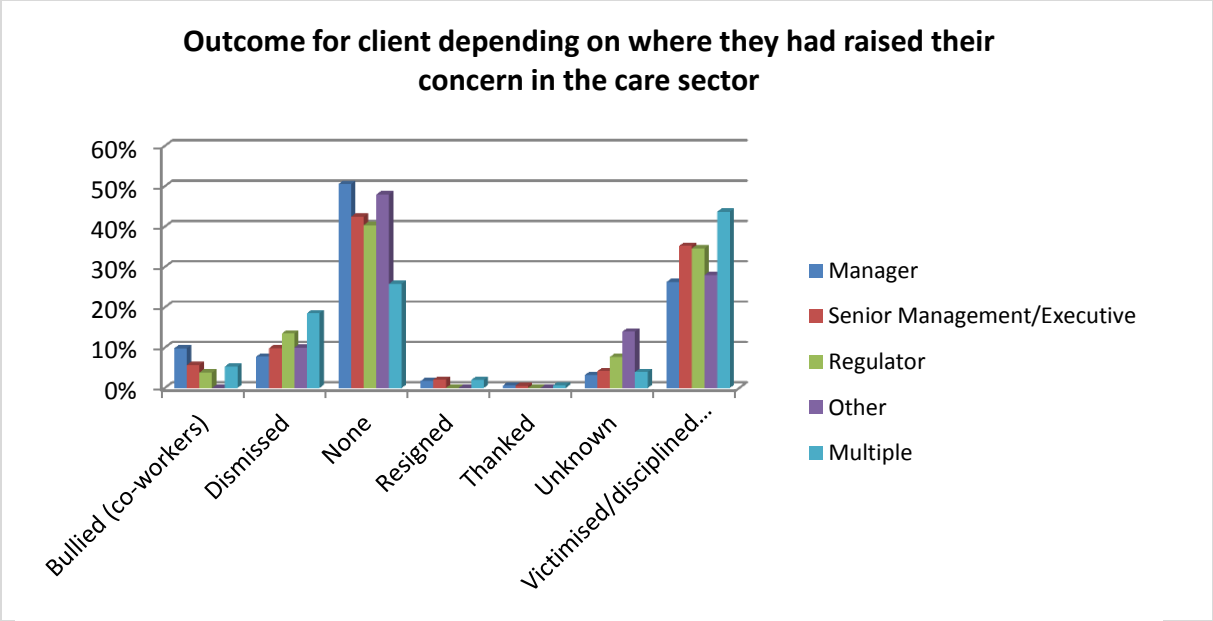
Where concerns are raised



This indicates the majority of workers in the care sector are raising their concern internally. Only 6% are raising a matter with a regulator and no one has already contacted the media when they call us. This indicates there is a huge opportunity for organisations to deal with a concern internally.

Outcome depending on where the concern is raised





The first graph indicates that if you raise the concern with a regulator it is more likely that your concern will be investigated. However, most individuals will only take the bigger step of raising a concern with a regulator if they consider it sufficiently serious. Additionally our data shows that those who raise a concern with many different people or in many different places are more likely to be subjected to negative treatment by management – either dismissal or disciplinary action.

The two graphs above taken in conjunction indicate the most common response from managers is to ignore or deny the concern and ignore the whistleblower. This suggests there is a training issue on handling and responding to concerns, revealing a missed opportunity for organisations to identify risks early, deal with the matter promptly and support those who speak up.

Simon's story

Simon worked as a senior care assistant. He had observed a change in behaviour in one of the nurses over the past year. Simon said he had seen this nurse slap residents and on one occasion saw the nurse put their hands around a resident's throat and force them into their room. Simon could only hear a scream and some banging after this. Simon was very worried as he felt unable to raise this internally. He did not trust the new manager as concerns had been ignored in the past and confidentiality breached (see page 18 for more on this case).

Other witnesses

When advising clients we ask if there are other witnesses and if they are able and willing to come forward as finding safety in numbers will encourage workers to raise a serious concern. Where there are no other witnesses it is a more daunting process for the whistleblower. This is compounded when confidentiality cannot be offered in situations where the wrongdoer is aware of what the whistleblower has seen. Significantly, it will be difficult for an organisation to address a concern if it is only one person's word against another.

From the control group of 100, in 8 out of 10 cases there were other potential witnesses – however in only half of these cases did other workers also raised their concern. Simon's story continues on page 18 and demonstrates how vital this can be in challenging abuse. A worrying 11% were too scared to come forward, usually due to a fear of the wrongdoer or management. In 30% of cases other workers were aware of the concern and did not come forward. Overall in half of the cases where other workers could have spoken up, the caller was the only witness to forward**.**

"in half of the cases where other workers could have spoken up, the caller was the only witness to come forward"

The danger of imposing a duty to report

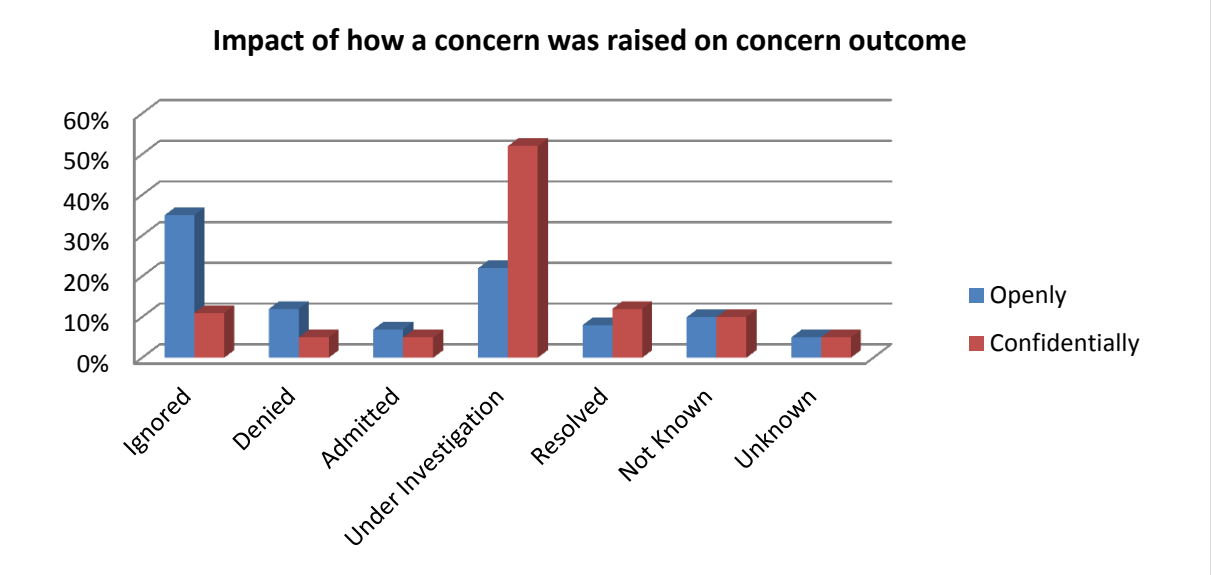
Some care providers, in an attempt to ensure they are informed about problems by staff, have introduced a blanket policy that staff must raise a concern. This, in our view, causes more problems than it solves and will not work as a shortcut to the work an organisation needs to do to ensure it is safe and accepted for staff to speak up. There are many reasons why this approach is counterproductive in practice and we have seen numerous examples of this on our helpline. For example, one group of clients were disciplined for a delay in raising their concern, despite the fact that their evidence was crucial in securing a successful prosecution and they had initially been genuinely fearful of the wrongdoer. Other clients have been dismissed for failing to co-operate with an investigation after threats of violence have led to a request to withdraw their evidence. The risk of imposing a duty to report for an organisation is that if staff feel too afraid to speak up immediately, they never will, for fear that they too will be subject to a reprisal. This jeopardises the quality of evidence available and the ability to take action against the real wrongdoers. Ultimately this will undermine confidence in the system.

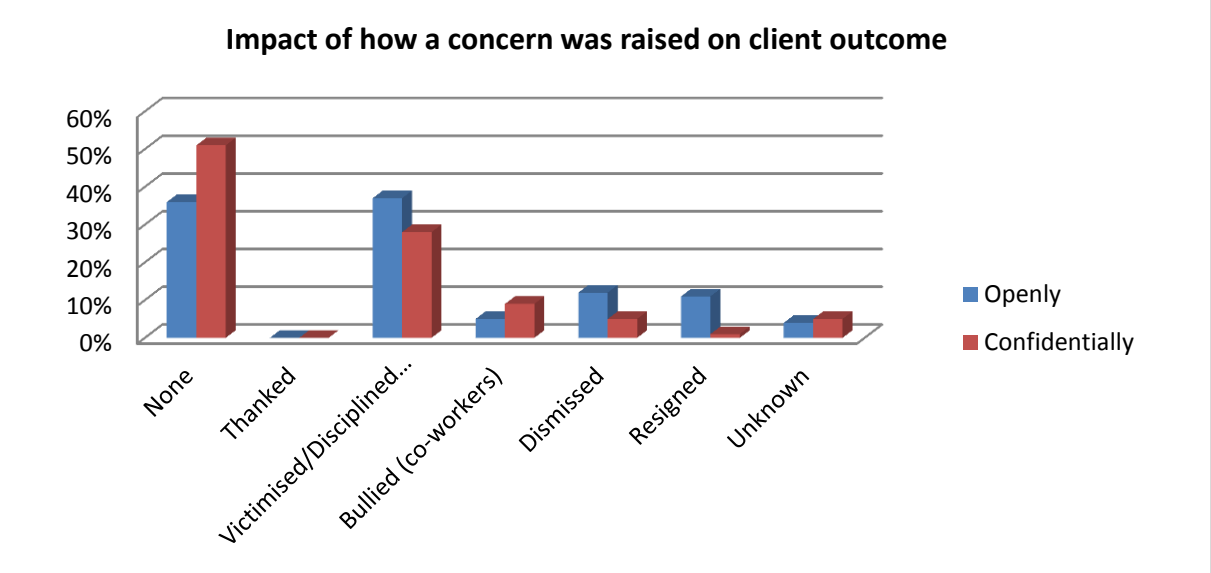
Anna's story

Anna worked at a residential care home for adults with learning difficulties. Anna had witnessed a care worker being rough with residents, culminating with a resident being yanked from a bed by his ankles onto the floor. Anna raised her concern internally and a witness statement was prepared. Off premises Anna was approached by the partner of the carer and her life was threatened if she did not withdraw her statement. Anna viewed

these threats to be genuine and asked to withdraw her statement. Despite assurances from her employer that they understood why she had taken this action, they dismissed her. Anna took a claim against the organisation under PIDA, which settled out of court for an undisclosed amount.

Outcome depending on how concerns are raised[5]





Callers report more positive outcomes if they have raised their concern confidentially. Two points can be drawn from this. Firstly the importance of providing good confidential

[5] Only 11 callers from the care sector had raised their concern anonymously.

options for individuals. Secondly, we are not yet where we need to be – individuals should be able to raise their concern openly and have it addressed appropriately.

Conversely, appropriate handling of confidentiality is a common problem area for organisations. Many organisations either fail to discuss with a member of staff the likelihood of someone guessing their identity, due to the very nature of the evidence or they do not realise what steps they can take to keep an individual's identity confidential, particularly where many individuals were witnesses. There is clear case law on how and when an organisation can use anonymised statements from staff when taking disciplinary action against another employee.[6]

Where a whistleblower's identity is revealed (or even suspected) this can lead to a particularly difficult situation for them, if the action taken by the organisation against the wrongdoer falls short of dismissal and they find themselves working side by side the following week.

Henry's story

Henry and other colleague witnessed a carer, John, hitting a resident across the back of the head with enough force to send them stumbling forward. Henry said although he was aware of other carers witnessing similar incidents, he was the only member of staff willing to raise the issue. Henry raised his concern with his manager, but no action was taken. A few weeks later Henry found the whistleblowing policy and raised the matter with the care regulator in confidence. The police and social services were involved, however his manager blurted out Henry's name in a meeting about the matter. On returning to work from a brief absence, Henry found himself ostracised by colleagues and left work upset. Henry was informed that his statement was the only evidence they had against John and as such it was possible John may return to work. Henry said he had tried to explain to colleagues why this had been the right thing to do, but this had only exacerbated matters. Henry said he did not feel able to return to work if he had to work with John.

Henry's case shows how organisations can unnecessarily miss opportunities to capture information at an early stage, protect the whistleblower, send out the right messages to staff, appropriately handle confidential information and ultimately protect vulnerable adults. The outcome for the organisation was the loss of a conscientious member of staff and reduced the likelihood of staff raising a concern in future.

[6] See Linfood Cash & Carry Ltd v Thomson [1989] IRLR 235 and Ramsey v Walkers Snack Foods Ltd [2004] UKEAT 0601_03_1302

Whistleblowing Policy

Of our control group only eight individuals had found a whistleblowing policy which they followed, a majority of these found and used the policy on prompting from an adviser at Public Concern at Work. Four had a policy that they did not want to use**.** This low awareness or lack of a good whistleblowing policy indicates a gap in good practice whistleblowing arrangements within the care sector. Many individuals will not know where to go outside of line management. If you couple the picture of many concerns being ignored at this level with a low awareness of a whistleblowing policy, a dangerous amount of information is being lost that could help prevent or limit harm.

"…low awareness or lack of a good whistleblowing policy indicates a gap in good practice whistleblowing arrangements within the care sector"

The role of independent advice

From our control group, the most common reason for contacting us was to escalate a concern (17), advice on their personal position (16), reassurance or support (13) or because the caller was being victimised for raising their concern (12).

We believe our free service is valuable and receive consistently high feedback on the helpline, with nine out of 10 helpline callers saying they would recommend our service to someone in a similar position. However, the most common feedback comment is that clients wish they had sought advice from us at an earlier stage. This is particularly the case in the care sector where over 80% call us after they have raised a concern, compared to 75% overall. Our advice is designed to avoid conflict and allow the whistleblower to be a good witness by raising the concern in a constructive way, minimising the risk to their own position. All staff should have access to support and advice, be it from a union, us or otherwise, and organisations should take steps to publicise our number and raise awareness of how and when to blow the whistle. This is all the more essential in a sector where fewer workers have access to advice from a trade union.

"All staff should have access to support and advice, be it from a union, us or otherwise"

Simon's story continued

When Simon called we spoke to him about what other options he may have if he was worried about speaking to the manager. Simon then raised the matter with the deputy

manager, who took his concerns seriously. Soon other workers felt able to come forward. Simon wrote to us some time later and said the following:

"I felt I had no one to turn to and was in a very difficult position. One of my biggest concerns was knowing who to tell so that I could be sure that they would take me seriously and effectively put a stop to the abuse. Your advice and support were invaluable at this time…although the weeks and months that followed were stressful and traumatic. I never regretted my actions…we had to give evidence in court for the prosecution, which we all found very difficult. We got through this ordeal by supporting each other and in the knowledge that we were doing the right thing. The defendant was found guilty of seven of the fourteen charges against him and sentenced to two years in prison."

Concluding comments

This first phase of our research highlights real problems for those who speak up in the public interest to protect vulnerable adults, but many simple things that can be done to improve the perceptions and experiences. The following steps for local authorities, regulators and care providers alike, would do much to improve matters:

1. Increased awareness among all workers of the signs of all variations of abuse

2. Proactive promotion of best practice whistleblowing arrangements that encourage open workplaces, help staff know when to raise a concern, how, with whom and give access to independent advice[7]

3. Training and guidance for managers on how to handle and elicit concerns, with particular attention on how to handle confidentiality

4. Demonstrable action in responding to the concern, providing feedback to the whistleblower and ensuring a zero tolerance attitude if a whistleblower is victimised for raising a concern

5. Clear, accessible pathways as to how and when to approach the local authority or the Care Quality Commission, particularly in relation to a concern about administering medication

While we have a lot of information from those who do speak up, the cases highlight there are many members of staff who speak up late or not at all.

The next phase of our research will involve a review of current systems for raising information both internally, with social services or the regulator to see where the gaps are and what improvements are necessary. More importantly we will be asking care workers what they see as the barriers and difficulties, and what we can do to remove them.

[7] For guidance see *PAS 1998:2008 Whistleblowing Arrangements Code of Practice, British Standards Institution*

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About Public Concern at Work

Public Concern at Work is the leading independent authority on whistleblowing in the UK. We run a free advice line for those who have witnessed crime, danger or wrongdoing at work. To contact our advice line call 020 7404 6609 or email **whistle@pcaw.org.uk**.

We also provide expert support and consultancy services to organisations wishing to implement effective whistleblowing arrangements. To contact us for services call 020 3117 2520 or email **services@pcaw.org.uk**.

For more information about who we are and what we do visit **www.pcaw.org.uk**.