Derby and Derbyshire Safeguarding Adults Boards

Organisational abuse: multi-agency guidance

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1. Purpose of this guide

This guide supports professionals working across all sectors to:

- Understand what organisational abuse is.
- Recognise indicators and risk factors.
- Respond appropriately and collaboratively to known or suspected organisational abuse.
- Apply relevant legislation and best practice.
- Promote a culture of safety, dignity, and accountability.

2. Safeguarding Adults Boards (SABs) resources

To ensure alignment with local safeguarding policy, procedures and expectations, the following official SAB documents should be referenced and linked within your internal policies and guidance:

- **Derby and Derbyshire Safeguarding Adults Policy and Procedures**

  Purpose: Sets out multi-agency responsibilities, safeguarding principles, definitions of abuse, and procedures for raising alerts and making referrals.

- **Derby and Derbyshire Safeguarding Adults Practice Guidance**

  Purpose: Offers operational guidance for professionals and volunteers across all agencies.

- **Adult Safeguarding Decision Making Guidance**

  Purpose: Supports professionals in determining when and how to make safeguarding referrals, distinguishing between poor practice, quality concerns, and abuse.

3. Legal definition of organisational abuse

Under the **Care Act 2014**, organisational abuse is defined as:

> "Neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies,

processes, and practices within an organisation." *Care Act 2014, Section 42*

This definition is supported by statutory guidance in **Chapter 14 of the Care and Support Statutory Guidance**, which outlines safeguarding duties and multi-agency responsibilities.

4. What is organisational abuse?

Organisational abuse refers to neglect or poor care practices resulting from systemic failures in a care setting. It can occur in:

- Residential and nursing care homes
- Hospitals
- Supported living
- Domiciliary care
- Educational or custodial institutions

It may involve:

- Multiple perpetrators or systemic neglect.
- A "closed culture" that discourages transparency.
- Harm to multiple individuals simultaneously.

5. Derbyshire County Council and Derby City Council – local authority safeguarding responsibilities

Under **Section 42 of the Care Act 2014** Care Act 2014 – Section 42, a local authority **must make enquiries**, or cause others to do so, if it has reasonable cause to suspect that:

1. An adult has **needs for care and support** (whether or not the authority is meeting any of those needs),
2. The adult is experiencing, or is at risk of, abuse or neglect, and
3. As a result of those needs, the adult is **unable to protect themselves** from the abuse or neglect or the risk of it.

These enquiries aim to determine:

- Whether any action should be taken
- If so, what and by whom

Derbyshire County Council works with partner agencies (for example, the police, NHS, care providers, community groups and others) to:

- **Prevent harm** before it occurs.
- Respond to safeguarding concerns through formal enquiries.
- Coordinate multi-agency safeguarding plans.
- Support adults to make informed choices and live free from abuse.

Professionals must:

- **Report safeguarding concerns** via the safeguarding adults referral process.
- Complete all required information to allow risk assessment.
- **Act immediately** if abuse is suspected.

6. Summary of key legislation and regulatory guidance

Legislation	Relevance to organisational abuse
Care Act 2014	Defines organisational abuse; mandates multi-agency cooperation.
Mental Capacity Act 2005 Mental Capacity (Amendment) Act 2019	Protects individuals lacking capacity; criminalises wilful neglect.
Children Act 1989	Safeguards children in institutional settings.
Criminal Justice and Courts Act 2015	Criminalises wilful neglect by care workers.
Safeguarding Vulnerable Groups Act 2006	Prevents unsuitable individuals from working with vulnerable people.

Legislation	Relevance to organisational abuse
Public Interest Disclosure Act 1998	Protects whistleblowers across all sectors.
Sexual Offences Act 2003	Defines and criminalises sexual offences, including those committed by individuals in positions of trust within care settings, ensuring that inappropriate sexual behaviour by staff or carers is recognised as a serious breach of duty and subject to legal consequences.
CQC Regulation 13 Regulation 13: Safeguarding service users from abuse and improper treatment - Care Quality Commission	The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. To meet the requirements of this regulation, providers must have a zero-tolerance approach to abuse, unlawful discrimination and restraint.
Human Rights Act 1998	Upholds dignity, autonomy, and protection from inhuman treatment.

7. Indicators of organisational abuse: how to recognise the signs

Organisational abuse can manifest in various ways across different settings. Recognising the signs early is crucial for safeguarding individuals and preventing harm. The full checklist to support in identifying organisational abuse can be found at Appendix 3.

General Indicators (applicable across all settings):

Lack of person-centred care	Individuals are treated as a group rather than as unique people with specific needs.
Rigid routines	No flexibility in daily activities such as meals, sleep, or personal care.
Inappropriate restraint or confinement	Use of physical or chemical restraint without justification or consent.
Unsafe or unhygienic environments	Poor cleanliness, inadequate infection control, or unsafe facilities.
Disrespect for cultural, religious, or personal preferences	Ignoring dietary needs, religious observances, or personal choices.
Over-medication or misuse of medical procedures	Use of sedatives or invasive procedures without clinical need.
Lack of stimulation or meaningful activity	Individuals left idle, isolated, or without access to enriching experiences.

Staff controlling finances or personal decisions	Involvement in financial matters without consent or transparency.

Additional examples of indicators by sector:

Health and Care Settings (i.e. hospitals and care homes)

- Repeated missed medications or treatments.
- Patients left in soiled clothing or bedding.
- Staff ignoring calls for help or pain relief.
- Lack of privacy during medical procedures.

Education Settings

- Excessive discipline or punishment.
- Lack of emotional support or pastoral care.
- Students discouraged from expressing concerns.
- Inflexible timetables that ignore individual needs.

Housing and Supported Living

- Tenants not supported to access community services.
- Unsafe living conditions (e.g., broken heating, poor sanitation).
- Staff making decisions without tenant involvement.
- Lack of support for independent living skills.

Custodial or Secure Settings

- Excessive use of isolation or control.
- Denial of access to legal or advocacy support.
- Lack of access to healthcare or rehabilitation.
- Disrespectful or degrading treatment by staff.

Voluntary and Community Sector

- Volunteers not trained in safeguarding.
- Failure to report concerns due to fear or lack of knowledge.
- Individuals discouraged from participating or voicing concerns.

8. Best practice for multi-agency working

Prevention

To prevent organisational abuse, it is essential to foster open and transparent cultures where concerns can be raised without fear. Staff across all sectors must receive robust and ongoing training to ensure they understand safeguarding responsibilities, person-centred care, and how to identify and respond to known or suspected abuse. Whistleblowing should be actively encouraged, with clear protections in place for those who report concerns. Additionally, prevention efforts should include joint audits and inspections across agencies to identify risks early, promote accountability, and ensure continuous improvement in care standards.

Response

Effective response to organisational abuse requires the use of clear and well-established escalation routes to ensure concerns are addressed promptly and appropriately. Information must be shared across agencies to enable coordinated safeguarding action and prevent further harm. Safeguarding meetings with providers should be held to clarify concerns, agree on actions, and promote transparency. Where risk is high, immediate action must be taken without delay. It is also essential to distinguish between safeguarding issues—which involve risk of harm or abuse—and quality concerns, which may affect service standards but not necessarily pose immediate danger. This distinction helps prioritise interventions and ensures the right processes are followed.

9. Key differences between safeguarding concerns and quality concerns

Quality concerns

These relate to **substandard care or service delivery** that may not pose an immediate risk of harm but could affect wellbeing if persistent or unaddressed.

Examples:

- A one-off missed meal or poor-quality food.
- A medication error that is identified and corrected before harm occurs.
- A fall resulting in minor injury, with appropriate medical response and care plan review.
- Temporary understaffing causing delays in care but not harm.

Response:

- Report to the service provider or manager.
- Monitor for patterns or escalation.
- Refer to commissioning or regulatory bodies (e.g. CQC).
- May trigger contractual or quality assurance actions.

Safeguarding concerns

These involve **actual or potential harm, abuse, or neglect**, especially where individuals are unable to protect themselves due to care and support needs.

Examples:

- Repeated missed meals or nutritionally inadequate food.
- Medication errors or omissions that result in harm or are part of a pattern.
- Falls with no risk assessment, medical response, or care plan review.
- Signs of physical abuse, unexplained injuries, or emotional withdrawal.
- Closed cultures, poor leadership, or systemic neglect.

Response:

- Must be reported to the local authority under **Section 42 of the Care Act 2014**.
- May trigger a **safeguarding enquiry**, multi-agency response, or police involvement.
- Requires risk assessment and protection planning.

When should quality concerns be addressed as organisational abuse?

Organisational abuse arises when **systemic failings** in care settings lead to **widespread harm or risk**. This often involves:

- Multiple individuals affected.
- Persistent poor practice or neglect.
- Lack of leadership, supervision, or training.
- Defensive or closed culture.
- Failure to act on complaints or feedback.

Example:

- **'**Unsafe moving and handling, poor medication management, lack of care planning, and absence of risk assessments across a service – affecting multiple residents – constitutes organisational abuse'.

Use of Professional Judgement and Escalation

If you're unsure whether an issue is safeguarding or quality (Appendix 4):

- Use **professional curiosity** to explore the context.
- Share concerns early with safeguarding leads or quality teams.
- Look for patterns, persistence, and impact.
- Consider whether the issue affects **one person or many**, and whether harm has occurred or is likely.

Contractual Actions

Health and social care are commissioned by the local authority or the ICB. Where care and support are commissioned jointly, commissioners will work as part of a multi-agency team to identify and respond to concerns. When organisational abuse is identified, a range of contractual actions may be taken to safeguard individuals and take steps to improve service standards. These may include **contractual sanctions**, such as the suspension of placements. In cases of systemic failure, or failure to improve following a period of monitoring and support the commissioner may choose to terminate contracts or remove providers from their framework. In this scenario **alternative provision** will need to be sourced to ensure safe and appropriate care or housing.

Regulatory Actions

The Care Quality Commission may impose **enforcement actions** where a provider is in breach of regulation. Examples of enforcement action could include warning notices, restriction to a provider's registration. Where the Care Quality Commission identifies significant failings, they can take action which will result in cancellation or suspension of registration. This will result in the provider being unable to deliver regulated activity and alternative provision will need to be sought for people using the services. Where abuse or neglect meets the threshold for criminal behaviour, a **criminal investigation** may be initiated, potentially leading to prosecution of individuals or organisations responsible.

10. Whistleblowing and confidential reporting

All agencies with safeguarding responsibilities should have clear and accessible whistleblowing policies that enable individuals to report concerns safely and without fear. These policies must include robust protections against retaliation, ensuring that those who speak up are not subject to victimisation or disadvantage. Promoting a culture of accountability is essential, where staff and volunteers feel empowered to raise issues and where concerns are taken seriously and acted upon promptly.

Appendix 1 – Case studies

These cases illustrate how organisational abuse can stem from systemic failures, poor leadership, and closed cultures. They also highlight the importance of whistleblowing, family advocacy, and robust safeguarding procedures.

1. **Winterbourne View Hospital (2011)**

   Setting: Private hospital for adults with learning disabilities and autism
   Location: South Gloucestershire
   Exposure: BBC Panorama undercover investigation

   Key issues:

   - Staff were filmed physically assaulting and emotionally abusing patients.
   - Use of restraint was excessive and punitive.
   - Management ignored whistleblower concerns.
   - Regulatory oversight by the CQC failed to detect abuse.

   Outcome:

   - Hospital closed.
   - Multiple staff members prosecuted.
   - Led to national policy changes including the **Transforming Care Programme**

   Key lessons:

   - **Closed cultures** can hide abuse from external scrutiny.
   - **Whistleblowers must be supported:** staff raised concerns but were ignored.
   - **Regulatory bodies need robust inspection frameworks**: CQC missed warning signs.
   - **Training and supervision are critical:** staff lacked skills to manage complex needs.
   - **Multi-agency coordination is essential:** failures in communication between health, social care, and regulator.

2. **Whorlton Hall (2019)**

   Setting: Specialist hospital for people with learning disabilities and autism

Location: County Durham
Exposure: BBC Panorama undercover filming

Key issues:

- Staff mocked, intimidated, and physically abused patients.
- Culture of bullying and fear among staff and residents.
- Whistleblowers were ignored or silenced.

Outcome:

- Hospital closed.
- Criminal investigations launched.
- Renewed scrutiny of closed cultures in care settings

Key lessons:

- **Bullying and intimidation by staff** can become normalised in isolated settings.
- **Undercover investigations revealed systemic abuse**, not just individual misconduct.
- **Leadership accountability is vital:** management failed to act on concerns.
- **Safeguarding must include culture audits:** not just compliance checks.
- **Staff attitudes and values matter:** recruitment must assess emotional intelligence and empathy.

3. **Coventry Care Home Case**

Setting: Residential care home
Victim: 71-year-old woman with Alzheimer's
Exposure: Family installed a hidden camera

Key issues:

- Carers dragged the woman by her wrists.
- Denied food and drink despite her diabetic condition.
- Ignored pleas to use the toilet.
- Bruising and distress prompted family action.

Outcome:

- Carers prosecuted.
- Highlighted the importance of family vigilance and hidden abuse

Key lessons:

- Family involvement can be crucial: hidden cameras exposed abuse.
- **Neglect can be subtle but harmful:** denial of basic needs like food and toileting.
- Safeguarding must include dignity and respect not just physical safety.
- **Training in dementia care is essential:** staff failed to understand the woman's needs

4. **Eldertree Lodge (2021)**

Setting: Mental health hospital
Exposure: CQC inspection and whistleblower reports

Key issues:

- Staff dragged patients to seclusion rooms.
- Poor staff training and supervision.
- Closed culture discouraged external oversight.

Outcome:

- CQC issued enforcement actions.
- Police investigated potential criminal offences

Key lessons:

- Use of restraint must be monitored and justified: patients were dragged and secluded.
- Staff competency must be regularly assessed: training alone is not enough.
- Whistleblowing mechanisms must be accessible and trusted.
- CQC enforcement powers must be used proactively: delays can prolong harm.

Key themes:

- **Culture matters**: Organisational abuse often stems from toxic or closed cultures.
- **Safeguarding is everyone's responsibility**: Across health, social care, education, and housing.
- **Transparency and accountability**: Regular audits, open-door policies, and external oversight are essential.

- **Empowerment of individuals**: People receiving care must be supported to speak up and be heard.
- **Multi-agency collaboration**: Effective safeguarding requires coordinated responses across sectors.

Appendix 2 – Resources

Organisational abuse refers to **neglect and poor care practice** within an institution or care setting, often resulting from **systemic failings** such as poor leadership, inadequate staffing, and rigid routines. It can affect multiple individuals and may be normalised within the culture of the organisation.

- Care Learning – What is Organisational Abuse?
- SCIE – Adult Safeguarding Practice Questions
- CQC Regulation 13 – Safeguarding from Abuse and Improper Treatment

National Guidance and Tools

Local Government Association (LGA)

A central hub of resources including:

- Definitions and indicators
- Closed cultures guidance
- Whistleblowing support
- Advocacy and Making Safeguarding Personal
- LGA Organisational Abuse Resource Page

Safeguarding Adults Reviews (SARs) Linked to Organisational Abuse – National Analysis of SARs (2019–2023)

This report analyses 652 SARs and highlights:

- Organisational abuse in closed environments
- Missed opportunities to identify systemic neglect
- Recommendations for sector-wide improvement
- Download the full SAR analysis report (PDF)

Best practice and prevention

- Promote person-centred care
- Encourage whistleblowing and transparency
- Ensure adequate staffing and training
- Use advocacy and safeguarding culture tools
- SCIE – Creating a Safeguarding Culture
- CQC – Safeguarding Quality Statement

Safeguarding Adults Board (DSAB) resources

The Derby and Derbyshire SAB websites provide extensive guidance, policies, and procedures for professionals working with adults at risk.

- Derby and Derbyshire Safeguarding Adults Policy and Procedures (PDF)
- Adult Safeguarding Decision-Making Guidance (PDF)
- Derby and Derbyshire SABs Policies, Procedures and Practice Guidance
- Derbyshire SAB Homepage
- Safeguarding adult reviews - Derbyshire Safeguarding Adults Board
- Derby SAB Homepage
- Safeguarding Adults Reviews – Derby SAB

These documents include definitions of organisational abuse, indicators, and decision-making frameworks for safeguarding referrals.

Legislation relevant to organisational abuse

- Care Act 2014 Care Act 2014 – Safeguarding Adults at Risk of Abuse or Neglect

The cornerstone of adult safeguarding legislation in England. It defines organisational abuse and sets out duties for local authorities.

Key sections:

- **Section 42** – Duty to make enquiries
- **Section 44** – Safeguarding Adults Reviews (SARs)
- **Section 43** – Establishment of Safeguarding Adults Boards

Other Relevant Legislation

- Mental Capacity Act 2005
- Safeguarding Vulnerable Groups Act 2006
- Sexual Offences Act 2003
- Public Interest Disclosure Act 1998 (Whistleblowing)

Regulatory Guidance

Care Quality Commission (CQC)

CQC enforces standards under the Health and Social Care Act 2008. Regulation 13 is particularly relevant to organisational abuse.

- CQC Regulation 13 – Safeguarding from Abuse and Improper Treatment

Social Care Institute for Excellence (SCIE)

SCIE provides best practice guidance for care homes and safeguarding professionals.

- SCIE – Safety and Safeguarding in the Care Home

Appendix 3 – Checklist of indicators of organisational abuse

Organisational abuse can manifest in various ways across different settings. Recognising the signs early is crucial. Below are some examples to look out for – professional curiosity is key:

Person-centred care and individual rights

☐ **Lack of person-centred care—individuals treated as a group.**
Example: Everyone is given the same meal regardless of dietary needs or preferences.

☐ **Decisions made without involving the individual.**
Example: Staff choose when someone goes to bed without asking them.

☐ **No support for independence or informed choice.**
Example: A person who can manage their medication is not allowed to do so.

☐ **Treating adults like children.**
Example: Using baby talk or infantilising language with older adults.

☐ **Disregard for cultural, religious, or personal preferences.**
Example: Ignoring requests for halal food or prayer time.

☐ **No provision for cultural or religious observance.**
Example: No space or support for religious practices like Sabbath or Ramadan.

☐ **Expressions of feeling powerless or unheard.**
Example: A resident repeatedly says, “no one listens to me” or “I don’t matter.”

Staffing and Leadership

☐ **Low staffing levels leading to rushed or missed care.**
Example: Staff skip bathing or meals due to time constraints.

☐ **High staff turnover disrupting continuity and relationships.**
Example: A person sees a new carer every week and struggles to build trust.

☐ **Inadequately trained staff lacking safeguarding, communication, or care skills**
Example: Staff fail to recognise signs of distress or abuse.

☐ **Poor supervision or leadership allowing poor practice to go unchecked.**
Example: A manager ignores complaints about rough handling.

☐ **Staff burnout or stress affecting care quality and attitudes.**
Example: Staff appear impatient, disengaged, or emotionally unavailable.

☐ **Unclear roles and responsibilities causing confusion and neglect.**
Example: Medication is missed because no one knows who is responsible.

Culture and Organisational Practice

☐ **Closed culture discouraging external oversight or whistleblowing.**
Example: Staff are told not to speak to inspectors or family members.

☐ **Task-focused routines prioritising efficiency over dignity and choice.**
Example: Everyone is toileted at the same time, regardless of need.

☐ **Resistance to change or external input.**
Example: Staff dismiss new training as “not relevant here.”

☐ **Punitive or controlling approaches to behaviour.**
Example: A person is isolated for shouting due to distress.

☐ **Arbitrary decision-making by staff.**
Example: Staff decide who gets to go outside based on mood or favouritism.

☐ **Failure to act on complaints or concerns.**
Example: Repeated reports of rough handling are ignored.

Environment and Daily Life

☐ **Unsafe or unhygienic physical environment.**

Example: Dirty bathrooms, cluttered hallways, or broken equipment.

☐ **Stark or deprived living areas.**
Example: Bedrooms lack decoration, personal items, or warmth.

☐ **Lack of stimulation or meaningful activity.**

Example: People sit in silence all day with no interaction or engagement.

☐ **Rigid routines with no flexibility in meals, bedtimes, or activities.**
Example: Breakfast is served at 7am sharp, regardless of individual preference.

☐ **Lack of privacy or dignity in care tasks.**
Example: Personal care is provided with doors open or in communal areas.

☐ **No access to personal belongings or clothing.**
Example: Individuals wear communal clothes and cannot access their own items.

Restrictive Practices and Medical Oversight

☐ **Inappropriate use of restraint or seclusion.**
Example: A person is locked in their room for shouting.

☐ **Overuse of medication to manage behaviour.**
Example: Sedatives are routinely used to keep people quiet.

☐ **Use of unprescribed medical procedures.**
Example: Staff administer medication without proper authorisation.

☐ **Over-medication or misuse of medical procedures.**
Example: Antipsychotics are used without review or consent.

Financial and Decision-Making Control

☐ **Staff involvement in personal finances without consent.**
Example: Staff buy items using a resident's money without permission.

☐ **Unnecessary staff involvement in personal finances.**
Example: Staff manage bank accounts for individuals who are capable.

☐ **Staff controlling finances or personal decisions.**
Example: A person is not allowed to choose how to spend their money.

Behavioural and Emotional Indicators

☐ **Fearfulness or withdrawal around staff.**
Example: A person flinches or avoids eye contact when staff approach.

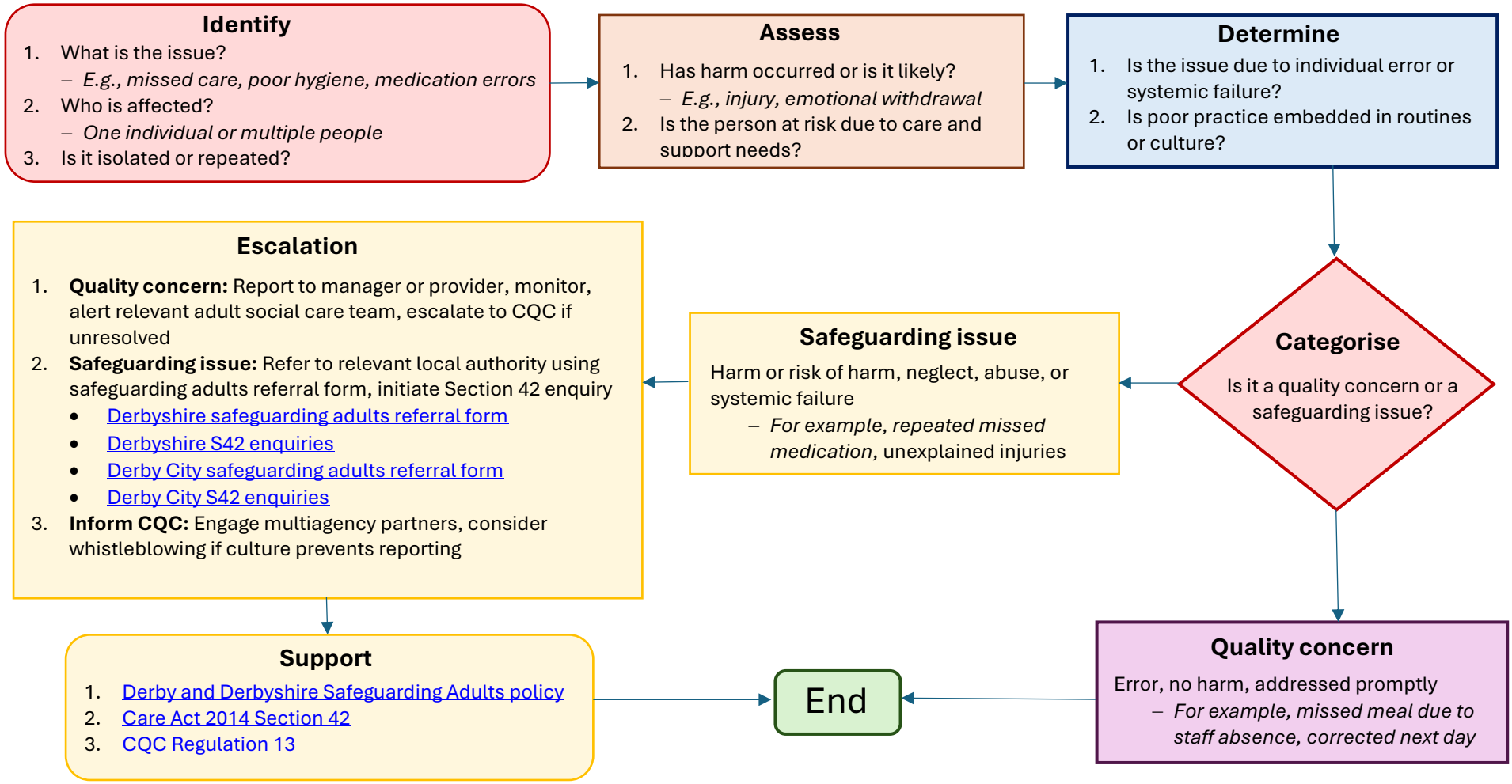
☐ **Sudden changes in mood or behaviour.**
Example: A previously sociable person becomes withdrawn or aggressive.

☐ **Reluctance to engage with services.**
Example: A person refuses to attend activities they once enjoyed.

☐ **Withdrawal from family or community contact.**
Example: Phone calls or visits are discouraged or blocked.

☐ **Unexplained injuries or deterioration in health.**
Example: Bruises or weight loss without documented cause

Appendix 4 – Decision-making flowchart: safeguarding vs quality concerns in organisational abuse



Appendix 5 – Reference list

National Guidance and Practice Tools

- SCIE – Adult Safeguarding Practice Questions
- SCIE – Creating a Safeguarding Culture
- CQC – Safeguarding Quality Statement
- Local Government Association – Organisational Abuse Resource Page

Safeguarding Adults Boards policy, procedures and practice guidance

- Derby and Derbyshire Safeguarding Adults Policy and Procedures (PDF)
- Derby and Derbyshire Safeguarding Adults Practice Guidance (PDF)
- Adult Safeguarding Decision-Making Guidance (PDF)

Case Studies and Reviews

- Winterbourne View (2011) – Serious Case Review (PDF)
- Whorlton Hall (2019) – Durham SAB SAR (PDF)
- Coventry Care Home Case – Coventry SAB Life Story
- Eldertree Lodge (2021) – CQC Closure Report

National Programmes and Reviews

- Transforming Care Programme – NHS England Overview
- National Analysis of SARs (2019–2023) – Safeguarding Adults UK (PDF)

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