

Herman Goldstein Award Submission 2018

The Croft Unit: Who's Behaving Badly?



Altogether Better Policing

1. Summary

The Croft Unit, Stanley is a Durham County Council commissioned private service, which offers around the clock supported accommodation for adult service users with behavioural and mental health issues, such as; schizophrenia; depression; bipolar disorder; self-harm; panic disorder; obsessive-compulsive disorder; attention deficit disorder; alcohol addiction and autism. The purpose of the unit is to offer short term support in order to help these vulnerable residents live independently.

In 2015 it became apparent that the calls for service to the Croft Unit were increasing and vulnerable residents were being criminalised. Scanning and analysis pointed to a number of elements associated with the higher frequency of calls; poor staff training and a lack of ability to diffuse escalating situations was a dominant factor. This was due to the complex needs of the residents not being met as a result of inadequate training of the staff employed to look after them. Also staff were using police to get problematic residents removed for the night and in doing so, criminalising them. Policies relating to notifying management of incidents where there was a police requirement were not being adhered to.

As a profit making organisation, the gap in service provision left by severe underfunding of skilled, capable staff at The Croft Unit was being filled by police. In particular, it was established that there was a significant increase in demand on police to deal with calls for service at the Croft Unit out of office hours. This demand was having a huge impact on the ability of the response teams working 24/7 shifts to deal with other incidents. In particular, the incidents at the Croft Unit were time consuming and difficult, involving high levels of reported crime, missing persons and concerns for safety. The problem solving plan set out to identify the reasons why police were being repeatedly called to the Croft Unit, the difficulties faced once there in dealing with incidents expeditiously and if it was justified and necessary to criminalise the residents at the unit.

The response was to hold management responsible for the Croft Unit to account in order to ensure they complied with the required professional standards. By forming a strong partnership with the governing body of such facilities, three years on from the implementation of the plan there has been a 94% reduction in calls to the Croft Unit.

2. Scanning

The nature of the problem was that the Croft Unit accounted for the largest percentage of crime within the Stanley area. The number of calls for service was continuing to rise and the nature of these calls and the people involved meant that there were barriers and policies in place that needed to be overcome in order to deal with them satisfactorily. Calls for service led to time consuming investigations involving appropriate adults and protracted incidents where suitable places of safety and mental health assessments needed to be sought for residents. In particular 71% of incidents were being reported between 5pm and 9am when the number of available officers is reduced. Officers were dealing with incidents in a “doing what we’ve always done and getting what we’ve always got” manner. The absence of Croft Unit management and other partner agencies outside of office working hours led to officers “having their hands tied” when it came to options for how to deal proportionately with incidents at the unit. The overall impact was that this prevented officers from managing other demands as they were consumed with chronic, drawn out issues at the unit. This presented a huge risk to the Police as prolific criminals and other areas of risk and demand could not be managed effectively.

This problem was identified through the awareness of officers repeatedly dealing with similar incidents and contacting the Neighbourhood Inspector with their concerns. Officers recognised that they were repeatedly dealing with the same staff and residents and voiced their concerns. This was both in writing to the Inspector and in the submission of vulnerable adult forms which are submitted to social services. Scanning of these forms showed that there were a number of concerns raised regarding the training and ability of staff to deal with residents in terms of their needs, restraints, violence and any other offences within the unit. It also highlighted that some staff displayed an attitude that “it was not their problem” and that the Police should deal with matters criminally or take responsibility for residents. Scanning identified that 82% of calls for service were made by staff to Police as opposed to the residents living at the unit.

At the time of scanning in June 2015, there had been 164 Calls for service at the Croft Unit in the previous 18 months. These ranged from crimes relating to violence against the person, sexual offences, criminal damage and public order amongst others. During this time there were 29 arrests for offences of violence against the person and criminal damage. 42 crimes were progressed to criminal proceedings and dealt with by means of a Police Caution or Charge. 73% of these crimes were committed against staff members or the Croft Unit i.e. Criminal damage to the Croft Unit or its contents. Non-crime related calls sighted unruly anti-social behaviour by service Users. Missing from home reports and concerns for safety accounted for the highest volume of calls. Alcohol consumption was also a major factor in many incidents.

The issue was selected for special attention as the demand from the Croft Unit meant that other risks were not being managed. In particular the risk posed by an active prolific burglar in Stanley during 2014-2016. This meant that during the night time when calls for service were at their highest, officers were not able to carry out taskings and patrols relating to the subject. In turn he was able to continue to commit crime throughout the night and this was happening numerous times each week. This in turn led to a demand on officers during the dayshift who had to investigate the burglary, take statements, forensics, CCTV etc. Burglary has a psychological impact on its victims and impacts on confidence in the police, especially given that Police struggled to get the evidence to bring this offender to justice. Also the protracted, time consuming and what appeared to be continuous and fruitless attempts of officers to deal with incidents expeditiously, impacted upon the wellbeing and motivation of Officers dealing with the unit. This reinforced the importance of solving the problem.

3. Analysis

Location – The Croft Unit:

- The location provided care for up to 25 people with mental health needs and supported daily living activities. The unit offered people with high support needs a package which included individualised support & care, in a stable environment, aiding activities of daily living.
- The care home was an adapted three story building located within its own grounds. There were 23 single bedrooms in total. There were also two flats with a kitchen, lounge, bedroom and toilet facilities. These were used to promote independent living. There were a variety of communal rooms.
- There were 24 people accommodated at the home in 2014-2015. This was essentially full capacity.
- The unit was in a residential street with rows of terraced housing either side and within close proximity.
- The home had proper policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The staffing levels for the home were one deputy manager, one senior and two support workers on duty from 8am till 10pm each day. During the night there were two ‘waking support’ staff on duty.
- A senior member of staff was on call during the night and weekends to respond to emergencies.
- There was a high turnover of staff who were low paid. This was a demanding role and therefore experience was lost, leading to lack of understanding and a lack of consistency in tackling issues.
- The unit operated on a set of rules which residents would accept and agree when starting their tenancy. The rules allowed for the consumption of alcohol on site, within communal areas until 11pm.

Victim – Staff & Community:

Staff

- The unit used a dependency tool to calculate the minimum number of staff that should be allocated in each area of the home during the day and night.
- A senior member of staff was always on call during the night and at weekends to respond to emergencies. The policy being that, unless urgent, duty staff should notify the on-call supervisor during out of hour times prior to a call being placed to police. This policy was not being followed by staff.
- Failure to adhere to this policy led to staff routinely reporting very minor incidents as assaults.
- Many staff members were the victims of assault and a select few were repeat victims. All of these assaults were injuries consistent with a common assault. These injuries can include; grazes; scratches; abrasions; minor bruising; swellings; reddening of the skin and superficial cuts.
- All offences of damage were minimal value and committed against the property e.g. damage to a hoover and window.
- Management acknowledged that there were varying degrees of capability/resilience within their staff and that this was contributing to some of the over-reporting to Police and non-conformity with reporting protocols.
- Staff appeared to be embellishing calls to police to elicit a more timely response and accounted for the largest percentage of victims of crime at the unit.
- Every person who lived at the home had a care plan which staff had access to. They describe in detail how people were cared for and have an assessment of their needs including how staff would support these needs. The assessments provided sufficient information about the users' conditions. These records were written, reviewed and updated by senior support staff, deputy manager and the registered manager to make sure they were up to date and people received the care they needed. In every

area of need there was a description of the actions staff were to take. This meant staff had the information necessary to guide their practice and meet these needs safely.

- Staff in possession of the care plans informed police that in many instances there had been an escalation in behavior that eventually led to a crisis where the police were called and arrests made. This led to the questioning of the possibility that the care plans were not managed effectively and there was a lack of interventions being initiated at an early stage to avoid the crisis point being reached.

Community

- Community tensions were increasing regarding the volume and frequency of police presence at the Croft Unit. As the police deployment protocol means that officers are routinely single crewed but the number of officers deployed is based on risk, each incident would involve a number of police vehicles at the location. The perception of the unit to the local community was that it was a 'bail hostel' where crime was committed regularly and not a facility that cared for vulnerable adults.

Guardian

- The unit was run by a company called Potens who owned similar facilities across the country.
- As a 'for profit' organisation, the lack of investment in the staff and facility was impacting on the behaviour and the living environment of the service users.
- As a commissioned service, Potens were able to claim more care and benefits if they could show that the user had more complex issues, as this required more one to one care. Potens failed to match these complex issues with the skill set and resilience required to deal with them effectively.
- The Croft Unit management were unaware of what was happening during 'out of hours'. The Croft Unit is overseen by the Care and Quality Commission (CQC) and

there is a legal requirement for any calls to police to be recorded within the Croft Unit and reported to the CQC. This was not being adhered to and gave an inaccurate perception to management at the unit of the number of calls being made to Police.

Supercontroller

- The independent regulator of health and social care in England, the CQC, monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety within establishments like the Croft Unit. They publish their findings, including performance ratings, to help people choose care.
- In August 2014 the CQC rated the Croft Unit as 'good'. The Croft Unit is overseen by the CQC and there is a legal requirement for any calls to Police to be recorded within the Croft Unit and reported to the CQC. This was not being adhered to and therefore the CQC were unaware of the issues.
- In August 2014 the CQC rated the Croft Unit as 'good'. In their inspection they made the following findings;
 - Care and welfare of people who use services - Met this standard
 - Cooperating with other providers - Met this standard
 - Safety and suitability of premises - Met this standard
 - Staffing - Met this standard
 - Assessing and monitoring the quality of service provision - Met this standard

Offender - Service User:

- The unit used a dependency tool that was completed at the point of referral; this was used to measure the level of one to one support each person needed. Each person was allocated a minimum of seven hours a week and had a care plan as described above.

- Identified offenders in many instances had not been known for their criminality before being placed within the Unit and were being criminalised as a consequence.
- In the 18 month period considered in the scanning phase, there had been 164 calls for service which resulted in 42 crimes being progressed to criminal proceedings and dealt with by means of a Police Caution or Charge. Service users were being criminalised and this was affecting their life chances as a consequence of residing at The Croft Unit.
- Identified offenders within the unit did not commit additional offences within the wider Stanley area, suggesting over criminalisation by reporting staff.
- Once recorded for criminal offences, the information is disclosed when the resident moves on from the unit which can make resettlement difficult and lead to a prolonged stay at the unit.
- Many identified offenders have complex behavioral issues and therefore the use of police custody as a means to resolve issues was not seen as the preferred best option and caused additional distress to the individual and inevitably, the individual would be returned to the unit which caused further friction.
- In many instances where arrests had been made, alcohol had been a factor in offending.

Handlers

- Handlers for the offenders were in many instances the carers within the Unit who had themselves been victims of assaults/damage. Again, this limited the ability to prevent further incidents from being reported.

1. Response

Stage 1 – Initial Response and Results

- On the 25th June 2015 Inspector Martin attended a meeting with all staff who worked at the Unit to address a number of issues and to change perceptions that service users made the majority of calls to police. Also discussed;
 - How staff were reporting the nature of incidents and how police responded according to risk and information known at the time. Accuracy was stressed as being crucial at the time of reporting in order to ensure that the call could be graded appropriately and the correct resource allocated to deal. The use of restorative approaches by the staff was also discussed.
- On the 29th June 2015 a meeting was held between Inspector Martin, Elaine Duffy- the strategic lead for Potens- and David Shipman, the strategic lead within Durham County Council (DCC), at County Hall. This was held to discuss concerns around the over criminalisation of users within the unit. It was done with the intention of focusing the performance of the unit and its staff around future funding. This was because Potens is a private company that is commissioned by DCC.
- On the 9th of July 2015 a meeting was held between Inspector Martin, Elaine Duffy and Kay Morris, the manager of the Croft Unit. This was held to discuss the proposed actions of the Unit to address the issues raised. A number of actions were agreed;
 - Restorative Approach training for all staff. This would be provided by police and would facilitate the correct and a more meaningful outcome. It would also provide intervention for offenders.
 - Enforcement of the out of hours reporting protocol by staff.
 - Accurate reporting to police by staff calling for service.
 - Early interventions to prevent crisis to be used by staff. For example; retraining; bidding for extra staff members during out of hours to assist with behavioral issues.

- No-alcohol policy to be considered as alcohol is a factor in many instances where arrests were made. This was not taken up in initial response phase.
- Internal communication of the POP plan to operational Police staff.
- Safeguarding consulted regarding their conduct and possible sanctions as a consequence.
- Link made to CQC (Aileen Gilbert- Inspector) to consult them regarding the possibility of fast tracking an inspection of the Unit.
- Additional information sharing discussed at this stage with regards to the CQC's records of reported calls to police by The Croft Unit staff and how this compared to police records.
- Standard operating procedure placed on the location and police encouraged to use body worn video to capture their interaction with unit staff to assist in training and identifying where the concerns were.
- Elaine Duffy to attend the local Police and communities together residents meeting on the 30th July 2015, to address unfounded community concerns and highlight the good work of the Unit.

1. Assessment of Initial Response

The initial response led to a reduction in calls to the Croft Unit. Overall the significant reduction was in concerns for safety and anti-social behaviour incidents. This reflects the different approach that staff were taking in dealing with behaviour issues within the unit. The number of violence against the person (VAP) and other crime and incidents also reduced (Appendix a). The cost to the Police to service the unit in 2014 was £88,108.00 and increased slightly in 2015 to £92,258.00. Following implementation of the initial response this reduced to £67,232 in 2016 (Appendix b). Overall the calls for service at the unit reduced by 35 from 2015 to 2016, with the total number of calls for service reducing from 96 to 61. The saving to the Police was £25,026.00.

At 6.07am on the 20th of January 2016, officers were called to a report of a suspicious male trying door handles in a housing estate in Stanley. They were free to attend and as a consequence detained the main sector target and a prolific burglar who had previously evaded capture. As a result he was convicted of three attempted burglaries and admitted a further 17 burglaries that had been committed between 2015 and 2017. He received a significant custodial sentence. This was only possible due to the officers being available to attend the report as opposed to dealing with demands like the Croft Unit. The value of catching and convicting a prolific criminal cannot be underestimated. If this information is compared against the staffing within the locality and pressure on staff at times of least resilience we can conclude that establishments that produce high demand at vulnerable times prevent the police's ability to address wider policing priorities, threats and risk. If the demand of the Croft Unit had not been addressed, would we have created an opportunity to catch our burglar in the act?

The following feedback was received from the Potens regional manager in November 2016; "Part of the bigger picture - I presented to our National Operations Team the benefits of our systems, particularly to Mental Health services, which are now been utilised companywide i.e If the need to contact Police is absolutely necessary, then the staff needs specific, accurate information and authorisation from on call management (if out of hours)". Using Restorative Justice Protocols, for our service users to take responsibility for any damages, small thefts and importantly not criminalising the vulnerable people we are supporting on their journey to lead independent and inclusive lives. What's interesting for myself too, is in the rise of the amount of internal incidents / near misses recorded from The Croft and the detailed information of the incident alongside interventions used to de-fuse situations safely rather than ring for Police assistance"

Despite a positive step towards reducing demand, the assessment highlighted two further concerns;

- 1) The attitude and honesty of out of hours staff when contacting Police and adhering to the out of hours protocol. An example of this was from the 7th February 2017 where an officer attended the Croft Unit to a report of a service user with self-harm issues and depression causing a disturbance at the location. When officers attended, the service user was visibly distressed stating that she had been assaulted by staff. The attitude of staff was that Police would need to “take her away” as they had other people to look after and could not have her there. She was subsequently charged with two assaults and a criminal damage. Later, no evidence was offered at court and no further action was taken against her. This led to the question, were staff following the actions agreed at stage 1?
- 2) Discrepancies were found with the accuracy of the Croft Unit reporting police contact to the CQC.

2. Stage 2 Response

As a result of these concerns, stage 2 of the response was triggered;

- In December 2016, Inspector Martin made contact with the super controller, the CQC, regarding the discrepancies in reporting Police contact. As a result of this the following occurred;
 - The CQC conducted a ‘no notice’ inspection in December 2016.
 - They found the service to be inadequate.
 - The Croft Unit was placed in special measures.
 - After finding numerous breaches in both Fire and CQC regulations, the CQC conducted a further ‘no notice’ inspection in May 2017.
 - The CQC initiated formal action against the Croft Unit, indicating it would be closed unless serious improvements were made.
 - One of the failings identified was a failure to report contact with Police.

- The Unit had a final notice served soon after which in effect meant it had 28 days until it was closed.
 - As a consequence, Potens, the company commissioned to run the Unit, sacked the manager in the summer of 2017 and replaced her with a manager who had a wealth of mental health experience.
- The new manager conducted his own internal inspection and found the following;
 - Staff are poorly trained and only understand control and restraint training and not specific mental health needs training.
 - The 25 bed facility is not capable of housing more than 16 service users at any one time. As a result service users are being managed out of the facility to more appropriate accommodation and bed numbers have reduced.
 - The complex needs of many of the service users could not be catered for at the unit and many should not have been placed there in the first instance. These individuals would be correctly assessed and rehomed.

3. Assessment of Stage 2 Response

This second stage response saw a dramatic reduction in the number of calls to the Croft Unit. In particular a reduction in the number of concerns for safety and missing from home reports which reduced by 30 to 5 and 10 to 4 respectively from 2014 to 2017. This significantly reduced the cost to the police to just £38,748, a further saving of £28,424.00 on the previous year.

On the 24th of January 2018, Aileen Gilbert from the CQC informed police that the commission and its legal services department were meeting with their head of service that afternoon, with a view to looking to change their policy on fines for breach of Regulation 18. This is the fining of a private business that fails in their statutory obligation to notify the CQC of any police contact. This is an offence. It had been highlighted through our joint work at The Croft Unit as they had not reported their police contact to the CQC accurately and had

massively under recorded. This led to policy change within the CQC. The Croft Unit received a fixed penalty notice for £1250.00.

Following this, it is of note that the calls from the Croft Unit significantly reduced and YTD (April 2018) stand at only 6 calls for service (Appendix C & D). In real terms this is a projected 90% reduction in costs from its peak in 2015, from £92,258.00 to £9,120.00 (Appendix E). This reflects the fact that the calls for service are less protracted including no calls for violence against the person offences or missing persons and therefore in real terms are a less costly to police.

There is a massive incentive for organisations like Potens to demonstrate good practice at establishments such as the Croft Unit. It has changed the way police deal with calls for service at these establishments and the vulnerable people they engage with. Officers will now ask the question about the governing body that oversees the facility, and if it is the CQC, ensure they are sighted on any unnecessary calls for service to the police or poor practice. This learning and good practice is now being shared at a strategic level within Durham Constabulary, led by Inspector Martin and Chief Superintendent Spraggon, who now meet with DCC commissioners with a view to influencing their decisions regarding the commission of such services in the future. The POP Plan has achieved its objective and is paving the way for managing demand in the future.

Temporary Chief Inspector 68 Kelly Martin

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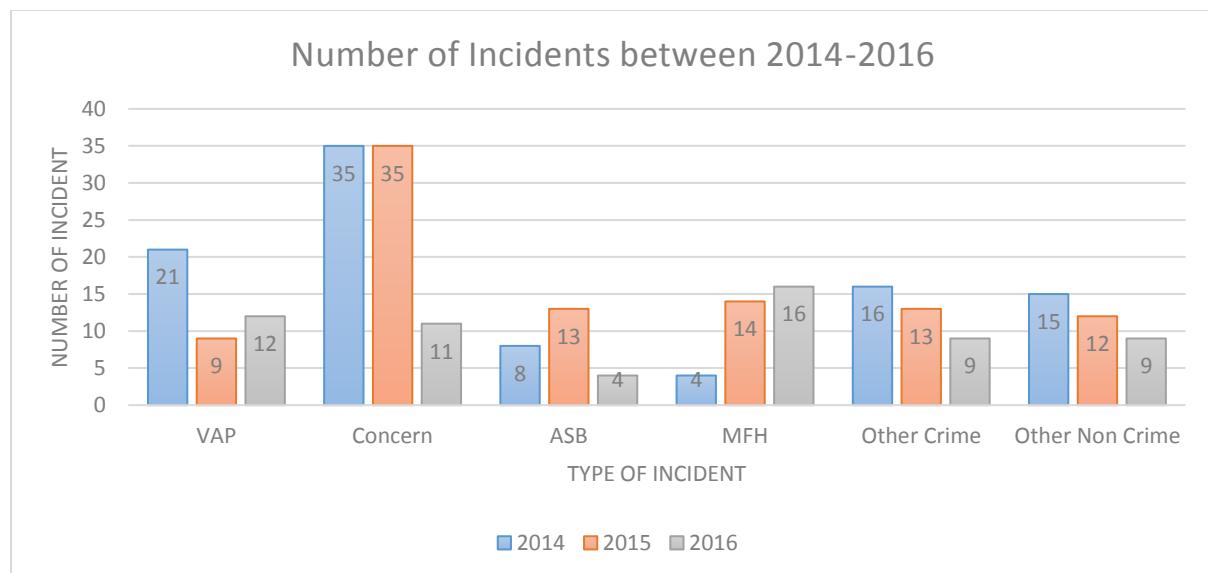
England

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Appendices

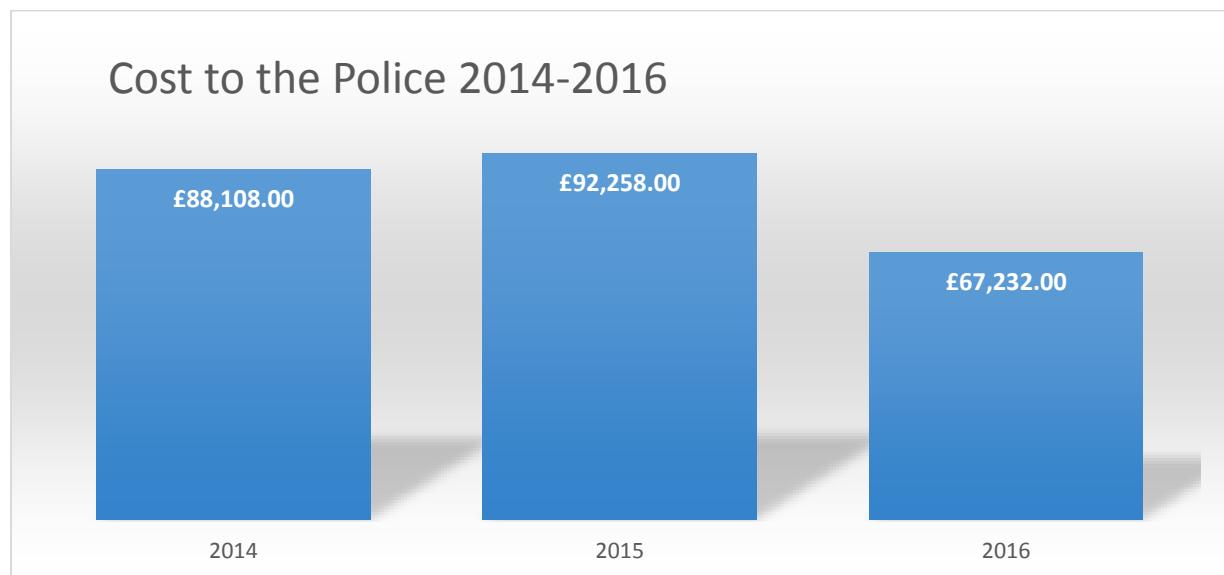
Appendix A

Number of Calls Following Implementation of Stage 1 Response



Appendix B

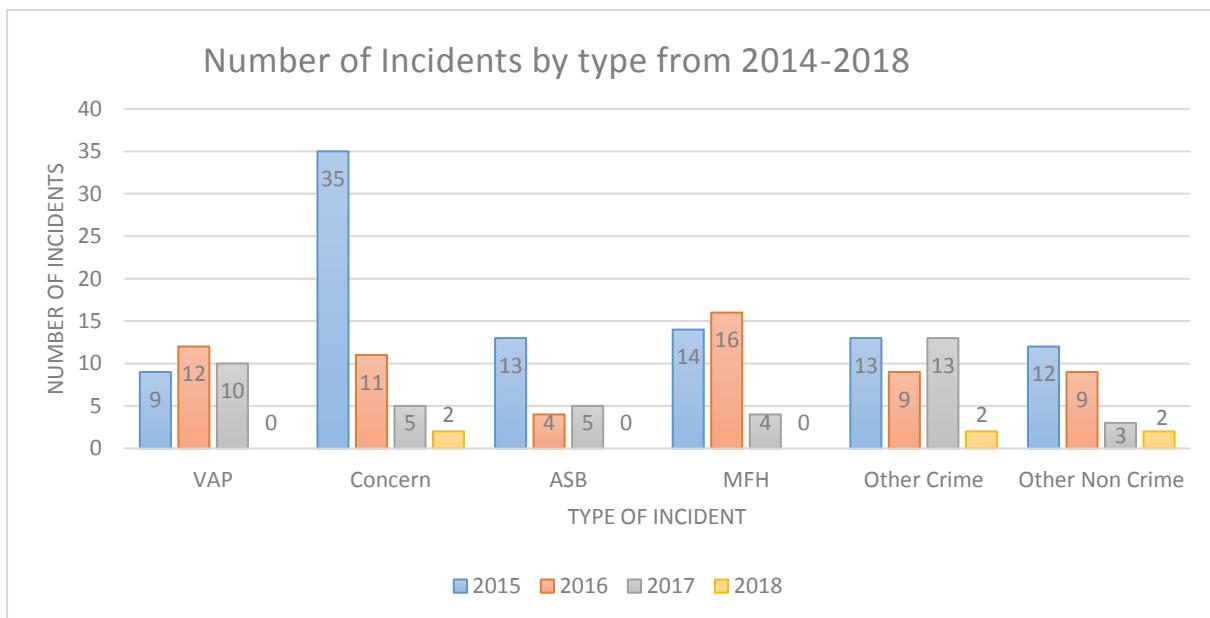
Cost to the Police to Service the Croft Unit From 2014 - 2016



Costs: Average crime £1040.00; Average ASB/Non-crime/Concern £240.00; Average missing from home; £1927.00

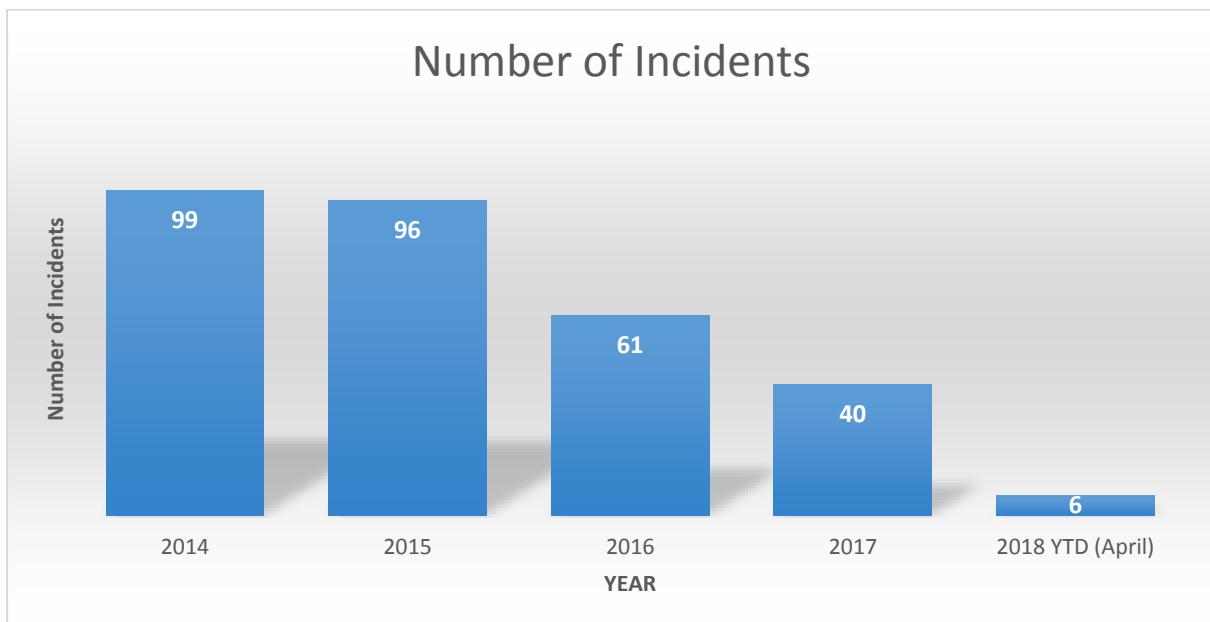
Appendix C

Calls for Service at the Croft by Incident Type 2014 – 2018 (YTD)



Appendix D

Overall Calls for Service at the Croft Unit 2014 – 2018 (YTD)



Appendix E

Overall Cost to Service the Croft Unit to Police 2014 – 2018 (YTD)

