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Nursing homes and residential care

Flagging the bad risks

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Introduction

In this Aspen Opinion, we examine the mounting difficulties of providing people with nursing home or residential care – whether due to age, infirmity or learning disabilities. For the reasons explained, exposure to severe legal liability claims from nursing and care homes is a matter for concern. Though this Opinion concentrates on the United Kingdom and, to a lesser extent, covers the USA and Australia, the potential problems are of course not confined to these countries.

Our **Conclusions** and the checklist of specific areas for examination by companies set out in the **Appendix** provide some detailed pointers when deciding which service provider represents a reasonable risk. Mistakes in selection can, and probably will, be costly in terms of subsequent adverse claims experience. Advice is given on how to judge which care providers may give rise to unacceptable risks as opposed to those which are inherent in dealing with people who present a variety of care needs and behavioural difficulties.

As with any sector where there is a carer/nurse to patient relationship, staff run the risk of sustaining injuries from lifting and shifting. There may also be falls and slips. Additionally, there may be assaults on staff by those in care – perhaps arising from mental health issues, geriatric behavior or dementia. Such risks cannot be avoided entirely, but the care sector remains marked by events that may too easily create unreasonable exposure for insurers.

Unacceptable problems include ignoring the dignity and human rights of those in care, as are assaults by staff and systematic abuse of patients, residents or others. It would be wrong to condemn a care facility for an isolated act of abuse. What is important when judging the suitability of a care home as a risk is, once revealed, how any isolated problems are addressed. From a claims standpoint, delays in reporting accidents and other problems are an important and urgent factor and that should be dealt with promptly and effectively.

As we outline later in this Opinion, conflicts and tensions may arise between different aspects of cover provided to a nursing or care facility.

Pressure on care

As people live longer and babies who once would have died increasingly survive though with lifelong health issues, so society is faced with tougher and more expensive demands. With loving families often fragmented by the global workplace and increased family breakdown, an ageing population can no longer expect to be cared for at home.

Delivering acceptable care requires a large pool of reliable and dedicated staff. However, in a sector that generally receives poor rates of pay for often deeply demanding work, securing sufficient high calibre staff can be very difficult. Despite extensive legal sanctions and the creation of forceful inspection agencies, maintaining acceptable standards of care using inadequate quality personnel is not easy. As explained below, with daunting staff turnover figures and an insufficient number of dedicated employees ready to shoulder the often stressful working conditions, management has an endless battle to deliver the standards to which they aspire – and which are required by law. The turnover rate adds to the burden of the hard core of pivotal staff who have to deal with the demanding array of day-to-day problems.

Part one – Overview of care in the UK

There are many nursing and care homes that operate successfully in the voluntary sector with the aid of local authority funding and charitable donations. However, some service providers appear to be more intent on profit than delivering acceptable care standards. That is not to suggest that all corporate care providers put profit before their obligations – indeed some of the worst cases of neglect come from facilities run by the National Health Service – see further on page 5.

Unfortunately, despite record funding for care provision, it is still not enough. Poor facilities, low wages and demanding working conditions can too easily lead to staff shortages and poor morale. Staff may snap under pressure or may have been recruited in ignorance of violent and other dysfunctional tendencies that render them unsuitable to be in charge of vulnerable people.

In relation to joint venture care, as often provided for elderly people, more than 40% of local authorities blame cost-cutting within the NHS for their problems. This has shifted the care burden to local councils who are already struggling to cope with ever greater demands on their limited financial resources. Whatever the causes, the end result is unacceptable levels of claims arising from patients or residents who have been mistreated or abused physically, sexually, financially or psychologically. The legal profession is focusing closely on this area.

Change of emphasis

Approaching one million people over 65 need help with daily life. The numbers are rising and so are the costs of delivering acceptable care. The quality of care provided by the present Local Authority driven systems has been widely criticised. To try an innovative approach, the Health Secretary Alan Johnson has just announced a significant reform from April 2008. The aim is for elderly persons to enjoy bespoke care because they will be funded to organise it themselves. They or their relatives will receive

Change of emphasis (continued)

a monthly cheque to buy in whatever care they need instead of being subject to a one-cap-fits-all Local Authority driven care package. This new philosophy may also lead to persons in long-term care being permitted to have a home-based regime created and run by them and funded by the NHS. Within twenty years, demand for care by the elderly will rise to around 1.3 million so that while this new approach may achieve some reduction in residential care placements in the short term, the demographics suggest that the overall demand for residential care will continue to mount.

Avoid harsh judgements

Without an appreciation of the problems faced daily by those providing care, it can be too easy to pass harsh judgements on staff and management – and on the hard-pressed personnel in social services departments who may sometimes be blameworthy, but who themselves are too often under-resourced and over-worked. **The disturbing statistics for staff turnover in care homes highlight the perpetual crisis for management. In this sector, 25% turnover per annum is routine. In hotspots with high living standards and more attractive wages in other sectors, it can reach a staggering 100%.**

Juggling which crisis to deal with next is a demanding daily routine for many care managers. Errors are inevitable. Many problems could be solved by more funding, but without increased taxes to pay for improved services, attracting more and better qualified staff through higher pay is always going to be a problem.

Here is an example of a typical situation that could easily lead to a large claim: A fictional male aged 26 who has learning disabilities and lives in a care home has become abusive or violent. In the interests of the welfare of other residents and staff, the care home decides it can no longer provide him with a place. The local authority must find a suitable alternative. However, only a small minority of facilities will be suitable or prepared to accept someone who could be disruptive and possibly a danger. While the local authority may be able to resolve the accommodation problem, the young adult presents a real risk to others. The alternative facility must be staffed with a well-trained team who know how to provide care for him and for the others in their care who present similar risks and problems.

Facts and figures

Care for people with mental health needs or learning disabilities may be provided by the NHS, a local authority social services department or by the voluntary sector through national charities like Mencap and United Response. Local authorities pay such charities, or the private sector, to provide care within their area.

By 2051, it is estimated that there will need to be over 1.1 million such care placements.

Facts and figures (continued)

The Alzheimer's Society estimates that 75% of the 700,000 elderly people currently in care suffer from dementia. By 2051, this figure will rise to 1.7 million. However, the growing longevity of the ageing population may not necessarily lead to a pro-rata increase in the demands on resources according to geriatric experts like Professor Raymond Tallis of Manchester University. They believe that these long-term survivors will continue to become less challenging to the health and care services. Professor Tallis believes that rising longevity (twice as long as 140 years ago) is not leading to corresponding increases in ill-health, though of course he acknowledges the known health problems associated with the elderly. He points out that the vast majority of people in later life already enjoy excellent health or have problems which can be controlled so as not to be a barrier to a full life. Even so, because of the rising numbers of people living beyond 65, considerably increased resources will still be essential. The implications for insurers, based on the level of present difficulties, are self-evident.

The laws and their structure

The inadequacy of existing legislation is not the problem, though 2007 sees the implementation of the Mental Capacity Act 2005 to bolster the protection to persons who are vulnerable to abuse in decision-making or financial matters. The past 25 years have produced many statutes and regulations as Parliament has sought to address potential shortcomings in the safety and quality of premises or the care standards on offer. Since 2004, the Commission for Social Care Inspection (CSCI) has had the right to carry out random inspections and report on social care rights across the spectrum of the care system. The CSCI has the provisions of the Care Standards Act 2000 as its yardstick. The CSCI targets its resources by focusing on those agencies or facilities that have been the subject of complaints, rather than wasting time on well-run service providers.

Complaints against NHS hospitals, if not resolved locally, are passed to the Health Service Commission (HSC). The HSC (Ombudsman) has the power to investigate and resolve complaints and, in appropriate cases, to award substantial compensation. The Local Government Ombudsman deals with complaints against social services departments.

Following complaints about neglect/abuse at community homes in Cornwall and in Sutton & Merton, the HSC is soon expected to report the outcome of an audit on 200 NHS facilities. Consistent with the reforms suggested in the December 2007 White Paper called *Valuing People Now*, a likely outcome is that the NHS will be relieved of its responsibilities, which would pass to Local Authorities, who would receive an additional £2 billion budget to fund their extra role. Additionally, another important reform was heralded by the Health Minister's announcement in *Putting People First* on December 10, 2007. The plan is for the elderly (and potentially across all adult sectors) to be directly funded by the Local Authority to organise their own care as they wish, with the object of them receiving bespoke, high quality services. Instead of being subject to a 'one-cap-fits-all' Local Authority driven care package, they or their relatives will receive a monthly cheque to purchase the types of care they need. While this might suggest less need for residential care, the demographics nevertheless still point to long-term growth potential for the residential care sector.

Recent compensation claims and court rulings

- Between 2003 and 2006, the Health Service Ombudsman handled around four thousand complaints. £180 million was awarded to remedy injustice. Much of this liability will pass to local authorities and service providers if the NHS is relieved of the role which it now fulfils.

- In Buckinghamshire in 2004, 54 claimants with learning disabilities were awarded £781,960 for sexual and physical abuse in a settlement approved by the High Court.

- In various NHS facilities, the apparent needless deaths of six patients with learning disabilities are being investigated following revelations in March 2007.

- In Manchester, a group of victims of sexual and physical abuse at 66 children's homes were awarded £2 million in compensation. The homes were mainly run by Manchester City Council Social Services Department. One victim claimed to have been abused by 19 different people in five different homes. Allegedly, complaints to Social Services were not followed through because of complicity in what was happening. The Assistant Director of the city's Social Services Department was jailed for 11 years for offenses committed when he had been a warden. Some others involved were jailed for between 12 and 14 years.

- The Sutton & Merton Primary Care Trust accepted the findings of the recent Healthcare Commission report into shortcomings at some of its facilities. Living conditions were sub-standard. There was institutional abuse of people with learning disabilities. Staff were neither properly trained nor supported. The head of investigations for the Commission blamed "the highest levels" for the staff failures. Those in care had been treated in infantilising ways and using outmoded methods. One woman had her arm in a splint for much of the day over many years. One member of staff was jailed for rape of a woman who had no mental capacity to consent to sex. A co-worker was given a suspended sentence for another sexual offense.

- At a Cornwall Partnership NHS Trust hospital, an elderly man who was unable to see, hear or speak was routinely tied to a bed for 18 hours a day. A number of other complaints about this hospital were investigated by the Healthcare Commissioner.

- On 10th December 2007 a married couple who worked at Parkfields Residential Home in Somerset were arrested on suspicion that they had murdered five elderly residents. This followed bodies being exhumed during the investigations.

- In Holloway, three staff from a residential care home operated by Craegmoor plc for the local council were jailed for mistreating patients and for wilful abuse.

- The Local Government Ombudsman awarded a resident £8,500 in compensation following the failure to carry out a proper assessment of needs and meet care needs.

- The same Ombudsman awarded £80,000 to a family that removed a resident from a home (and thus incurred expense) because of lack of care and failure to create an adequate care plan.

- Law Lords ruling on private care homes
  In June 2007, the House of Lords reached an important decision in a test case relating to privately run care homes. The ruling raises what many see as an anomaly in the law that could affect some 300,000 people. The case concerned a woman named only as Mrs YL,

Recent compensation claims and court rulings (continued)

who was in her eighties and being cared for in a facility (also un-named for legal reasons) operated by Southern Cross Healthcare. The home's managers wanted her removed because of disagreements with her family. Mrs YL was supported by the UK Government because the case raised issues involving the Human Rights Act. Critically, the Law Lords ruled that a private care home is outside the Act. As a result, a number of charities have claimed that vulnerable elderly people could be open to neglect, abuse and eviction without the Act's protection. Although this would appear to be something of an overstatement, until the law is amended by Parliament, residents might find themselves removed from a care facility through no direct fault of their own, in particular in cases of familial interference. The Government is considering how to amend legislation to address this anomaly. Had Mrs YL been cared for in a local authority home, she would have been protected by statute and could not have been forced to leave. The anomaly is compounded by the fact that her care fees were being funded by her local authority.

While naturally there have been outcries about the ruling, the Act was designed from a legal point of view to prevent abuse of human rights by the state and by public bodies – not by private institutions. Even so, this was only a 3-2 majority decision.

- Lister v Hesley Hall Ltd (2001) 2 All ER 769
  The House of Lords held an employer liable for intentional sexual abuse of children by a warden in a residential care home. The misconduct was closely connected to the warden's work and so the employers were vicariously liable - but note the different Australian approach (see page 9) and the issue of policy wording for intentional misconduct.

- Palmer v Tees Health Authority (1999 Lloyd's Medical Reports)
  In 1993, a man was admitted to hospital for psychiatric care. He had a psychopathic disorder involving a history of drugs, drink problems and sexual abuse. He warned authorities that: "Yes ... I have sex feelings and on release a child will be murdered." The next year he was discharged and murdered a four year old girl. However, the Court of Appeal rejected the subsequent claim on the grounds that there was no duty of care towards the child because any child, at any time, was in the same danger. Furthermore, as the patient did not suffer from a treatable mental illness, they ruled that there was no legal right to either treat or detain him. This controversial decision may reflect an attempt by the senior judges to curb liability on the grounds of public policy.

- Islington Borough Council v London Hospital NHS Trust CA (2006) PIQR 29
  A woman who suffered a stroke due to negligence during hospital treatment was provided with long-term care by Islington Borough Council. Islington sued the Hospital Trust for the cost of care provision and lost. The Court of Appeal ruled that while the loss was reasonably foreseeable, there was no sufficient proximity. This was a public policy decision with concern expressed for the effect on other health providers.

- L v Pembrokeshire County Council May 2006
  A social worker suspected that a father was guilty of child abuse and placed the child on the Child Protection Register without following the due procedures. Mr Justice Field held that there was no liability for a good faith error of judgement. There was no duty of care only a duty of good faith in the investigation.

Recent compensation claims and court rulings (continued)

- KR v Royal & Sun Alliance (2006) EWHC 48(QB)
  In a case where a care home was found liable for damages for negligence for sexual and physical abuse of children in care homes, an insurer was held unable to rely on an exemption clause to escape liability. The Chief Executive (called B) was the majority shareholder of the company running the homes. He was convicted of indecency offenses. At issue was whether the words "deliberate act or omission of the insured" assisted the insurers. The judge held that liability for the assaults against B had been based on negligence in management of their homes and not for deliberate assault. Accordingly, the exemption did not prevail.

Part two – Overview of care in the US

The US has experienced similar problems to the UK including potential abuse and infringement of human rights. The US also faces the considerable additional challenge of financial fraud by care home providers. Phantom patients and false accounting have proved to be highly prevalent. Kickbacks for referrals used to be widespread but are now generally prohibited by legislation. Nursing homes have been criticised for being mere warehouses to store people rather than providing adequate care. In comparison to the larger corporate providers, not-for-profit facilities have arguably been shown to deliver a higher standard of patient care, though it would be wrong to make any simplistic assumptions.

- Across the country, there are about 71,000 people aged 100 or more. By 2050, this figure is projected to reach a staggering one million.[1]
- With increasing numbers of people moving into care and a significant rise in both the incidence of claims and size of awards, premiums for nursing home liability rose sevenfold over the ten years to 2003.
- According to two studies[2], as many as half of the deaths in care arising from falls, choking, homicide or restraint may have been covered up. Many deaths were falsely recorded as heart failure.
- In a 1999 survey by State inspectors[3], as many as 30% of nursing homes presented serious or life-threatening problems to residents. However, a 2005 report[4], while noting an apparent drop to 16%, overall expressed concern about inconsistent surveys and under-reporting by inspectors – as evidenced by some states reporting up to 54% of such problems while others were as low as 6%. This indicates that there is a serious and unacceptable ongoing problem.
- A Congressional Report in 2001[5] found that one-third of the 17,000 nursing homes studied had been cited for abuse over a two year period.
- The number of persons in nursing care is projected to rise from around 1.6 million at present to 6.6 million by 2050[6].

[1] US Census Bureau
[2] Miles SH: HEC Forum 2002 and Corey TS: *Journal of Forensic Science*
[3] US General Accountability Report 1999
[4] US General Accountability Report Dec 2005
[5] The Waxman Report to Congress July 2001: *"Abuse of Residents is a Major Problem in US Nursing Homes."*
[6] *Coalition for Nursing Home Reform* and Waxman ibid

Part two – Overview of care in the US (continued)

With damage claims continuing to provide a rich seam of work for plaintiffs' attorneys, there is no reason to believe that the intervening years since 1999 have led to significant improvements in standards. Although tort reforms have lowered some of the awards (see below), they do not provide a panacea for the liability issues that remain common across the country.

A number of large corporations are heavily involved in the provision of nursing homes. Some are now international and some like Manor Care (US$3.6 billion) and Kindred Healthcare (US$4.3 billion) have a turnover running into billions of dollars annually[7]. Some two-thirds of facilities are run for profit, though their funding comes mainly from the Medicaid/Medicare (Government) programmes. The number of US nursing homes has rocketed with a consequent shortage of suitable staff. In turn, this has led to shortcuts, neglect and abuse of residents. However, Congress has been reluctant to intervene with imposition of higher federal standards for staffing because of the effects on costs – the Government being the paymaster for a large portion of the expense of care provision.

Tort reform

Following significant tort reforms at Federal and State levels from around 2003 onwards, there is evidence that the size of jury awards has generally been falling. Caps on damages and restrictive new laws on class actions have made some difference. Curbs on the extent of punitive damages arising from Supreme Court decisions are also taking effect, as are moves by insurers to a Claims Made approach.

Even so, abuse of elderly or vulnerable people is naturally emotive. Although there has been some recent calming in jurors' approach to medical malpractice claims against doctors, many nursing home abuse claims are filed against giant corporations who are more likely to be punished as a result. The nursing home industry is dominated by politically well-connected corporations which constantly lobby for more protection against legal liability. Campaign contributions were over US$13 million and around US$80 million was spent on lobbying of politicians[8]. Beverly Enterprises Inc, spent US$507,000 in 2006 and Kindred Healthcare US$270,000[9]. These amounts have varied year on year.

The shift in power from Republicans to Democrats at both a Congressional and state level makes it unlikely that law reforms to assist these big corporations will occur. Another obstacle to law reform is the widespread perception, based on official reports like those already quoted, that too many nursing homes deliver inadequate care standards and are undeserving of sympathy.

Nursing and other care facilities are subject to state laws and regulations, though this is within the context of the Nursing Home Reform Act, a 1987 federal law. As in the UK, there are clearly laid down guidelines about the quality of care to be provided. Facilities receiving Medicare funding must be certified to adopt and meet specific federal requirements and may have to meet higher state standards. Other care agencies are licensed at state level.

The following examples reveal how susceptible the biggest providers are to extremely high jury awards. Some companies have acted fraudulently as well giving rise to potential Directors and Officers liability exposure. It is scarcely surprising that juries are tempted to lash out with punitive awards in view of the emotive evidence often put before them and the profitability of the businesses in the dock.

[7] SEC Annual Filings
[8] *Center for Responsive Politics* published data
[9] Center for *Responsive Politics* published data

Tort reform (continued)

- In Texas in 2000, Horizon Healthcare was ordered to pay US$11 million damages by the Texan Supreme Court for the death of a resident.
- An award of US$20 million against Extendicare for alleged negligent care was subsequently adjusted as part of a confidential settlement.
- A jury found that a resident of Red Rocks Health Care Center in Denver had been neglected and awarded over US$4 million including interest. There were 21 citations for care deficiencies and Medicare/Medicaid payments for new patients had been temporarily
- stopped in consequence.
- In California, a 79-year-old woman who was scalded by coffee due to alleged lack of care and supervision accepted US$900,000 in settlement.
- In California in February 2001, what is perhaps the nation's largest care provider, Beverly Enterprises Inc, settled fraud allegations from the Justice Department. The company paid a fine of US$170 million and gave up control of ten nursing homes. Despite this, in 2006, the company was again in trouble when it had to pay another US$20 million to settle further fraud allegations in California.
- In Florida in 2007, a jury awarded US$150,000 to the family of a woman whose end-of-life wishes were ignored and who endured forceful intubation.
- In 2006 in Idaho, a jury awarded US$18 million for the death of an elderly man. This followed allegations that the staff had committed more than 700 violations of regulations.
- In New York in 2006, a grand jury indicted a nursing home owner for stealing US$3 million from Medicaid.

Part three – Overview of care in Australia

The Australian care sector includes many smaller ecclesiastical insurers that provide policy protection. They face mounting problems. The Bureau of Statistics projects that by 2051 around 25% of the population will be over 65 as opposed to around 13% at present. As in the UK and US, residential care is being provided by an increasing number of large corporations being run for profit, supplementing those charitable businesses run on a not-for-profit basis. The law is a mix of federal and state legislation. Taking New South Wales as an example, the law revolves around the (federal) Home & Community Care Act 1985, the Aged Care Act 1997 and NSW laws like the Community Welfare Act, the Nursing Homes Act and the Retirement Villages Act.

A number of nursing home scandals broke at the beginning of the decade. The widespread concern about abuse of vulnerable people led to serious attempts to improve supervision of residential care homes. However, concern did not disappear and rightly so. Further examples of abuse of elderly people emerged. Just as in the UK and US, quality and training of staff are core factors.

Part three – Overview of care in Australia (continued)

Facilities putting profit before people remains an issue as does an overall shortage of funds at a time of rising demands for low level care in hostels and high level care in nursing homes. Youngcare, a Queensland charity, is easing the burden by setting up special care units for young people with high dependency needs. Their statistics showed that besides thousands of young people being cared for in hospitals, there were 6,300 more in older age care units – a situation that is wholly inappropriate.

A new law is going through Parliament called the Aged Care Amendment (Security & Protection) Act 2007. If passed, the law will encourage whistleblowers. Additionally, the post of Aged Care Commissioner would be created. These changes should reinforce efforts to reduce problems like these:

- In Victoria, 57 residents were bathed in kerosene to treat scabies. One patient is alleged to have died. Many suffered significant pain.

- At the George Vowell Centre in Victoria, staff were allegedly aware of sexual and physical assaults on elderly patients but did not report them. A care worker has now been charged with four counts of rape and two other sexual assaults involving women aged over 90.

- The Immanuel Gardens Nursing Home in Queensland was found to have breached 25% of standards regarding pain management and infection control.

- New South Wales v Lepore; Samin v Queensland, Rich v Queensland (2003) 195 ALR 412; [2003] HCA 4 High Court
  These test cases were argued before the highest court in Australia. They do not directly concern nursing homes but the judgments make clear that the legal principles are similar. The claimant children were assaulted at school by a teacher. The employers were held not liable under the concept of non-delegable duty of care. The judges confirmed there was no strict liability, but the court held that there could be liability for negligence. Save perhaps in exceptional circumstances, there was no vicarious liability for criminal assaults committed during school hours because this was outside the course of employment, The UK decision of Lister (see page 6) and a similar supporting Canadian leading case were considered but not applied.

- Sullivan v Moody (2001) 207 CLR 562
  This Australian High Court ruling about mistakes made in good faith preceded Mr Justice Field's decision in England and the two are consistent. A care worker who misjudged a parental abuse situation in good faith was not liable. The court ruled that it was "inconsistent with proper and effective discharge of (statutory) responsibilities..."

Insurance exposure

Legal liability may arise under a variety of guises and will vary between the US and the UK, but the most pertinent policies are these:

- Employers Liability for workplace accidents and injuries, harassment, and racial or sexual discrimination.
- Workers Compensation Acts Liability for workplace accidents and injury (US).
- Commercial General Liability for emotional injury following racial or sexual abuse, especially when involving geriatric residents (US). Issues arise on the vicarious liability for deliberate acts of employees and the different approaches to this in the UK and Australia have been noted. Policy wording in the US may indemnify in limited cases relating to injury sustained that was neither intended nor expected from the standpoint of the insured. Clearly, an employer will not intend sexual abuse of residents by employees and will not normally expect such behavior, but it might be expected if there had been a history of complaints or incidents. Issues of negligence would arise.
- Products Liability if a resident is injured by a drug, administered by the home, that proves to have side effects, even though primary responsibility more reasonably rests on manufacturers and perhaps physicians.
- Commercial General Liability by extension to nursing care for claims by residents who are administered the incorrect medication by nursing staff.
- Public Liability for accidents or injury to visitors and residents on premises.
- Public Liability for claims arising when a resident who is off premises due to negligence, causes accident or injury.
- Professional Indemnity for medical mistakes causing injury or loss to residents.
- Directors & Officers exposure may arise from management actions including financial misconduct or fraud to the detriment of shareholders.

Conflicts may arise if a nursing home has a package policy providing Employers Liability/Workers Compensation cover and General Third Party Risk. A resident might, for example, need to be lifted but the carer declines to do so because of awareness of the need to avoid lifting excess weight.

Conclusions - Avoiding the pitfalls

James Churchill is Chief Executive of ARC (Association for Real Change), a UK charitable umbrella group of service providers for people with learning disabilities. He also provides independent consultancy services on the sector. As a panel member of the Care Standards Tribunal and having worked for a national charity providing residential care, he knows the care profession from all sides.

According to Mr Churchill, "the biggest problem facing even the most motivated and well managed care providers is securing the quality of staff to support people presenting a wide variety of different needs. Tight budgets for local authorities and the NHS are a factor of course: levels of pay are often not high enough to attract sufficient good quality personnel. Additionally, some care agencies are insufficiently concerned about the staff they employ. This creates an important risk factor for management and their insurers."

Drawing on observations from Mr Churchill, we have created a **Checklist** of some key indicators that insurers would do well to consider when assessing the nature of the exposures likely to arise. These are set out in the **Appendix**. Although specifically geared to the UK, the underlying factors that create risk could equally apply elsewhere.

In some situations, insurers might well benefit from enquiries or opinions from experts like James Churchill. Such up-to-date analysis can be invaluable in making assessments of risks that may prove very expensive if the policyholder ignores, tolerates, encourages or is recklessly ignorant of institutional and systematic abuse of vulnerable people.

Looking ahead, the care sector faces the vexed question of whether to use video cameras for surveillance. From an insurance perspective this would be helpful, but the intrusion on personal freedoms has elicited strong concerns. Meanwhile, what is evident is that from now on it will be increasingly difficult to excuse employers that hire unsuitable staff who can give rise to costly claims. Efforts are being made to close loopholes and to end sloppy procedures. This has to be balanced against the rising demands for placements that constantly push resources to the edge of a precipice.

Appendix

United Kingdom Nursing Homes and Residential Care - Checklist

Institution characteristics

Age of Institution	Explore date of creation and potential for history of past abuse being brought to light during disclosure process in a new claim.
Type of patients	Are patients and residents high risk, e.g. persons who have been abuse victims or persons who are now abusers? For care homes that provide support in higher risk situations, check if there is proper support from the local authority or primary care trust.
Type of care provided	Is the staff appropriate for the patients' needs?
Membership in umbrella organisations	Umbrella organisations are dedicated to raising standards. Membership may be a pointer of intent to prioritize quality of staff training and development.
Secrecy	An unwelcoming approach to visitors, especially visits by families, may be cause for concern.

Safety

Safety of premises	Check for certification of design and fire hazards.
Commission for Social Care Inspection (CSCI) reports	CSCI can carry out random inspections and report on social care. Resources are concentrated on those agencies or facilities about which they have received complaints.

Appendix (continued)

United Kingdom Nursing Homes and Residential Care - Checklist

Staffing

General Social Care Council (GSCC) Register	GSCC will begin registering domestic care workers this year and into 2008. Meantime, a check on individuals can be made in the Social Care Register.
Independent Barring Board (IBB)	The IBB will begin its operations in 2008, placing unsuitable individuals on an Adult Barred List. Employing a person on the Barred List will be a criminal offense. This will become a valuable factor in keeping known offenders away from vulnerable people.
Employment Policy	Secure by warranty that the service provider carries out checks on job applicants with the Social Care Register, the CSCI and IBB.
Training	Are training programmes used for staff development? Does the staff receive appropriate training for spotting abuse or possible health and safety problems?
Staff turnover	High staff turnover should be taken as a warning sign, though this must be kept in perspective. Check with CSCI whether the turnover is unusually high for the location and the type of care provided.
Whistleblower policy	Does the institution have a suitable whistleblower policy to ensure exposure of abuse?
Criminal Records Bureau	CRB Disclosure at Enhanced (highest) level is mandatory when job applicants will work with children or vulnerable adults. Where not mandatory, better service providers may still insist that job applicants provide CRB clearance at the Enhanced level.
Protection Of Vulnerable Adults (POVA) check	Check that the service provider has complied with its mandatory obligations (1) to check the POVA Register before offering employment to staff who will deal with vulnerable people and (2) to report staff abuse for recording on this Register. NB: Staff employed before 26 July 2004 are not covered by the scheme and may thus have unsatisfactory records.
Protection Of Children Act (POCA)	For homes providing care for children, the mandatory obligations are the same as under POVA but reference is to the POCA Register.

Appendix (continued)

United Kingdom Nursing Homes and Residential Care - Checklist

Claims and complaints

Claims History	Check the number and nature of past claims.
Inspection Reports	Review Inspection Reports which are on-line at www.csci.org.uk
Staff Complaints	Depending on their nature, staff complaints would usually be kept at CSCI's local office.
Serious Incidents	Investigate what serious incidents were disclosed to the CSCI in the previous three years. Minor incidents and accidents should not cause concern but patterns indicating weakness in management and quality should be investigated further.
Local authority	In addition to checks via the local office of CSCI, the local authority (usually a main funder of placements) deals with complaints. This is a useful research source.
Health Service Commission	The Health Service Commission records and deals with complaints against NHS hospitals.
Local Government Ombudsman	The Local Government Ombudsman records and deals with complaints against social services.

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For more information about Aspen's expertise on this issue, please contact Tony Spice or Peter Rowe.

T +44 (0)20 7184 8000