Browne Jacobson

Charity Commission opens inquiry into care charity following Coroner's report

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In May 2016 an inquest into the charity's care was opened following the death of Sophie Bennett. In February 2019 that inquest concluded leadership and oversight of the charity's board was 'grossly inadequate'. The Coroner identified serious failings by the trustees to keep their beneficiaries safe from harm. Following this report the Charity Commission opened a statutory inquiry on 5 March 2019.

Coroner's report

The inquest found neglect contributed to the death of Sophie Bennett. She had been cared for at Lancaster Lodge, a therapeutic community run by Richmond Psychosocial Foundation International ('RPFI'), since April 2015.

The home had previously received a rating of good from the Care and Quality Commission (CQC) and was well run.

In January 2016, a number of changes were made to the home. A decision was made to cancel external therapies. The decision to cut therapies and all external clinical supervision compelled the then registered manager to resign.

After protests from residents and staff, therapies were continued, but the standard of care at the home fell to the extent that the CQC assessed the service in March 2016 as 'inadequate'. In evidence, the CQC inspector described the home at that stage as 'chaotic'.

An adviser to the home, although understood by other staff to have a medical degree, in fact had a doctorate in public management and administration from Knightsbridge University – an unaccredited institution in Denmark. In the inquest RPFI were unable to produce any record of the adviser's credentials.

The home manager accepted in evidence that she would not have the qualifications and experience to be a registered manager of the home.

Some newly recruited support workers had no relevant qualifications or experience.

On 28 April 2016, Sophie told staff she was experiencing suicidal thoughts and urges. Staff contacted Crisis Line – they advised an urgent admission to hospital for assessment. Staff did not take her to hospital but chose to monitor her; this was a 'management' decision.

She was placed on close observations. However, on 2 May 2016 she was allowed behind a closed bathroom door where she was not subject to close observations. She was found hanging in the bathroom.

At the conclusion of a three week inquest with HM Coroner for West London, the jury concluded that Sophie's death was contributed to by neglect on the part of RPFI. In particular, the jury held that:

- Replacement staff across all levels were not adequately trained, skilled, educated or experienced.
- Leadership and oversight of the RPFI board was grossly inadequate.
- A grossly inadequate observation plan of Sophie was put in place and not understood or followed.
- Changes were based on a one day audit which was grossly inadequate.
- Advice was provided by the founder and followed by RPFI staff without ever meeting with or having any knowledge of residents.

Charity Commission Inquiry

The Charity Commission opened a statutory inquiry on 5 March 2019. Their focus is on governance and compliance under charity law. The focus of the inquiry is:

- the trustees' compliance with their duties and responsibilities under charity law; in particular their oversight and governance of safeguarding arrangements.
- the trustees' response to the Coroner's report into the death of Sophie Bennett and the governance changes that are necessary as a result.

Michelle Russell, Director of Investigations, Monitoring and Enforcement at the Charity Commission emphasised that the Coroner found that the governance failings of the charity directly contributed to Sophie's death and the opening of this inquiry reflected the seriousness of the Coroner's report.

The Charity Commission said it had been engaging with RPFI on a number of matters since 2016 and is continuing to work with the CQC and the adult social services teams at Richmond and Wandsworth.

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