Safeguarding Adults Review Briefing

'Colin'

About This Briefing

A Safeguarding Adults Review (SAR) has been undertaken by a local Safeguarding Adults Board (SAB) in England.

This briefing aims to summarise key learning from that review, to facilitate the learning being shared with other SABs and their partners.

Please take time to reflect on these issues and consider how you can learn, develop and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

What is a Safeguarding Adults Review?

An SAB, as part of its statutory duty, is required to commission SARs under the following circumstances:
(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –
(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if –
(a) the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if –
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

Safeguarding Adults Review into the death of ‘Colin’

Colin was a man in his early twenties who lived in supported living accommodation. He had a learning disability and some physical problems. Colin was murdered by peers in the local community.

Colin had been in foster care as a child and had special educational needs. He made the decision to move to supported living accommodation to develop his independence. However, records show that Colin had less independence in the supported living environment than he did when he lived with a foster carer.

With the help of his foster carer, Colin began to develop his relationship with family members, which continued until his death.

A psychologist’s report for Colin gave insight into his development and recommended preparatory planning for independence. Unfortunately, no such work was undertaken with Colin until shortly before his death. Instead, the provider continued to rely on a voluntary agreement with Colin, who was deemed to have capacity to make health and welfare decisions, that he would not go out unaccompanied.

Over time, Colin began to exhibit more disruptive behaviour and some violent incidents ensued, culminating in the Police being called when carers felt that they were unable to manage his behaviour.

In the weeks and months prior to Colin’s death, he started asserting his right, as an adult, to go out into the community unaccompanied. Colin began to socialise with a large group of people of a similar age, and with similar vulnerabilities. Late-night incidents occurred, including in an incident where Colin was a victim of an assault, with an unsubstantiated ‘throwaway’ comment made that Colin was a paedophile.

Colin continued to associate with the same wider group after his assault and was subsequently killed by two of his peers.

Key Learning

Key learning point 1: Transitional planning and risk management:
As it had been established (by the MCA assessment in Oct 2011) that Colin had capacity to make decisions about going out unaccompanied, there should have been greater emphasis on preparatory work to develop his independence in the community and effectively manage risks. This work should have commenced from early in his placement with the Supported Living Provider, rather than waiting until very shortly before Colin (not unpredictably) started asserting his right as an adult, to go into the community without supervision.

Key learning point 2: Staff knowledge of MCA and DoL / DoLS:
All care and support staff working in accommodation-based services for people with learning disabilities should:
• Have at least a basic understanding of Mental Capacity Act (MCA) and Deprivation of Liberty (DoL / DoLS) as they apply to their resident group
• Know which residents are / are not subject to DoL
• Have clear and practical guidance on what actions they can take to lawfully restrict liberty where care amounts to a deprivation of liberty, or the Court of Protection has authorised a DoL.
• Have a clear understanding of the lawful rights of residents who have capacity to consent to care and treatment, to freedom of movement.
• For residents with such capacity, have strategies and skills to support residents to evaluate and manage any potential risks arising from decisions to go out unaccompanied.

Key learning point 3: Care Plan Reviews
When a provider of accommodation and support services makes a specific request for a care plan review, there is a responsibility on Adult Social Care managers and commissioners to urgently and positively respond to that request. In the absence of an appropriate and timely response, the provider should follow this up and (if necessary) escalate the matter with more senior managers.

Key learning point 4: Involving families in review processes
The value of engaging supportive family members in support planning and risk management processes should not be under-estimated. With the consent of the adult in question, consideration should always be given to inviting family members to attend review and planning meetings and generally to have an active input into these processes. Decisions not to involve family members in this way should be recorded, along with a clear rationale for the decision.

Key learning point 5: Violent incidents in care and support settings
If there is evidence of a pattern of violent incidents involving people with care and support needs (as perpetrators and / or victims) in a supported living or care home environment, this should be considered as a potential safeguarding issue. Whether there should be any formal police action against perpetrators who are also service users is a matter for police professional judgement, based on the unique circumstances of each incident. This judgement should be informed by discussions

with the victim and with other professionals with responsibility for care and support planning. Even if the decision is for no formal police action, confirmed incidents of assault should be recorded as crimes.

Key learning point 6: Inter-agency communications and professional challenge.
Where there are safeguarding concerns, effective and timely communication, care planning and risk assessment processes are of paramount importance. These are matters which should be recognised as having joint ownership, rather than 'tasks' to be passed from one agency to the other. If one of the agencies does not carry out agreed actions, professional challenge should be applied by the partner agency.

Key learning point 7: inter-agency communications, care plan reviews and contingency planning
Poor communications from Supported Living Provider staff to police officers contributed significantly to a difficult situation becoming out of control, with an outcome of a vulnerable and partially sighted young man being forcibly restrained and arrested, with the use of an irritant spray. This should have been recognised as further reason to urgently review Colin's care plan, to include:
• Contingency planning for Supported Living Provider staff and Police responses, in the event of similar incidents happening in the future.
• Consideration of whether the Supported Living Provider was suitably equipped to meet Colin's support needs and adequately manage the risks which were highlighted by this incident.

Key learning point 8: Engagement with families in support planning and risk assessment and management.
Where people with care and support needs have a positive and supportive family (or close friend) relationship, the option of directly involving the relative (or close friend) in reviewing care and support plans and risk assessment / management strategies, should be explored regularly (as a minimum in advance of each annual review) with the service user. This should happen on a pro-active basis, rather waiting to see if the service user asks for family involvement.

Additional Learning: Allegations of paedophilia
The incident when Colin was the victim of assault should certainly have triggered a safeguarding adults referral. A critical element of this incident was the completely unsubstantiated accusation that Colin was a 'paedophile'. It should have been recognised that, once such an accusation had gained local currency, Colin could be at increased risk from further assaults. This was particularly so, because he was continuing to associate with this group of young people.

Other reviews of murders of people with disabilities have similarly highlighted that allegations of paedophilia – even when the allegations are based on no credible evidence – should be recognised as a highly significant risk factor for potential abuse and serious physical assault of the person subject to those allegations.*

**There is no evidence to support the view that Colin was murdered for these reasons.*

Good Practice

The SAR has not identified a specific or direct cause and effect link between transition arrangements and the tragic outcome of Colin's murder. There are elements of transition planning which are identified as having been **good practice.**

Bearing in mind the allegations of assault and criminal damage, Police Officers had a power of arrest, but made a judgement that this was not most appropriate course of action. This judgement was made with reference to colleagues who had knowledge of Colin's history and background, which was an example of **good practice**.

As the incident had significantly calmed down when the police arrived and there was no indication that Colin was likely to cause further harm (to himself, others or property) the decision not to arrest him was reasonable and proportionate.
The Police Officer gave helpful advice for the Officer in Charge to inform Adult Social Care of the incident and to pursue a review of Colin's care plan. This was also good practice.

This supervision record confirms that there was management oversight of the Social Worker's involvement, which is expected **good practice**.

The psychologist's conclusions were well founded (and an example of **good practice**). This assessment accurately foresaw the need for an approach based on positive risk taking and regularly updated risk assessments. Unfortunately, the care plan which followed was not sufficiently informed by the Psychologist's conclusions.

There was a pending referral from the social worker for further psychology support, around Colin accessing the community on his own safely and to determine if he posed a risk to others around sexual inappropriateness. Again, this referral is identified as **good practice** by this newly allocated social worker.

The involvement of the 16+ Team evidences that the local authority met their statutory responsibilities, to continue supporting Perpetrator A, up to his 21st birthday. At this point in time, he was facing particular challenges with housing needs and the revelation that his girlfriend was shortly to have a baby. On this basis, support was continued for some months beyond his 21st birthday and this can be seen as **good practice**. It also evident that there was good communication from the 16+ worker and Children's Services in relation to concerns about the baby. This was also **good practice**.

Colin was supported to engage with therapeutic and educational work to address the kinds of behaviours which had put himself and other children at significant risk

"Perpetrator B's apparent agitation and needing to be told to calm down was understood to be due to his disbelief that the plain clothes officers were genuine Police Officers. It was for this reason that a request was made for a uniformed presence."

The decision of the plain clothes officers to request a uniformed presence was **good practice**. The Sergeant's actions in removing Colin from the scene, taking him to a place of safety and ensuring that the Supported Living Provider was aware of the incident, was also **good practice**. Similarly, keeping the incident open as an active police enquiry to allow Colin time to consider (with support from the Supported Living Provider and his Social Worker) whether to make a formal complaint of assault, was another example of **good practice.**

"During the period under review, Perpetrator B had quite frequent contact with at least 5 different health and social care professionals, trying to support him with various aspects of his life"

There is clear evidence that the different professionals were communicating with each other. There were also joint visits, indicating that the need for collaborative work was recognised. To this extent, this was **good practice by the individual professionals involved.**

Local Multi-Agency Recommendations

Overview Recommendation 1
Children's and Adults' Services, including social care and health services, should jointly review transition pathway processes, in the light of learning from this SAR. This should include consideration of:
• The need for a stronger focus on positive risk taking as part of the process of preparation for independence
• The need for better recognition of positive family relationships and the key role family members may play in support planning, risk assessment and risk management strategies, where appropriate.

Overview Recommendation 2
The SAB should ensure that learning from this SAR is shared as widely as possible. Approaches could include multi-agency seminars / workshops / conferences arranged by the SAB, and single agency training, led by the relevant safeguarding leads within those agencies.
Key themes to be covered in these events would include:
• Multi-agency communications, risk assessment and risk management approaches, focusing on the relevant learning points from this SAR
• Planning and implementing multi-agency safeguarding strategies within limited time constraints
• Involvement of families and other informal networks in risk assessment and risk management approaches
• Safeguarding in the context of adults who have mental capacity but make decisions which place them at high risk of significant harm.

Overview Recommendation 3:
The SAB to ensure that this report is shared in full with the local Safeguarding Children Board.

Is Your SAB Assured?

Transitions Pathways (Children Services, Adults Services and Health)
Does your local transition pathway process focus on positive risk taking as part of the process of preparation for independence? Does it recognise the key role family members may play (where appropriate) in support planning, risk assessment and management strategies? Is coordination between agencies robust in order that the individual's holistic care needs are fully addressed within their care plan?

Contact by the Police with Persons with Learning Disabilities and Autism
It is important that initial contact by the police with persons with learning disabilities and autism does not exacerbate a difficult situation. Does your local force provide training to front line offers and police staff in respect of contact with individuals with learning disabilities and autism?

Duty of Care
Where applicable are staff encouraged to raise concerns about any actions, or lack of action, that they felt were having an impact on service delivery, safety or their ability to complete their role and uphold their duty of care?

Policies, Procedures and Guidance
Do agencies have in place case recording guidance, case transfer guidance, risk assessment guidance allocation principles, handover guidance, and safeguarding policies?

Reflective Practice
How do organisations encourage reflective practice in relation to safeguarding and managing risk?

Multi-Agency Risk Assessments
Are multi-agency risk assessments of a sufficiently high standard and include feedback from key agencies and significant others in the individual's life? Are assessments reviewed and updated regularly?

Criminal Justice Liaison Diversion (CJLD)
How well does your CJLD communicate with individuals with cognitive impairments?

Care Programme Approach (CPA)
Is the consideration and rationale for any CPA decision clearly documented in the patient's records at initial assessment and when the needs of a patient change?

Allegations of Paedophilia and Associated Risks
Do SAB partners recognise allegations of paedophilia as a highly significant risk factor for potential abuse and serious physical assault of the person subject to allegations?

Commissioning Supported Living Providers
Are processes used to manage and monitor assurance from providers that their staff are trained in, and understand, the Mental Capacity Act and associated terminology 'fit for purpose'? What internal reporting and recording pathways do you have for concerns about service providers?

Useful Resources

Paedophilia allegations:

- Bijan Ebrahimi
  https://www.bristol.gov.uk/documents/20182/35136/Multi-agency+learning+review+following+the+murder+of+Bijan+Ebrahimi/c2b17b97-c9ec-a5f4-70e4-fc82d1ccb119
  'Local belief that an individual is a sex offender or a paedophile must be regarded as an important risk of harm indicator. The many examples of individuals being targeted for violent attacks on suspicion of them being paedophiles illustrates a prevailing 'moral compass' amongst many in UK communities that is tolerant or even permissive towards such victimisation[31].'
- Steven Hoskin
  https://www.cornwall.gov.uk/media/3633936/Steven-Hoskin-Serious-Case-Review-Exec-Summary.pdf
  '3.1.11 Finally, the allegations that Steven was 'a paedophile' and 'a known sex offender' cannot be proven. Steven had no convictions for sex offences and had not been subject to any police investigations yet Darren advanced these allegations to his girlfriends. A rumour-dynamic of this order is impossible to suppress and, as the final hours of Steven's life testify, it had chilling consequences.'