Wiltshire Safeguarding Adults Board

Local Learning Review - Adult H

Our review

This briefing outlines the learning from a review carried out by the Wiltshire Safeguarding Adults Board (WSAB) in relation to an Adult at Risk (referred to here as Adult H).

The Care Act 2014 states that Safeguarding Adults Boards (SAB) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of, or is thought to have suffered, abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

This review does not relate to the death of an adult at risk, however the Board received a referral after a serious safeguarding incident and made the decision to undertake a review on the basis that there was a significant opportunity for partners to identify learning.

The purpose of a SAR is to promote effective learning and improve action to prevent future deaths or serious harm occurring. The aim is to learn from serious incidents and improve the way agencies work together. The purpose is not to re-investigate an incident, nor is it to apportion blame - other processes exist for such investigations, including criminal proceedings and disciplinary procedures.

The methodology used for this review was our own Local Learning Review (LLR) process. Each organisation completed a report for the WSAB and these, along with other relevant information, were considered at a desktop review session. That session was attended by those agencies and chaired by the Independent Chair of the WSAB. A report was produced to capture that discussion and to identify findings and recommendations.

The findings from this report have been shared with Adult H and, in accordance with her wishes, the full report will not be published. However this briefing provides a summary of that report. We encourage all those working with vulnerable adults to read this briefing and reflect on how you can challenge your own thinking and practice to better protect vulnerable adults.

This document includes a feedback sheet to capture how you have used this learning. This should be completed and returned to LSAB@wiltshire.gov.uk

Executive summary

In September 2018, a referral was made to WSAB by Wiltshire Council in relation to Adult H. This followed two incidents concerning Adult H and another adult, Adult I, which were reported to Wiltshire's Adult Multi-Agency Safeguarding Hub (MASH).

Adult H, who is in her 70s, was at the time a permanent resident at a Care Home in Wiltshire where she had access to around the clock care and support services. Adult H has dementia and other care and support needs.

An initial referral was made to the adult MASH by staff at the Care Home after Adult H activated an alarm when a male resident was in her room. Staff entered the room to find the male resident on the bed with Adult H, touching her inappropriately. Adult H was found to be greatly distressed and the male resident was asked to leave the room. However, three hours later the male resident accessed Adult H's room again and was found lying on the bed, partially dressed, on top of Adult H.

The male resident, Adult I, is in his 90s and has dementia, although he was assessed as having capacity to make decisions in relation to sexual relations and consent at the time of the incidents.

After the incidents had been reported to the adult MASH, a police investigation began and it emerged that the male resident, Adult I, had a number of convictions, serving several sentences for serious sexual offences against minors. As a result, he was on the Violent and Sex Offender Register (ViSOR). Neither the Care Home or Wiltshire Council, who paid for the placement, had previously been made aware of Adult I's history of offending.

Wiltshire Police investigated the incident and a safeguarding enquiry was carried out. Adult I was moved to a male-only care home. Crown Prosecution Service thresholds for prosecution were not met and, in May 2019, the police investigation was closed. When officers visited Adult H to inform her of that decision, it is reported that Adult H did not remember Adult I or the incident at that time.

The case was referred to the WSAB to assess how partners can learn from what happened to Adult H and ensure that, in future, adults at risk are better protected from harm.

Learning - what needs to change?

Learning Point: If a crime has been committed, the police should be called immediately – adult MASH does not need to be contacted before that call is made. WSAB should provide a briefing to all agencies for staff, setting out when it is appropriate to call the Police and when adult MASH should be the first point of contact.

Learning Point: When police are aware that a person on the ViSOR has moved home, they will disclose this status to the housing provider and any local authority funded provision.

Learning Point: The care provider will review the specific questions they ask new residents regarding their criminal convictions. This should happen in conjunction with associated organisations within the care sector.

Learning Point: Where the Probation Trust or Police are aware of the deteriorating mental or physical health of an individual on the ViSOR, a plan must be agreed with the individual that ensures appropriate information is shared with care and support settings to effectively manage risk. Wiltshire Police and the Probation Trust should provide a report to the Board evidencing:

- How assessment will be made of individual cases to which this recommendation applies.
- Plans to ensure that information is appropriately shared in those cases.

Learning Point: Clarity is needed from the police when a Housing Association are given sensitive information about a tenant by the police, about what they are expected to do with the information should something in the person's circumstances change.

Learning Point: Police should be clear when disclosing information with any agency about what they expect that agency to do with it.

Learning Point: Housing Associations should inform a tenant's Offender Manager if they are aware that the person is moving out of their property. This places the responsibility for managing that risk and informing the new housing provider on the Offender Manager, which is their role.

Learning Point: All victims of sexual assault are entitled to the same protections regardless of age or the state of their mental or physical health. The Review recommends that, when a sexual assault takes place in a residential health or care setting, the police and commissioning agency should seek to immediately speak to the victim of the assault to ascertain their wishes and ensure they have access to support services and, where appropriate, offer alternative accommodation.

Learning Point: Professionals should have confidence in disclosing and sharing information between and within agencies that care for adults at risk (or children and young people) when that information is being shared specifically to protect those in their care from harm (advice on sharing information can be accessed here).

National Learning: There is a need to highlight the learning from this review nationally to expose a gap in national policy around those with responsibility for telling others that they are on the Violent and Sex Offender Register who also have declining mental capacity which may prevent them from doing so. That gap is more significant given the increasing prevalence of dementia, and that the onset of dementia can markedly change a person's behaviour (as described in this paper by Alzheimer Scotland).

A copy of the Board's report will be sent to Michelle Skeer QPM, Cumbria's Chief Constable. Michelle is the National Police Chiefs' Council lead for the Management of Sexual Offenders and Violent Offenders.

Good practice - what works?

What happened in this case demonstrates areas where we can and must do more to safeguard adults at risk. It also highlights the work done by professionals in Wiltshire to try and do that. For example:

- It is vital that we acknowledge the voice of the adult at risk - Adult H has praised the support she was provided with at the Care Home and the efforts made by staff.
- Staff at the care home received effective and timely advice from Adult MASH which, at that time, was staffed by the Local Authority and the police.
- The Housing Association were made aware that Adult I was on the ViSOR and Wiltshire Police's Offender Manager worked proactively with colleagues at the Housing Association to try to ensure that, if Adult I moved, information regarding his status was passed on.
- Staff at the Care Home made a safeguarding referral and called the police. A safeguarding enquiry and a police investigation then took place in relation to these incidents.
- Other residents at the Care Home were kept safe from harm and steps taken after the incident also meant that Adult I was safe from any retaliatory actions.

Feedback

To further help us share this learning, please complete the short form below and send back to us at lsab@wiltshire.gov.uk.

Name	Date
Job title	
Agency	
Who was this briefing cascaded to (e.g. District Nurses, Social Workers)?	
Where was this briefing used (e.g. 1:1/group supervision, team meeting, training event with how many staff)?	
Changes to your organisation's practice following the learning:	
1. **2.** **3.** **4.** **5.**	
Other feedback:	