Northamptonshire Safeguarding Adults Board

Learning from Safeguarding Adult Reviews

Key findings and learning from Safeguarding Adults Review - Ref 016 - 'Dean'

The Purpose of a Safeguarding Adults Review (SAR) is to promote learning and improve practice where there is concern that partner agencies could have worked together more effectively to protect the adult. A SAR will not re-investigate or apportion blame but supports professionals to adjust practice in light of the lessons learnt from the review.

Sharing Learning from both local and national Safeguarding Adult Reviews (SARs) and other reviews is a key priority for Northamptonshire Safeguarding Adults Board (NSAB).

Following the Safeguarding Adult Review Ref 016 - 'Dean', an action plan is in place with key multi-agency and single-agency recommendations and actions for organisations linked to the case. Progress will be monitored via the NSAB Quality & Performance and Safeguarding Adult Review Sub Groups.

This learning briefing summarises the key findings and recommendations from the review.

Managers should discuss this briefing with their teams to ensure that the learning is used to enhance existing good practice and to make improvements where necessary. Feedback will be sought from partner agencies via the NSAB Learning & Development Sub Group to ensure that the learning has been cascaded.

The Safeguarding Adult Review Summary - 'Dean' was recently published and a summary report is available on the NSAB website.

The review evaluates multi-agency responses concerning the death of 'Dean' who died in June 2018.

Dean had known alcohol issues and was placed in supported housing accommodation with a man with a long history of violence, alcohol and drug abuse, and had been subject to MAPPA.

There was no risk assessment made as to the men's suitability to reside together in the same house.

Dean's housemate was subsequently convicted of Dean's murder.

The timeline of the review was determined as being from 1st August 2015 (the date that the perpetrator was referred to the housing provider to the date of Dean's death on 22nd June 2018.

Note: NSAB is also referred to as 'the Board' throughout the recommendations in the report.

The Safeguarding Adult Review

The Safeguarding Adult Review was led by an independent author who used a systems based approach that included detailed agency chronologies and a practitioners' event. No Independent Management Reports (IMRs) were requested from agencies. The review examined a number of key areas of concern:

- The perpetrator's supervision via MAPPA following his release from prison in 2007 after serving a 10-year sentence for Grievous Bodily Harm for attacking his wife with a bladed weapon when she visited him in prison, where he was serving a custodial sentence for arson with intent to endanger life.
- The sharing of information between agencies and their compliance with the Northamptonshire Safeguarding Adults Board Information Sharing Protocol of August 2019, particularly with regard to the perpetrator's repeat offending whilst in possession of bladed instruments.
- The risk assessment process at the supported housing provider when considering the placement of residents.
- The lack of professional curiosity between agencies.
- The manner in which complaints by Dean and his housemate, were dealt with.
- The manner in which Dean's request to be moved from the perpetrator in supported housing were dealt with.

Conclusions

Information sharing

- The Northamptonshire Safeguarding Adults Board Information Sharing Protocol is clear that information can be shared between agencies where there is a safeguarding issue, and it is safe and legal to do so, but consent should be sought where possible. For this case, there was a distinct lack of information sharing between agencies regarding the perpetrator's criminal history and that more recent incidents involving the perpetrator were looked at in isolation.
- There was a clear lack of coordination and communication between agencies resulting in decisions being based on the limited information available at the time; this included agencies not being made aware of a number of incidents involving the perpetrator being caught in possession of bladed instruments.

Lack of Professional Curiosity

- During the eight months that Dean and the perpetrator lived in the same house, there were a number of warning signs regarding the deterioration in their relationship, and the lack of professional curiosity from the management and staff at the housing provider regarding concerns raised by both men.
- The perpetrator was involved in three separate acts of violence involving a bladed weapon between 2016 and 2018 and these and other incidents were looked at in isolation of each other.
- Further incidents regarding the perpetrator were dealt with in isolation and there was a lack of co-ordination and information sharing between public protection agencies and the housing provider.
- The housing provider appeared to consider the perpetrator a risk when involved in 'domestic' incidents only, but in reality he was a dangerous man and anyone was at risk of his violent behaviour.

Risk Assessment

- There was no evidence that there was adequate risk assessment in place when Dean was placed in the accommodation with the perpetrator.
- There were missed opportunities to re-assess the risk to both Dean and the perpetrator as a result of complaints made to staff.

Dean's concerns

- A short time before his death, Dean had confided in the street drinkers he associated with, that he was scared of his housemate and that the perpetrator had threatened him with a knife. Matters came to a head and on 21st in June 2018, Dean made a complaint to staff at the supported housing provider that the perpetrator's behaviour towards him was unbearable and he wanted to move to different accommodation. Arrangements were made to move him the following day, which Dean was happy about. That same evening, the perpetrator went into Dean's room and stabbed Dean to death while he was sleeping in his bed.

Recommendations

1. Where individuals who are under license but do not meet the criteria for MAPPA (Multi Agency Public Protection Arrangement) and where the police, probation or other statutory agencies have significant concerns regarding the risk that the individual poses to themselves or others, then a professionals meeting should be considered by the lead agency to ensure effective information sharing and management of risk. The concerns may be based on incidents that involve the use of weapons, violent behaviour, making threats or other concerning patterns of behaviour. Evidence should be provided to Northamptonshire Safeguarding Adults Board by both police and probation and that this process is embedded in practice.

2. With the introduction of Northamptonshire Police Prevention and Intervention Command, the Head of that Command should provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they have made progress with plans to embed a process to prioritise the collation of information from Offender Management systems, MAPPA, Probation and risk management systems in order to gather and assess intelligence which results in proactive action.

3. All agencies and housing providers to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they are aware of Northamptonshire Adult Safeguarding Board Information Sharing Protocol of August 2019 and that this is embedded into training and practice.

4. The housing provider to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that risk assessments will be conducted by adequately trained staff on all new and existing residents to ensure that their respective histories indicate that they are suitable persons to share accommodation and maintain a safe environment. Also, that any differing resident needs are considered by Richmond Fellowship staff appropriately and in a timely manner. That these risk assessments are kept up to date and are regularly reviewed and revised when circumstances change or new information comes to light. All risk assessments should result in a plan to reduce risk where necessary.

5. The housing provider, Northamptonshire Police and National Probation Service to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that the training for all staff includes issues around professional curiosity and holistic and person centred assessment, to ensure that in such circumstances in the future, robust and immediate action will be taken to alleviate potentially volatile situations.

6. National Probation Service to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that the service is compliant with the relevant recommendations made in the Inspection Report 'An inspection of central functions supporting the National Probation Service' January 2020.

7. All agencies to provide assurance and evidence to Northamptonshire Safeguarding Adults Board that they have implemented the learning, changes and recommendations set out in their respective actions plans following the Practitioners' Event by 30th June 2021.

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Good Practice

- In June 2018, when the perpetrator reported that he had had an altercation with a man and had held a knife to his throat and that he could have killed him, good practice shows that the housing provider, the police and the senior probation officer were informed of this incident.

General Observations

- Whilst agencies appeared to support Dean and the perpetrator, it was often in isolation of other agencies, and there was little good practice to be identified in relation to information sharing and multi-agency working.
- Whilst the housing provider supported Dean and the perpetrator with housing, their efforts do not appear sufficient to meet the men's complex needs.
- There were missed opportunities in respect of the risk that the perpetrator posed to others as he was not subject to any re-assessment of risk of his sentencing plan.
- There were also a number of missed opportunities from all agencies, statutory or not, regarding the importance of multi-disciplinary meetings, and where cases fall outside the criteria for the Adult Risk Management (ARM) process, that they should consider holding a multi-agency professionals meeting and acknowledge that there are no barriers to doing so.

Key Points for Learning

- There were a number of missed opportunities for multi-disciplinary meetings to discuss concerns regarding the perpetrator's risk to others, particularly when the formal arrangements for public protection or MAPPA. The incidents the perpetrator was involved in were dealt with in isolation.
- The Police Public Protection Notice (PPN) process should be used to share information and assess whether a professionals' meeting is required.
- When criteria for MAPPA is not met and there are concerns, a professionals' meeting should be considered in order to share information. This responsibility for organising the professionals' meeting sits with the lead agency in that case, or the one that has the greatest responsibility for managing, supervising or supporting the offender.
- Information should be shared with agencies as per the Northamptonshire Safeguarding Adults Board Information Sharing Protocol.
- When considering placing adults in shared accommodation, thorough risk assessment should be given to the individual's history and suitability for sharing a dwelling.

You can find the published summary on the Northamptonshire Safeguarding Adults Board Website

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