SAFEGUARDING ADULT REVIEW LEARNING BRIEFING

JANUARY 2021

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

A Safeguarding Adult Review (SAR) is a multi-agency process which seeks to determine what relevant agencies and individuals involved with an individual could have done differently to have prevented harm or a death from taking place.

The Care Act 2014 states that a Safeguarding Adults Board* must commission a SAR when:

• An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more or effectively to protect the adult

• An adult in its area has not died, but the adult has experienced significant abuse or neglect, whether known or suspected.

*In Bristol, the Keeping Bristol Safe Partnership includes the function of the Safeguarding Adult Board.

MARTYN SAFEGUARDING ADULT REVIEW

Martyn was a 25 year old man with mild learning disabilities and foetal alcohol spectrum disorder. He tragically died in October 2018. Video evidence from the hours prior to his death showed that he had been the subject of abuse from his 'friends' whilst the group was intoxicated. The cause of Martyn's death could not be definitively linked to the abuse and was recorded as 'unascertained'.

Why was a SAR commissioned?

Although Martyn's death could not be attributed directly to the abuse he suffered prior to his death, it was agreed that the circumstances met the criteria to hold a SAR. Martyn had multiple care and support needs and a number of organisations had contact with him or were involved in his care. Some of the 'friends' involved in the incident were also eligible for care and support services.

SAR process

As part of this SAR process, the agencies involved with Martyn provided written reports and attended a series of review team meetings. An independent author analysed this information and produced the final report, including recommendations for improvement to practice in Bristol.

BACKGROUND INFORMATION

- Martyn was adopted as a baby into a caring family. He had a 'strong and positive relationship' with his mother throughout his life.
- From an early age, Martyn had displayed behaviours which were observed as aggressive and disruptive and as a result underwent assessments in order to understand these. A diagnosis of foetal alcohol syndrome was made. It was also noted that Martyn had traits associated with Asperger's Syndrome, delayed puberty and hormonal imbalance, Raynauds Disease and asthma.
- Martyn attended special education residential schools for the majority of his education.
- Martyn first came to the attention of Bristol City Council Adults Social Care through a referral to the council's Preparing for Adulthood Team regarding his transition from a residential educational college.
- Martyn held a Bristol City Council housing tenancy.
- Martyn received support from an organisation called Second Step to help him develop a range of daily living skills and to sustain his tenancy.
- Martyn received art therapy sessions from Bristol Community Health Community Learning Disability Team to support him with parts of his behaviour, which were impacting on his day to day life.
- Martyn came to the attention of the police 18 times in the year leading up to his death. Often contact with the police was when Martyn had concerns for his friends or following arguments with friends where evidence of alcohol and/or drug use was a contributing factor.

KEY EVENTS

- **Sexual assault and moving tenancy**
  In September 2016, Martyn disclosed to his Art Therapist that someone had recently attempted to sexually assault him in his flat. A safeguarding adults referral was made by the therapist, at which time Bristol City Council Housing and Landlord Services, Social Services and the police were already aware of the incident and were undertaking assessment and support planning. With support from Bristol City Council Housing and Landlords Services, using the HomeChoice Bristol allocation scheme, Martyn bid to move from his home to another area in the city at a distance from the alleged perpetrator. This application was successful and Martyn moved the following month with his support package remaining in place.

- **Volunteer role**
  Martyn trained to be a volunteer with Second Step in May 2017 and began working as a 'meet and greet' volunteer at events. This role was chosen for him as it was seen as the least demanding role available at the time, however Martyn struggled with elements of the job, in particular interactions with members of the public and this made it hard for him to continue. The role ended and he declined support to find another opportunity elsewhere.

- **Ending support service**
  Martyn raised a complaint with Second Step, because he was not satisfied with the support he received. It was evident that there was some confusion between Martyn, Second Step and Bristol City Council about the number of hours of support Martyn should receive which added to this. An Investigating Officer was allocated to look into the complaint and met with Martyn to discuss the findings and recommendations. Martyn seemed pleased with these, but still decided to cancel his service in September 2017.

- **Hospital admission**
  In June 2018, Martyn was admitted to hospital following excessive alcohol and cannabis intake, and an altercation with his neighbours. Hospital staff deemed him to lack capacity when he became agitated and aggressive and he was sedated. When Martyn awoke he assaulted and threatened a doctor who was attempting to restrain him. He had no recollection of having been in hospital when interviewed in police custody the following day, and he denied alcohol dependency. It was noted that he was autistic and Martyn's mother had been in contact with the hospital to give advice on how to manage his behaviour, but unfortunately this did not get to staff ahead of the incident.

- **Dispute with neighbour**
  In August 2018, Martyn contacted the police to report that a neighbour was threatening him and alleging that he was a paedophile. The same neighbour contacted the police the next day with concerns that 14 year old boys were entering Martyn's flat. Police visited the neighbour in question and several other neighbours, most of whom accepted that Martyn might have learning disabilities and other issues that might affect his behaviour, but he did not pose a risk to children. The police contacted the council's Housing Officer to raise concerns about the dispute. The Housing Officer was aware of the allegations, and together with the police, they completed a joint visit to both addresses and worked together to find a solution. The neighbour was advised to stay away from and to report any incidents or concerns to the Housing Officer or the Police. Martyn was referred to Victim Support, an independent charity for people affected by crime and traumatic events. A safeguarding adults referral was also made to Bristol City Council regarding Martyn, with safety measures implemented by the police and Bristol City Council Housing and Landlord Services. Martyn continued to allow young boys to visit him, leading to further concerns. A further safeguarding adults referral was made in September 2018 regarding this, but a strategy discussion determined that Martyn posed no threat to them.

- **Circumstances of Martyn's death**
  On the morning of 21 October 2018, Martyn was found unresponsive and not breathing on the sofa at a friends' home and an ambulance was called. The previous evening Martyn and a group of friends had been drinking heavily and, at some point, Martyn fell asleep on the sofa. Once he had fallen asleep the other persons took advantage of him by assaulting him whilst taking photographs and filming this abuse on a mobile phone. As Martyn died in suspicious circumstances, a forensic post-mortem was held. The cause of Martyn's death was recorded as 'unascertained' and could not be definitively linked to the abuse, therefore the perpetrators were charged with Actual Bodily Harm (ABH).

GOOD PRACTICE

- **Multi-agency understanding and implementation of safeguarding adults protocol and processes**
  The Art Therapist made a referral to both the police and Bristol City Council Social Care following Martyn's disclosure about an attempted sexual assault. The incident was logged internally and passed on appropriately, showing a clear understanding of when professional duty of care must override confidentiality.
- **Identification of vulnerability**
  The police demonstrated an understanding of Martyn's learning disability and behaviour. They record positive ways of managing difficult community situations and good communication between officers and with other agencies. There are examples of 'going the extra mile' to safeguard Martyn, with follow up calls actioned as well as advice. Call handling staff showed professional insight in identifying serious concerns underlying a call about a neighbourhood dispute. Since the review period, Avon and Somerset Police have implemented a BRAG (Blue, Red, Amber, Green) vulnerability tool and rating system to help staff identify and risk assess all forms of vulnerability and safeguarding. This was not used formally regarding Martyn, but issues were identified and acted upon.
- **Consistency of staff**
  The Housing Officer was the same throughout Martyn's tenancy, which facilitated a good working relationship. The same Social Worker was also involved with Martyn for many years adding to the consistency of support he received.
- **Communication between organisations**
  There was evidence of good communication between the police and Bristol City Council Housing and Landlord Services with documentation of events, evidence of emails, meetings and joint home visits to resolve problems. This facilitated swift decisions and problem solving.

LEARNING THEMES

Mental capacity

This SAR describes situations in which 'unwise decisions' led to difficult and dangerous circumstances, and may have been contributory factors in Martyn's death. It is therefore important to consider whether his mental capacity to make these decisions was sound. Mental capacity is decision specific and depends on the individuals' understanding of the facts around the decision to be made, and their ability to weigh up risks. It is assumed that a person has capacity unless there is evidence to the contrary, in which case further assessment and actions may be required under the Mental Capacity Act 2005.

The organisations supporting Martyn did not report doubt that he lacked capacity at any point in their work with him, apart from when he was intoxicated in hospital. The council's Preparing for Adulthood Team state that they considered mental capacity in some of the risks that he presented, but it was felt that he had the capacity to make his own decisions and access help if required. The work done by the Art Therapist during 2016 indicated that Martyn had insight into his challenges. The therapy helped Martyn understand his options in making his own decisions and his choices were respected. The therapist facilitated exploration with Martyn regarding his relationships with others, his alcohol consumption and discussed coping strategies, and he demonstrated capacity and insight.

Martyn's Social Care Assessment and Care Plan in 2015 identified a range of needs and established a support package to facilitate his independent living in the least restrictive environment available to meet his needs. This plan worked as Martyn's self-care and housekeeping skills improved, however despite input to support Martyn socially, the problems with friends and neighbours continued. It would appear that Martyn's need for acceptance and inclusion by his peers, along with his lack of social insight, led him to make risky choices which were further compounded by his substance misuse. Martyn terminated his support package, believing it was of no help to him and it was not provided effectively. He did not take up Second Step's offer to review his support service and, on reflection, may have lacked the insight that it was necessary to him. There was little discussion with Martyn about his options when he chose to stop the Second Step service and his case was closed to the council's Preparing for Adulthood Team. In making the decision to stop the input from Second Step, it seems that Martyn was not aware of its value to him or that different options were available. Since then, Second Step's Floating Support Service has undertaken a number of improvements. One element of this work has been to reach an agreement with Bristol City Council that Second Step is able to complete reviews of client's

changing support needs without direct input from a Social Worker (the Social Worker would provide scrutiny and sign off of any proposed changes to the hours and/or focus of support). This removes an administrative step from the process of tailoring services to meet needs and should avoid confusion for the service user, which led partly to Martyn's complaint. In addition to this, Second Step has introduced a 28 day 'cooling off' period after a service user requests to end their service. This offers the opportunity for further reflection about the need for services and to provide a transition should the client wish to transfer to another service.

Martyn appeared to have the capacity to make choices, although these were considered to be unwise ones at times, with his judgement impaired significantly when drugs and alcohol were a contributing factor. The review noted that during the final months, a pattern emerged of Martyn making 'unwise choices in relation to his friends and in the community'. This had made him more vulnerable to risk and harm. Martyn continued to have support and advice from services and his family around this time, but on occasions he chose not to follow this which resulted in him experiencing harm. Was he unwilling, or unable to act on the advice or learn from the repeated experiences? With the benefit of hindsight, it is suggested that Martyn may have lacked the 'executive' capacity to follow through.

Further reading and resources

- Mental Capacity: resources for professionals on the Keeping Bristol Safe Partnership website
- Resources from the 2019 conference about mental capacity on the KBSP website
- NHS briefing document with further information about executive capacity

Social isolation and meaningful activity

Martyn was a vulnerable young person who acquired the skills to live independently in terms of self-care and maintaining his home environment, but he struggled to develop the skills and behaviour to keep himself safe at times. It would appear that he did not have enough to do to occupy his mind and keep him from boredom. His mother feels strongly that Martyn needed help to find meaningful activity, but that the right sort of help did not seem to be available.

In early 2017, Martyn took on the role of a 'meet and greet' volunteer with Second Step. Martyn struggled to fulfil this role, and as a result, the staff team decided to end his involvement. We are unable to really know how this experience affected Martyn, but it is possible that he would have seen it as a failure and dented his self-esteem. With hindsight, the service concluded that this placement was not well suited to Martyn, despite the commitment and additional support provided by the team. Since then, the Volunteer Service at Second Step has put a number of improvements in place including extending the assessment process, increasing clarity around the additional support the team are able to offer, and developing work with staff and the service user to offer additional support to volunteers with lived experience. This includes increasing the awareness of and making it easier to access other similar opportunities within Second Step.

In September 2017, Martyn's social work support from the council's Preparing for Adulthood Team and community support from Second Step finished, albeit at his own request. In November 2017, his art therapy concluded. After that Martyn was left with limited input from services, but continued to have support from his family and received reactive input from Bristol City Council Housing and Landlord Services and the police when he needed it. There has not been any conclusion regarding any action or service which would have changed the tragic outcome for Martyn. However, it is possible that further assessment by the council's Preparing for Adulthood Team might have identified other ways in which Martyn's social needs could be met. On reflection, the team consider that the case closure may not have been the most appropriate action in a complex case, particularly as Martyn had moved to independent living relatively recently. Since the review, the council's Preparing for Adulthood Team has improved its risk assessment for service users in transition when case closure is under consideration. It is also establishing a new 'Transitions to Adulthood Team' to promote greater independence from age 14.

Further reading and resources

- Bristol WORKS for Everyone programme: Employment Support services for people with a learning difficulty, from age 14 to retirement. To find out more visit the Bristol WORKS for everyone website
- Activities for adults with learning disabilities listed on the KBSP website

The SAR report will not be published. This is because the circumstances of this case mean that those involved could be readily identifiable, and in particular we wish to protect the privacy and dignity of Martyn. Martyn's mother has written a public statement which has been published alongside the KBSP response to this SAR and the recommendations.

Read both statements here: www.bristolsafeguarding.org/adults/safeguarding-adult-reviews/martyn/

FEEDBACK, IDEAS AND SUGGESTIONS

Tell KBSP how you have used this briefing in your team or send us your feedback.

Email: KBSP@bristol.gov.uk

Website: www.bristolsafeguarding.org/contact-us

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Mate crime

Martyn was described by those that knew him as a friendly person who craved company, so it is not surprising that he was keen to make friends with anyone who would show an interest in him, without having the ability to differentiate between a genuine friend and someone who may exploit him. He received advice on how to set boundaries from his Art Therapist, and had advice from the police and his Housing Officer, but he may not have been able to translate this into his day to day life or ignored warning signs as his need was so great. This is in keeping with the findings of the Thematic Mate Crime Review (2018) undertaken by Bristol Safeguarding Adults Board and Safer Bristol Community Safety Partnership.

Further reading and resources

- Mate Crime Thematic Review (2018) on the KBSP website
- Mate crime leaflet and other resources on the KBSP website
- Quarmby (2013) Mate Crime: A Challenge for the Police, Safeguarding and Criminal Justice Agencies
- A SAR with similar themes in regards to mate crime: Warwickshire Safeguarding Adults Partnership Serious Case Review: The Murder of Gemma Hayter 9th August 2010

Substance misuse

Martyn's judgement appeared to be impaired significantly when drugs and alcohol were a contributing factor resulting in him making decisions which made him more vulnerable.

After his support services and art therapy ended in late 2017, there were few services involved with Martyn. The GP practice reported that Martyn did not take up the offer of an annual review of his health needs recommended for everyone on the Learning Disability Register. Whilst this is voluntary, the practice considered that they could use their database more effectively to highlight 'low attenders' and take appropriate action. It is not clear how this would have impacted on the outcome for Martyn, but the process may have identified the threats to Martyn's health, such as the excessive alcohol and drug use, smoking and his asthma, and offered opportunities for support and onward referral.

Further reading

- Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews on the Alcohol Change UK website

FINAL THOUGHTS

The partnership would like to end this briefing by expressing condolences to Martyn's family along with thanks to Martyn's mother whose engagement with the review has provided an invaluable perspective on Martyn's experiences. The partnership is committed to delivering change as a result of the findings from this review.

Martyn's mother has written her own public statement, which is available to read on the KBSP website alongside the Keeping Bristol Safe Partnership full response to how we will implement the recommendations from this review.