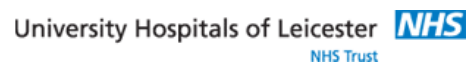




# Executive Summary of Serious Case Review in relation to A and B

## **LEICESTER, LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD**

September 2008



## 1) INTRODUCTION

### **Circumstances leading to the decision to hold a Serious Case Review**

- 1.1 A and B died in 2007. Subsequent investigation by the police did not identify any suspicious circumstances concerning the deaths. No further details will be given in this summary in order to protect the identities of A and B. However, the circumstances were such that the Chairperson of the Leicester, Leicestershire and Rutland Safeguarding Adults' Board proposed that a review be set up to investigate what lessons might be learnt from this in relation to individual and multi-agency policy and practice in safeguarding vulnerable adults.
- 1.2 The need for a serious case review was confirmed on 17<sup>th</sup> December 2007 at a special joint meeting of the Adults' Safeguarding Board and the Local Safeguarding Children Board. It was also confirmed that, as B was eighteen at the time of her death, the review would follow the procedures agreed by the Safeguarding Adults Board but draw on the experiences of the Local Safeguarding Children Board in carrying out serious case reviews.
- 1.3 In addition to this joint review, both Leicestershire Police and Hinckley and Bosworth Borough Council set up internal reviews to consider their involvement with A and B.
- 1.4 The first meeting of the Serious Case Review Panel agreed that there should be an independent Chair, from an authority not involved with A and B.
- 1.5 The Review Panel set up to look at the agencies' involvement with A and B had representatives from:

Leicester City Council (independent Chair);  
Leicestershire Police;  
Hinckley and Bosworth Borough Council  
Leicestershire Children's and Young People's Service, Social Care safeguarding;  
Leicestershire Youth Offending Service;  
Leicestershire Adult Social Care Services;  
Leicestershire connexions;  
Leicester, Leicestershire and Rutland Safeguarding Adults' Board  
Leicestershire County Council Legal Services;  
Leicester, Leicestershire and Rutland Primary Care Trust;  
Leicestershire Children's and Young People's Service, Targeted Services.

### **Purpose of the Serious Case Review**

- 1.6 Serious case reviews are well established in Children's Services and required by statute. This is not the case in services for vulnerable adults: however, they are seen as good practice and a national review currently being carried out by the government may result in their also being put on a statutory basis.

Safeguarding vulnerable adults is still a relatively new process for agencies working together in the United Kingdom. The first government guidance in this area<sup>1</sup> - *No Secrets* – was published in 2000. In 2001, the first policies and procedures were agreed in Leicester, Leicestershire and Rutland. These were revised in 2004<sup>2</sup>. These were supplemented in November 2007<sup>3</sup> with the first agreed protocol for serious case reviews involving vulnerable adults. This serious case review has been the first undertaken locally under this protocol.

1.7 Under the agreed protocol, the purpose of having a case review is not to reinvestigate or to apportion blame. The emphasis is on learning from the review so that individual and partnership practice can improve. In this, the approach is consistent with serious case reviews in Children's Services, in which government guidance says that 'Serious case reviews are not inquiries into how a child died or who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate'.<sup>4</sup>

1.8 The Review Panel agreed the following purposes for this case review:

- to establish whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- to review the effectiveness of procedures (both multi-agency and those of individual organisations);
- to inform and improve local inter-agency practice;
- to improve practice by acting on learning;
- to prepare an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action;
- to translate recommendations from the overview report into an action plan, which should be endorsed at senior level by each agency.

## **Contributors to the Review**

1.9 In line with the agreed protocol, the Review Panel sought management reports, including a chronology of involvement, from all agencies who had contact with A and B. Agencies were asked to analyse their involvement, to draw out lessons and to make recommendations.

---

<sup>1</sup> Department of Health and Home Office (2000) *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* London: Department of Health.

<sup>2</sup> Social Services, Health and Police in Partnership with the CSCI and the Voluntary and Independent Sector within Leicester, Leicestershire and Rutland (2004) *NO SECRETS Multi-Agency Policy and Procedures for the Protection of Vulnerable Adults from Abuse*.

<sup>3</sup> Leicester, Leicestershire and Rutland Safeguarding Adults' Board (November 2007) *Vulnerable Adult Serious Case Review Protocol Leicester, Leicestershire and Rutland*.

<sup>4</sup> Page 170 in HM Government (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* London: The Stationery Office).

1.10 Agency management reports were prepared by:

- Leicestershire Police;
- Hinckley and Bosworth Borough Council;
- Leicestershire Children's and Young People's Service, Education;
- Leicestershire Health;
- Leicestershire Youth Offending Service;
- Leicestershire Children's and Young People's Service, Social Care ;
- Leicestershire Adult Social Care Services, Transitions;
- Leicestershire connexions

1.11 This Executive Summary provides a resume of the circumstances of this case, the main issues arising from it and recommendations which have been made to further improve safeguarding arrangements in Leicester, Leicestershire and Rutland.

## **2) INVOLVEMENT OF AGENCIES WITH THE FAMILY**

- 2.1 In what follows, factual information from agency management reports is summarised. The focus is on the period from mid 2005, but information was also gathered for before this where relevant.

### **Leicestershire Police**

- 2.2 There were nineteen reported anti-social behaviour incidents in 1997 - 2006 relating to A and her family: ten of these were in 2004. Police records show that they attended or made contact with A in over 70% of the reported incidents. There were thirteen incidents recorded in 2007.
- 2.3 Police responses are graded according to the seriousness of incidents, with Grade 1 requiring the speediest responses. These concern emergencies where there is danger to life, use, or immediate threat of use, of violence, serious injury to a person and/or serious damage to property. Grade 2 responses include situations where a person involved is either in extreme distress or is deemed to be extremely vulnerable. Grade 3 responses are scheduled responses, which refers to situations in which an immediate response is not required and an appointment can be made. In relation to A and B, incidents were variously graded 2 or 3. The police management report notes that 66% of the incidents received either a telephone contact or a visit. A chose not to pursue prosecution when asked, preferring that any identified offender be warned about their behaviour.
- 2.4 There were 31 incidents of anti-social behaviour reported in A's road in the first ten months of 2007. A small number of repeat offenders accounted for the majority of these.

### **Hinckley and Bosworth Borough Council**

- 2.5 In February 2007, the Council responded to a complaint from A about anti-social behaviour by local children. Names and addresses of the offenders were established and anti social behaviour warning letters sent to the parents of the children involved. The families of all alleged perpetrators were advised of the anti-social behaviour and warned against any further misbehaviour. All but one family responded positively.
- 2.6 A further anti-social behaviour complaint was received in April 2007. Letters were sent to parents of the alleged perpetrators requesting a meeting. A voluntary anti social behaviour contract was signed with one of the families involved, but the other failed to respond to the letter. There was no indication from A that this was anything other than low level nuisance behaviour.
- 2.7 In April 2007 a case referral was made to the Weekly Information Sharing Team (WIST) by the police following continued nuisance behaviour by children in relation to another family in the road. WIST involves weekly meetings between the Council's Anti-Social Behaviour Coordinator and police, housing, benefits and other youth justice agencies. The group targets 'hot spot' areas,

specific crime and disorder problems and prolific and priority offenders. A WIST case file was opened to provide joint agency interventions in incidents of anti-social behaviour. An additional referral to WIST was made concerning misbehaviour by other children. There was no evidence that these incidents were linked to A's family. Information was sought from local residents on anti-social behaviour in June, but no information or evidence was received that A or members of her family were subject to abuse or nuisance behaviour.

### **Leicestershire Children's and Young People's Service, Education**

- 2.8 The report from the school notes that B made good progress over time, particularly in relation to her communication skills and in interactions with other pupils. The school was looking at a possible placement at a local college when B left school in 2008. The school was aware of the family experiencing bullying in the neighbourhood, information often reported in the weekly diary shared between home and school.

### **Health Services**

#### **a) Primary Care Trust**

- 2.9 The school nurse had involvement with the family dealing with health care.

#### **b) Leicester City Community Health services**

- 2.10 Speech and Language therapy and specialist health visiting services had contact with the family via school. No specific concerns arose with regard to the family.

#### **c) General Practitioner**

- 2.11 The medical records for A show that in recent years she attended the surgery only for consultation on asthma and for vaccinations.

#### **d) Leicestershire Partnership Trust**

- 2.12 No contact made within the last two years with A or B.

### **Leicestershire Youth Offending Service (LYOS)**

- 2.13 Two families came to the attention of LYOS between 2005 and 2007 for a number of anti social behaviour incidents and other public order offences against other families in this locality. The referrals contained no information that linked the families with these vulnerable victims.

### **Children's Social Care**

- 2.14 The Children's Social Care management report notes that the service had several contacts with the family between February 1993 and July 2005. Bullying and harassment were mentioned in some of these contacts.

- 2.15 Since 2005 there had been two contacts. Support was offered but declined by A, who indicated that she knew where the social services were and would contact them if necessary. Since 2004 there had been no reference in social care records to bullying and harassment.

### **Transitions Team**

- 2.16 The Transitions Team supports young people with social care needs in the process of moving from children's to adults' services. Their intention is to make this as smooth as possible and to look at longer term plans based on the needs and wishes of young people and their families. Cases will usually be allocated to a team member in the September/October before the young person leaves school. Where there are complex needs in relation to severe challenging behaviours or multiple disabilities, this will happen earlier.
- 2.17 On 26.02.2007, a representative from the Transitions' Service attended a transitional review meeting at school. Contact was planned for later in the year. There was no further contact because of the deaths.

### **Leicestershire connexions**

- 2.18 Connexions' Personal Advisors (PAs) working in this field are recruited to work with those young people who are learning disabled and in special schools: they receive additional training for this work. The first contact was in March 2003, when the PA linked to B's school met B and attended the Transitional Review of Statement of Special Educational Needs. This contact continued through the next three years. The PA noted from the 2006 review that there was mention of general problems where B lived, in which the police were involved. In October 2007, the PA met B to begin to plan for the transition from school to a new placement in the academic year 2008 - 2009.

### **Other information available**

- 2.19 The police management report also notes that A wrote twice to her MP about anti-social behaviour in her locality.

### 3) ANALYSIS

3.1 Arrangements for conducting serious case reviews are well-established in children's services, and operate on a statutory basis. Work on the effective safeguarding of vulnerable adults is however at a much earlier stage of development nationally. The first government guidance in this area<sup>5</sup> - *No Secrets* – was published in 2000. In 2001, the first policies and procedures were agreed in Leicester, Leicestershire and Rutland. These were revised in 2004<sup>6</sup>. These were supplemented in November 2007<sup>7</sup> with the first agreed protocol for serious case review involving vulnerable adults. This serious case review was the first undertaken under this protocol by agencies in Leicester, Leicestershire and Rutland, and forms part of the learning that will inform policy and practice development.

3.1 This tragic case brings together three important areas:

- the nature and impact of anti-social behaviour and Hate Crimes;
- approaches to the support of vulnerable adults;
- partnership working between agencies.

#### **Anti-Social Behaviour and Hate Crimes**

3.2 All agency reports identify persistent anti-social behaviour as a key concern of and pressure on A.

3.3 The Crime and Disorder Act (1998) defines anti-social behaviour as:

*Acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the defendant.*

3.4 Anti-social behaviour has emerged as an important national public policy concern in recent years. The Home Office's Anti-Social Behaviour Unit notes the impact of anti-social behaviour on communities:

*Anti-social behaviour doesn't just make life unpleasant. It holds back the regeneration of disadvantaged areas and creates an environment where more serious crime can take hold.*

---

<sup>5</sup> Department of Health and Home Office (2001) *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* London: Department of Health.

<sup>6</sup> Social Services, Health and Police in Partnership with the CSCI and the Voluntary and Independent Sector within Leicester, Leicestershire and Rutland (2004) *NO SECRETS Multi-Agency Policy and Procedures for the Protection of Vulnerable Adults from Abuse*.

<sup>7</sup> Leicester, Leicestershire and Rutland Safeguarding Adults' Board (November 2007) *Vulnerable Adult Serious Case Review Protocol Leicester, Leicestershire and Rutland*.



- 3.5 Leicestershire policing data show the scale of the problem across Leicestershire. Nearly 40,000 calls were received between April and October 2007 relating to anti-social behaviour; over 1500 a week.
- 3.6 People with learning disabilities/difficulties are particularly vulnerable to bullying and harassment. MENCAP estimates that 82% of children and young people with a learning disability have experienced bullying. They also estimate that they are twice as likely to be bullied as other children.<sup>8</sup>
- 3.7 The police management report provided for the Serious Case Review notes that there was a response to over 70% of reports from A. However, it notes that each incident was taken in isolation and that there appeared to be no recognition of the possible vulnerability of the people involved. It also notes that some of the incidents might better have been classified as constituting possible Hate Crimes. A Hate Crime is one where the person is targeted because of their personal identity: in this situation, because of disability. Under the policy for Hate Crimes, the police commit themselves to a robust response and to providing appropriate support to victims.

### **Approaches to the support of vulnerable people**

- 3.8 This was a household consisting of individuals with varying degrees of vulnerability. Individual vulnerability was compounded by exposure to much anti-social behaviour.
- 3.9 The national guidance on safeguarding vulnerable adults, published in 2000<sup>9</sup>, provides the basis on which the Leicester, Leicestershire and Rutland defines a vulnerable person as anyone over eighteen:

*'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.*

- 3.10 Such guidance is valuable, but those involved need to be able to recognise vulnerability in the first place. When vulnerability is recognised, support then requires effective collaboration between agencies. This is a developing area nationally for agencies.

### **Partnership working**

- 3.11 It is seldom if ever possible for one agency to deal effectively by itself with a family in difficulty. There is clear acknowledgement in the police management report that partnership working was lacking at various points in their interventions. These interventions for the most part followed policies and procedures in relation to anti-social behaviour response expectations, but

---

<sup>8</sup> MENCAP (2007) *Don't stick it, stop it! Bullying wrecks lives: the experiences of children and young people with a learning disability*

<sup>9</sup> Department of Health/Home Office (2000) *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*

there was insufficient sharing of information with other agencies. In relation to gaps in multi-agency working, the school management report also noted that many agencies were involved with B, but that the co-ordination was limited to those invited to attend the Annual Review.

- 3.12 The arrangements in Hinckley and Bosworth Borough Council for information-sharing through WIST provide a positive model of multi-agency working that offers the opportunity for effective partnership in responding to anti-social behaviour.
- 3.13 In relation to supporting vulnerable adults, the Leicester, Leicestershire and Rutland multi-agency procedures include provision for the setting up of an Adult Protection Case Conference after a safeguarding investigation. However, under current arrangements, and those in place in 2007, if any agency had made a referral to social care, this would probably have been seen as a request for services, not as a safeguarding matter. No abuse had taken place within the family or professional support system and the incidents of anti-social behaviour and bullying directed towards the family would have been regarded as matters for police and council interventions under their duties and responsibilities. A much more rounded assessment of the complex range of pressures on this family would have been required in order for the assessment to have identified any significant problems. Increased knowledge and understanding of risk factors would also enable other agencies to recognise safeguarding concerns
- 3.14 From A's perspective, it appears that the persistent anti-social behaviour was her most serious difficulty. The Hinckley and Bosworth Borough Council management report is confident that earlier action could have been taken against perpetrators if more information had been available. This action can take various forms, from voluntary anti-social behaviour contracts to seeking termination of tenancy of council property. The Council began court action in August 2007 for an anti-social behaviour injunction when voluntary agreements had not had positive results with one family. This was granted in November 2007 for a six month period.
- 3.15 Robust legal action in relation to anti-social behaviour takes some time from the decision to instigate it through to court hearing. What we cannot know with any certainty is whether such action taken earlier, in response to better information sharing, would have made a sufficient difference for A.

## **4 RECOMMENDATIONS**

- 4.1 Serious Case Reviews have an important function in drawing out lessons to inform future policy and practice. These can concern individual agency issues or multi-agency working.
- 4.2 Where appropriate, individual agencies identified recommendations in their management reports. These are summarised below.

### **Recommendations from individual agencies**

#### **Leicestershire Police recommendations**

- 4.3 The police recommendations concern reviewing policies relevant to this situation to ensure that they remain fit for purpose. These policies concern:
- the Force Anti Social Behaviour policy;
  - the identification of potentially vulnerable anti-social behaviour victims;
  - the policy on Hate crime to ensure that disabilities issues are appropriately identified.

The police recommendations also concerned ensuring that mechanisms are in place to enable vulnerable victims to be better identified in recording processes.

- 4.4 All the above policy reviews have now been completed, and work is on-going on recording processes whilst IT systems are developed.

#### **Hinckley and Bosworth Borough Council recommendations**

- 4.5 The Council's internal review identified recommendations in relation to ensuring:
- the accountability of actions taken by partner members of the Weekly Information Sharing Team (WIST) group;
  - full and appropriate engagement of and case referral to relevant wider partnership agencies/support services not represented on WIST;
  - cases removed from WIST continue to be monitored for any further incidents that may require reprioritisation of cases to enable further interventions;
  - the Council's internal procedures relating to anti-social behaviour complaints and cases are effective;
  - Police Officers are aware of WIST cases to enable WIST to be fully aware of any new incidents relating to current or closed cases;
  - there is a mechanism to provide information sharing with key partners;
  - the Council's internal service area anti-social behaviour information sharing processes are effective;
  - processes to address anti-social behaviour complaints are not unduly delayed;

- there is a co-ordinated response within the Council's services towards recording, tackling and monitoring anti-social behaviour;
- Victim Support service is available to non-crime anti-social behaviour/nuisance offending victims;
- victims of anti-social behaviour are kept informed of progress and are provided with an opportunity to update;
- there is improvement in the confidence of people and communities to report anti-social behaviour to the Council.

4.6 Hinckley and Bosworth Borough Council has completed work on these recommendations above, although some problems remain in accessing some key agencies. The proposed joint anti-social behaviour team with the police has significantly moved forward and accommodation has been secured. Once technical support has been installed the new team will be operational in later in the year. It is expected that this new arrangement will overcome any outstanding information sharing problems identified in police and council management reports for this review.

#### **Leicestershire Youth Offending Service recommendations**

4.7 The Leicestershire Youth Offending Service has recommended that the referral form from partner agencies to its Anti-Social Behaviour Team be reviewed and redesigned and that the quality of recording of contacts with external agencies on the case record be improved.

4.8 These recommendations have been implemented.

#### **Leicestershire Transitions Service recommendations**

4.9 The Transitions Service management report notes that there are already measures being put in place which will improve the multi-agency transitions process for everyone. These include:

- the development of a system which will identify a named transition co-ordinator;
- person-centred school reviews from Year 9 onwards;
- a continuing improvement in communication and co-ordination of the roles of the different agencies involved.

4.10 As a result of reviewing practice in this situation, the Transitions Service has decided to put into place a clear process for determining the timing of any input into each case and a recorded analysis of any risk factors that would have a bearing on this.

#### **Recommendations Relating to all Agencies**

4.11 The Review Panel welcomed these actions, many of which have already been implemented. The Panel therefore focused on those areas of activity shared between agencies in coming to its recommendations. At the heart of the case lies the policy basis on which agencies collaborate in carrying out

their duties towards vulnerable people. Indeed it has been difficult for the panel to make sense of what happened without reflecting on the policy base for safeguarding. In particular, the current policy, following national guidance, defines a vulnerable person (as noted in paragraph 3.14 of this report) as someone:

*'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.*

It was the view of the Serious Case Review Panel that a referral to Social Care during 2007 would have been responded to in terms of individual eligibility for services rather than in relation to the overall context of an individual or family. A focus on individual or family vulnerability, regardless of eligibility or presenting need for specific care services, would be more likely to lead to a multi-agency safeguarding response.

Panel members were able to identify a significant number of people in similar situations, either through professional experience or improved agency databases. These databases have begun to identify people about whom there are concerns but who currently are at risk of falling through the safeguarding net. The panel is aware that any widening of criteria might have resources implications, such that some investigation of likely numbers would be important.

#### 4.12 Recommendation 1

This case has therefore raised questions about the extent to which current safeguarding policies and procedures allow for holistic, multi-agency interventions in situations where families or individuals are vulnerable and under considerable community pressure. The Panel therefore recommends that:

***The Safeguarding Adults' Board should initiate a policy review, to establish whether current definitions of vulnerability are inclusive enough and whether current procedures are sufficiently well developed to enable effective responses to individuals or families subject to significant community pressures. This review should include the identification of risk factors and an exercise to assess the current size of the problem.***

This is the overarching recommendation of the Review Panel, and the recommendations below should be seen as following on from this. The Review Panel notes that the Safeguarding Adults Board's development plan for 2008-2009 already includes a commitment to review policies and procedures, and this recommendation therefore best fits into this wider review.

#### 4.13 Recommendation 2

The impact of anti-social behaviour on vulnerable people has been a key feature of this case. The Panel therefore recommends that:

***The Multi Agency Policy and Procedures and the associated training on safeguarding adults should incorporate attention to anti-social behaviour and its impact on communities and individuals.***

#### 4.14 Recommendation 3

The review has also highlighted the importance of communication between agencies when one agency wants to express concern about the possible need for a safeguarding intervention. The Panel therefore recommends that:

***Those responsible for referring concerns on safeguarding to social care should ensure that such referral make it explicit that it is a safeguarding concern that prompts the referral.***

Although agencies must decide how best to do this, it is likely to be achieved through the training programmes currently provided within and between agencies.

#### 4.15 Recommendation 4

Vulnerability comprises a range of factors, and can only be properly understood through an assessment of the individual/family in its overall social context. The Panel therefore recommends that:

***Agencies responsible for assessment should ensure that it is informed by holistic ways of viewing people and their social context, as well as by the need to assess eligibility for services.***

#### 4.16 Recommendation 5

Anti-social behaviour has been identified nationally as causing significant problems, and has been a key aspect of this case. The Review Panel has been impressed by the WIST arrangements in Hinckley and Bosworth Borough Council, and is aware that such arrangements are not in place uniformly across Leicester, Leicestershire and Rutland. The Panel therefore recommends that:

***Councils with anti-social behaviour responsibilities should consider the benefits to communities that might arise from setting up partnership arrangements such as WIST in Hinckley and Bosworth Borough Council. Within this, added benefits for communities and agencies would arise from the development of consistent approaches across councils.***