Safeguarding Adult Board Waltham Forest

Safeguarding Adults Review
Adult Lucy

Final report
Date: 12 July 2016

Contents

1. Introduction

Why this case was chosen to be reviewed

Lucy has learning disabilities and lives in a residential care setting. She was physically assaulted six times over a seven week period by a fellow resident.

The Safeguarding Adult Board in Waltham Forest (SAB) decided this case met the criteria for a Safeguarding Adults Review (SAR) under the Care Act 2015 and agreed to review this case using the Social Care Institute for Excellence (SCIE) 'Learning Together Case Review methodology (LT)'.

Methodology and Process of Review

This case has been reviewed using a systems approach; the focus of this approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

The data is gathered from a variety of sources, including the review of existing documentation alongside data provided by front line practitioners and their managers, who had involvement in the case during the timeline under review. Within this report, these professionals are referred to as 'the Case Group'.

The review is completed by a team of senior managers, who did not have line management responsibility for the case, led by two lead reviewers. Together, they make up 'the Review Team'.

One of the lead reviewers[1] was independent and commissioned by the SAB. The second lead reviewer is internal, the Head of Strategic Partnerships, and an accredited lead reviewer.

The data, gathered during the course of this review, the analysis and findings, are the subject of scrutiny by the Review Team. There are repetitive cycles of feedback and amendment, by the Case Group and Review Team, which is a central feature of case reviews, using this methodology.

A critical aspect of a review, using this methodology, is the perspective of family members. In this case the Lead Reviewers met with Lucy's mum, Angela. Angela is herself vulnerable and agreed she was not in a position to advocate for Lucy at the time. She is very aware of the need to put her own needs to one side to support Lucy as best as she is able and is in a stronger position now to do this. Angela expressed that she would want to know immediately if anything significant happened to Lucy. Angela was able to inform the reviewers about Lucy'.

[1] A trainee Lead Reviewer by the Social Care Institute of Excellence (SCIE)

Details of the methodology, data sources and structure of the review process, are outlined in **Appendix 1.**

Succinct summary of the case

Lucy, who is the responsibility of Waltham Forest, moved to a residential care setting in Waltham Forest in July 2014, and was living with two other male residents. In November 2014 Adebayo moved in. Adebayo was placed by another borough who hold statutory responsibility for him.

There was little interaction between Lucy and Adebayo, until the 9 January when Adebayo assaulted Lucy for the first time. Adebayo then assaulted Lucy on six occasions between 9th January and the 27 February. During this period safeguarding procedures were instigated but they did not prevent further assaults on Lucy.

Following the 6th assault on the 27 February the care home manager made the decision to move Adebayo to a separate flat and no further incidents have occurred.

About Waltham Forest

The London Borough of Waltham Forest (LBWF) is a borough in north-east London. The south of the borough contrasts markedly with the north (split by the North Circular Road) in terms of its mixed ethnicity and socio-economic indicators. Taken as a whole, Waltham Forest comprises built-up urban districts in the south with inner-city characteristics, and more affluent residential development in the north with a variety of reservoirs, open space, small sections of Epping Forest, parks, and playing fields, which together cover a fifth of the borough. It is located between Epping Forest District Council in the north, London Borough of Redbridge in the east, London Boroughs of Newham and Hackney in the south, and London Boroughs of Haringey and Enfield in the west (where the River Lea and the surrounding parkland forms a green corridor, traditionally separating north and east London).

The borough includes one of the highest ethnic minority populations in Europe, consisting mostly of Eastern European and Black British. It also has an established British Pakistani residential settlement and business.

Waltham Forest has a younger than average population with higher proportion of children aged 0 to 15 (22% compared to 20% in London and 19% nationally). Conversely, there are proportionately less people aged over 50 living in Waltham Forest (24%) and London as a whole (26%) compared to the UK average (35%).

Deprivation has increased in Waltham Forest, both relatively (i.e. compared to other boroughs) and absolutely. There are increased numbers of families and individuals in receipt of benefits and applying for social housing.

2. Window on the system

What light has this case review shed on the reliability of our systems to keep adults safe?

A case review plays an important part in efforts to achieve a safer adult protection system. Consequently, it is necessary to understand what happened and why in this particular case, and go further to reflect on what this reveals about gaps and inadequacies in the safeguarding adults system. Using the SCIE LT methodology, this particular case acts as a 'window on the system'[2].

For this to happen, the outcome of the review has to say more than what happened in this particular case and provide messages to the local Safeguarding Adults Board (SAB) about usual practice and normal patterns of working. These messages are presented as 'findings' and provide the SAB with an insight into the underlying patterns that influence professional practice, and outcomes for adults.

By responding positively to the findings, the SAB has the opportunity to change how the safeguarding system operates, and to make it safer. It makes sense, therefore, to prioritise the findings to identify those that need to be tackled most urgently, for the benefit of adults and families, even though these may not be the issues that appeared most critical in the context of this particular case. In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of these underlying patterns. The ordering of these is not fixed and will change according to which issues are felt to be most fundamental for systemic change. Locating findings within these categories helps the SAB identify where (and with whom) in the multi-agency system potential solutions should be discussed and taken forward.

The categorisation of findings is as follows:

- Tools
- Family-professional interactions
- Management systems
- Patterns of multi-agency working in response to incidents/crises
- Patterns of multi-agency working in longer-term work
- Innate human biases (cognitive and emotional biases).

The findings from each category convey a message to the SAB about how that element of the multi-agency safeguarding system was working at the time of events under review. They state succinctly what is, or was problematic, about the system, and are therefore helpful to the reader. It is not uncommon for there to be overlap between the categories of findings.

In what way does this case provide a useful window into our systems?

[2] Vincent (2004) Analysis of clinical incidents: a window on the system not a search for root causes

At the start of this SAR, the Review Team identified that this case held the potential to shed light on particular areas of practice, and sought to examine the following issues, within the course of the review. Four research questions were agreed, covering the areas the Review Team felt most strongly that they wanted the review to try to answer:

- How well is information on known risks shared across the system when placements are made, particularly from different settings (eg acute to residential)?

- Are there systems in place across providers and commissioners to ensure that when placements are made full impact assessments are undertaken, on both the service user being placed and existing residents that includes insight around potential safeguarding issues. How well are these systems implemented?

- How well do our systems and processes support the identification of physical violence between residents with learning disabilities in care settings, and their subsequent protection?

- How well do we ensure that the role of the Independent Mental Capacity Advocate (IMCA) service in working alongside people with learning disabilities is sufficiently understood in order to provide them with the best possible support in all aspects of their life?

Taken as a whole, this case illustrates the complexities that professionals face in their efforts to safeguard adults in situations where there is physical violence by one person without capacity towards another person without capacity, where both are living together in a care setting.

Context

This case involves the responses of agencies between 9 January 2015 to 28 February 2015 for Lucy and Adebayo. This section provides an overview of ‘what’ happened in this case and ‘why’. The explanation for ‘why’ will be explained in the findings and a cross reference will be provided in this section. Along with the explanation of what happened, the following makes explicit the view of the Review Team about the timeliness and effectiveness of the responses provided to Lucy, including where practice was below acceptable standards. Such judgments are made in light of what was known and was knowable at that point in time. There has been much discussion nationally and locally regarding the term good practice and accepted practice. This report refers to practice as acceptable practice and anything exceeding this as good practice.

Local agency context under the time line under review

The Review Team felt it was important to provide some detail on the local context within which services were operating under the timeline under review and invited agencies to provide this. There were a number of challenges which are detailed in the following section.

North East London Foundation Trust (NELFT)

During January to March 2015 the Waltham Forest Community Learning Disabilities Team (CLDT) were undergoing some significant changes and in a state of flux. This was following a period of poor performance which included concerns about delivery on key performance indicators, integrated ways of working, lack of leadership and ability to deliver a safe and high quality service to its service user group. The service was subject to a contract improvement notice and was part of a transformation project. The focus of the transformation project was looking to improve the overall functioning of the service to deliver on some key aims which included; integrating health and social care processes, streamlining service provision, and improving the leadership within the service (including recruiting permanent management). There was also a specific focus on ensuring that the initial triage process, which included safeguarding alerts, was robust. The service had an interim management team who were struggling with the day to day tasks and to deliver the changes expected by North East London Foundation Trust (NELFT), Waltham Forest Clinical Commissioning Group (WFCCG) and LBWF.

Waltham Forest Council

Adult Social Care

Waltham Forest Council has a Service Level Agreement with NELFT to deliver its care management duties, which include safeguarding adults' processes. At the time of the incident there was scrutiny of these functions by the Local Authority in order to gather greater assurance of compliance.

3. Overview

Good practice

An example of good practice was when the police attended the care home on the morning of the 28 February to support the staff with Adebayo's move. The police were not attending a crime situation but being a supportive partner and additionally they responded positively to the advice of the care home staff regarding how the situation should be managed.

Another example was attendance by the Contracts and Commissioning Officer at the second strategy meeting where they worked alongside Lucy's social worker to escalate concerns to the Head of Safeguarding Adults, LBWF. The direct involvement of Contracts and Commissioning Officers when there are safeguarding concerns is good practice. It is not usual practice in all boroughs.

Timeline

Date	Event
09/01/15	**Ist assault:** Adebayo bit Lucy's thumb. The care home raised a safeguarding alert and put in place risk management for Adebayo. A safeguarding alert was raised and the Community Learning Disabilities Team (CLDT) decided not to progress with the safeguarding process but to see whether the risk management measures prevented further assaults.
16/01/15	**2nd assault:** Adebayo pushed Lucy cutting her lip and bruising her. Lucy was assessed to see what medical intervention might be needed and her GP was asked to do a home visit but he did not get back to staff, a safeguarding alert was completed but not raised at the time.
20/01/15	**3rd assault:** Adebayo pushed a support worker out of the way to reach Lucy and pushed her hard into French Doors from behind. A safeguarding alert was completed but not raised at the time, Lucy's GP was again called but he says there was no reason for him to attend.
24/01/15	**4th assault:** Lucy came downstairs and staff were not able to intervene as Adebayo moved quickly and managed to push her into fire doors.
25/01/15	A near miss was reported when Adebayo injured a staff member in an attempt to reach Lucy.

Date	Event
26/01/15	Safeguarding alerts covering the 16th, 20th, 24th and 25th were raised/submitted and the CLDT deputy manager arranged a safeguarding strategy meeting for 06/02/15.
06/02/15	A safeguarding strategy meeting held and review date set for 13th February, the meeting was poorly managed and there were no clear outcomes.
13/02/15	An IMCA referral was made for Lucy.
15/02/15	**5th assault:** After his breakfast Adebayo went calmly but quickly upstairs and used the PIN code number to access Lucy's bedroom which he entered. Lucy was in her bed and he hit her in the mouth. A safeguarding alert was raised the police were called. A decision was made not to proceed to charge Adebayo with assault.
16/02/15	The risk management plan was updated for Adebayo.
19/02/15	A safeguarding investigation was conducted.
3/02/15	A safeguarding strategy meeting was held; initially this was to be a review of the meeting on the 6th February but due to the incident on the 15th February it was changed to a strategy meeting. There was agreement that Adebayo was now targeting Lucy. A review meeting was confirmed for 6/03/15.
26/02/15	The IMCA referral was chased following clarification from the Head of Safeguarding regarding the issue of a formal capacity assessment.
27/02/15	**6th assault:** Adebayo moved from the sitting room to the kitchen and punches Lucy in the side of the head. The police were called. However as Adebayo was asleep when they arrived a joint decision was made not to move him that night but to leave it until the morning. The police were asked to re-attend then.
28/02/15	Adebayo moved to the adjoining flat. After breakfast he was shown the flat by staff and was happy to move there. The police, although present, were not needed to help support the move.

Appraisal of practice

Adebayo is a 25 year old Black British man of Nigerian descent and is a tall, large man. Adebayo has learning disabilities and communicates using Makaton and some verbal communication. He also understands verbal communication. The professionals working with him advised he does not have the mental capacity to understand and make informed choices for himself, as defined under the Mental Capacity Act 2005. The Review Team was not provided with any information regarding a specific assessment of capacity in relation to the assaults and challenging behaviour. Adebayo was having contact with his family but less regular than usual during the period under review.

Lucy is 30 years old and has learning disabilities. Lucy is nonverbal and her communication is enabled by the use of Makaton and understands verbal communication when people don't speak too fast or rush her. Lucy has a sign for when she understands and clearly indicates when she doesn't agree. The professionals working with her advised she does not have the mental capacity to understand and make informed choices for herself, as defined under the Mental Capacity Act 2005, but the details and the specificity was not clarified further. Lucy has a small frame and is short with very long hair which she likes in a plait. Lucy then often touches her nose with her hair. Lucy enjoys swimming and riding her bike fast and watching others play football. Lucy enjoys baking, eating out, and being out in the rain. Lucy's mother lives in the borough and visits regularly.

A risk assessment was completed as part of the assessment process to identify if the care home was a suitable placement for Adebayo. The placement assessment and risk assessment were detailed and included the potential for Adebayo to physically assault staff and residents. The assessment appropriately identified what action needed to be taken at the time if Adebayo assaulted someone, but did not include a long term/strategic plan for what to do if this behaviour was to again become a pattern. The previous assaults were not identified as a pattern of behaviour, which then framed the context for how staff addressed and worked with Adebayo when he started to assault Lucy. **This is discussed in Finding 1.**

At some point between Christmas and the 9 January 2015 Lucy touched Adebayo, who does not respond well to being touched. The exact details of this incident are not known as staff involved have now left.

On the 9 January Adebayo bit Lucy on the thumb and she was assessed for any medical need. Adebayo was redirected to his room and told that this was not acceptable behaviour. All staff had been trained in Maybo techniques (conflict resolution techniques that do not use physical restraint). This incident was managed by the care home by creating an internal incident report as part of the care home procedures and a safeguarding alert in line with the home's and Waltham Forest's policies. Staff thought that the trigger for this assault could have been because Lucy previously touched Adebayo, as this had been identified in his initial assessment as a trigger for previous assaults. The belief that this was the trigger prompted staff to view this as a one-off incident and something that could be prevented in the future. The staff team were relatively new and some were inexperienced which may have contributed to minimising the risk and impact of the assaults.

The historical information regarding Adebayo's previous behaviour was not taken into account and so there was no discussion as to whether this was a developing pattern of behaviour. Good practice would be for the care home staff to use the historical information to develop an understanding of potential repeated behaviour patterns in the future. At this point the care home staff could have also put in place measures to ensure that residents in the home were protected, and that there was active monitoring of Adebayo's behaviour. **This is discussed in Finding 2**. It would have been appropriate at this point to have shared information with Lucy's Social Worker (SW) about Adebayo's previous violent behaviour. This was not done and is not acceptable practice.

On receipt of the safeguarding alert on the 10 January Lucy's SW and her manager decided not to progress with the safeguarding process but rather see how successful the management plans put in place by the care home staff were. They were unaware of Adebayo's previous behaviour history because this had not been shared with them as yet. The decision to not proceed down a safeguarding route is reasonable given the information they had.

On the Thursday 16 January Adebayo pushed Lucy hard with both hands; she suffered a cut lip and bruising as a result. The care home staff used the same strategy as before: they redirected Adebayo and reassured Lucy, checking for any medical need. This was raised as a safeguarding alert by the care home but not forwarded to the safeguarding team at LBWF or Lucy's social worker until the 26 January. Adebayo's behaviour plan was updated. At the shift handover staff were fully updated regarding the assault and the amended plan. The police were not contacted about the assault. The fact that this was now the second assault by someone who had a history of assaulting others should have given the care home greater pause for thought and at this stage a notification to the police should at least have been considered. The police could also have supported the care home staff in stressing the consequences and seriousness to Adebayo of his actions. The care home has now changed its policy and always contacts the police when there is physical violence between residents. The behaviour plan should have been amended to address a potential pattern of behaviour and a longer term strategy for addressing this should have been developed which included something more explicit to safeguard Lucy and the other residents. **This is discussed in Finding 1.**

The safeguarding alert should have been sent immediately. The practice at the time in the care home was that only certain members of staff could send the alerts which caused delays. This practice has now been changed by the care home and alerts are sent immediately.

The care home staff requested Lucy's GP to do a home visit but he didn't respond for several days, when he then decided no intervention was required. This is the first time the GP had been asked to visit in response to the assaults and he declined. We have not been able to determine the reason for this and while it was noted by the Review Team that there can be times when identifying a GP who understands the complexities of supporting people with learning disabilities can be challenging this was not identified as widespread by the Review Team. Due to Lucy's autism it is unlikely that she would ever be able to attend the GP surgery herself and wait in reception to be seen. The care home staff team knew how distressing a visit to the GP and hospital were for Lucy and she often would refuse to enter the building on arrival. When Lucy was registered with the GP her particular needs in relation to home visits should have been explored with the surgery. It is not clear whether this was done or that any conversation took place with the GP about why a home visit was required as the staff involved have now left. The lack of engagement from the GP is poor practice and it is not clear due to the staff involved leaving how proactive they were in addressing this with the GP. The care home did not escalate the concerns regarding the GP response to WFCCG/ National Health Service England (NHSE) which would have been expected. Prompt and effective GP contact could have provided Lucy with another spokesperson for her safety. The GP is reported by the care home staff to have spoken disrespectfully in front of Lucy and this supports the possibility that the GP was inexperienced around autism and was not confident about how to communicate. The care home has since changed GP for Lucy to someone who has a particular interest in learning disabilities.

On the 20 January Adebayo pushed a staff member out of the way to reach Lucy. He then pushed her hard with both hands from behind into some french doors. Lucy's arms were very bruised as a result. The staff followed the same procedure as on the other occasions, redirected Adebayo, reassured Lucy and checked for medical need. They called the GP again and he again said he did not feel it necessary for him to see Lucy. A safeguarding alert was raised but not forwarded to the safeguarding team at LBWF or the SW until the 26 January due to the policy at the time in the care home.

On the 24 January Adebayo moved quickly when Lucy came downstairs and staff were not able to intervene. Adebayo pushed Lucy hard against fire doors. Lucy had bruising to her upper arms. Adebayo was redirected and Lucy was reassured. It is unclear if the behaviour plan was reviewed on this occasion.

On the 25 January Adebayo and Lucy were sitting at the dining room table together with members of staff. Adebayo's mood changed quickly, which was noticed by staff, and when Adebayo reached out to punch Lucy a staff member moved between the two of them. Lucy was supported by staff to go to her room. The staff member's back was hurt and he went home with advice to go to Accident and Emergency (A&E) if pain continued. Medication prescribed for use when required (PRN) was administered to Adebayo, in order to calm him. The staff who were coming on the next shift were contacted by the senior team leader to advise them of this incident and what to expect when they come on shift.

This was now the fifth event between Adebayo and Lucy over a short space of time. The staff were looking for triggers for the assaults, but their response remained the same; reviewing the behaviour plan, not contacting the police and importantly not seeing either a pattern of behaviour by Adebayo or a targeting of Lucy. The care home staff were now aware that Lucy was cautious around Adebayo and was spending more time in her room but did not perceive at this point that Adebayo was targeting Lucy. Their understanding could have been influenced by a perception of minimising violence between people with learning disabilities. **This is discussed in Finding 2**.

All the professionals involved advised that they were working with in a safeguarding framework however the evidence of the intervention suggests that the practice was more one of a care management approach. The Review Team would have expected a more proactive approach and intervention in regard to safeguarding Lucy.

On 26 January a safeguarding alert (which was previously written but not sent by the home) listing all incidents was sent to LBWF safeguarding team and Lucy's SW by the care home. LBWF safeguarding team did not forward this to Contracts and Commissioning as it was not the practice at the time. This practice has now changed. As a result a safeguarding strategy meeting was held on the 6 February. The holding of the meeting was acceptable practice; the delay in sending alerts was not.

Lucy's mum, Angela, was not alerted to these incidents by Lucy's SW or by the care home staff as all agreed that Angela was anxious and they did not want to make it worse. Lucy's SW planned to meet with Angela to explain face to face rather than over the phone. In this situation Lucy should have been viewed as unbefriended and therefore in need of an IMCA. Lucy's SW recognised this but did not prioritise the referral to the IMCA due to workload and she felt it was important to have

the strategy meeting first.

The Care Act 2015 and the MCA Act 2005 define the occasions when an IMCA should be involved and safeguarding issues is one of them. The referral to the IMCA should have been made sooner and Lucy's SW should have identified that although Lucy's mum was not able to advocate for Lucy, she could have been a valuable resource for the IMCA and the advocacy process. **This is discussed in Finding 4.**

Adebayo's SW had been made aware of the assaults and was invited to the strategy meeting. She reviewed the risk assessments and guidelines for Adebayo with the care home. She made a referral to Adebayo's psychiatrist and a psychologist to address what she believed to be a personal relationship issue between Lucy and Adebayo, to address why they were not getting on.

The safeguarding strategy meeting was held on the 6 February, chaired by the deputy team manager for the CLDT. The minutes of the meeting were taken but never circulated to those present and only found during this SAR process.

The people present at the meeting were the care home manager, Lucy's SW, the deputy team leader for the CLDT and Adebayo's SW. The police were not invited. The meeting lacked direction and decision-making and there was no clear outcome in regards to how Lucy would be safeguarded. Lucy's SW requested that Adebayo was moved. This was not agreed and instead a decision was made (which was not further challenged) to see if Adebayo could amend his behaviour with support from his psychologist and psychiatrist, alongside other practical measures that the home had already introduced to reduce the amount of time Lucy and Adebayo were together. However Adebayo was between psychiatrists and psychologists due to his move and his SW was trying to resolve this. The chair requested a safeguarding investigation but decided not to proceed to a safeguarding conference but to have a review meeting instead. Lucy's SW was aware that her team were under scrutiny from the Trust senior managers and the local authority safeguarding team because they were not meeting standards in relation to safeguarding processes; this may have influenced the decision not to proceed to a conference. The Review Team advised that the chair of the meeting left LBWF following the commencement of capability procedures around this time. There was no evidence to suggest that this poor practice was widespread. Several of the professionals at the meeting had met previously in different roles in stressful circumstances and this contributed to the dynamics in the meeting. This, coupled with the poor safeguarding practice of the chair all added up to what is described as *"a very negative atmosphere"*. Several staff identified that the meeting did not adhere to safeguarding policy and practice but did not escalate this to the LBWF safeguarding team. They attributed the negative atmosphere as contributing to their decision not to escalate.

The strategy meeting was chaired poorly, not recorded appropriately and did not adequately address the issue of safeguarding Lucy. From the information available it would have been usual practice to proceed to a case conference. Therefore, it is possible that the decision was based on the scrutiny from senior management rather than acceptable practice. Part of the scrutiny was in relation to timescales and cases within formal process, not taking this case to a case conference took the case out of formal processes and therefore it would not be included in the cases under scrutiny.

The failure to involve the police is poor practice. A crime had been committed and Lucy had the right to expect that the crime would be investigated by the police. Other partners did not recognise the value of involving the police in the safeguarding process. **This is discussed in Finding 2 and 3.**

On the 13 February Lucy's SW made a referral for Lucy for an IMCA. There was a delay in allocating an IMCA due to misunderstanding by the IMCA organization relating to a formal capacity assessment. The IMCA visited Lucy on 5 March and attended a safeguarding meeting the next day. The IMCA report was delayed and the quality of the report was poor in relation to the quality of analysis, the lack of grasp of the present situation and lack of opinion of the advocate. There was no evidence in the report or from reports from the case group that the IMCA made any contributions to the safeguarding process. Both Lucy and Adebayo were unbefriended. Staff referred to Adebayo's lack of intent, and reported this as a reason for not recording physical violence as safeguarding. His lack of capacity in relation to these events was not formally assessed or recorded and it appears untested as to what extent he understood the impact of his assaults or the degree to which it was unacceptable behaviour. A referral to advocacy could have been made for Lucy at any time after the second assault and for Adebayo prior to the first safeguarding meeting. This demonstrates poor understanding and practice in relation to use of IMCA in safeguarding procedures by both the care home staff, SW and the IMCA service. **This is discussed in Finding 4.**

On 15 February Adebayo, after his breakfast, walked upstairs and entered Lucy's room using the PIN code lock on her door. Lucy was in bed. Adebayo punched her in the mouth and her lip bled. Staff demonstrated good practice by using Picture Exchange Communication System (PECS - for adults with autism and other related disabilities) and Makaton which uses signs and symbols to help people communicate and is designed to support spoken language) to help decide what Lucy would like to happen in relation to her medical care. Lucy didn't want to go to hospital and pain relief was administered. Adebayo's behaviour plan was revisited. Staff were instructed to prevent Adebayo and Lucy meeting anywhere in the home. This was part of a range of measures including staff being present on the stairs, and providing constant one-to-one support to both Lucy and Adebayo. The lock was changed on Lucy's door. A safeguarding alert was appropriately raised and the police were appropriately called. The police decided not to proceed with charging Adebayo with assault and recorded that they felt that the staff should be doing more to safeguard both residents but did not escalate this. **This is discussed in Finding 3.**

The door locks for all the bedrooms were the same. Before Adebayo moved in the other residents were not able to remember the pin number. Staff were teaching all the residents to learn the code but none had been able to remember. Staff then became aware that Adebayo had learnt the code. Therefore at this point staff should have changed the other locks to ensure privacy and safety of the other residents. The care home has now changed this practice across all their homes.

Adebayo was able to walk upstairs, enter Lucy's bedroom and assault her which suggests that the measures that had been put in place to manage his behaviour were not sufficient to protect Lucy. The focus of the plan was mainly on managing Adebayo's behaviour rather than actively safeguarding Lucy. Previously Adebayo was reported to have responded successfully to behaviour modification and support from his psychiatrist and psychologist. However, at this point, due to issues of transferring care, Adebayo had still not had any psychology input but had seen his

psychiatrist and his medication had been changed.

On the 19 February Lucy's SW undertook her safeguarding investigation. This investigation did not offer any new information. An investigation should bring together all the relevant information and check whether appropriate procedures were followed. The report should offer analysis of the situation and detail solutions and options. This report only documented the timetable of events and comments from staff.

On the 23 February the meeting that was going to be the review of the previous safeguarding process was changed to a strategy meeting following the assault on 15 February. The meeting was chaired by the same deputy team manager and the Contract and Commissioning Officer from LBWF also attended. The meeting was attended by the care home and staff for both Adebayo and Lucy. This review team heard that the meeting was acrimonious. A review meeting was set, but there was no agreement as to an effective protection plan for Lucy. There were no clear outcomes or decisions and the notes for the meeting were later challenged as not being accurate. There was now an agreement that Adebayo was targeting Lucy and Adebayo's SW confirmed she had secured agreement for Adebayo to return to the adult assessment and treatment centre, but felt this was a last resort and still wanted to pursue the behaviour management route. She did not agree to move Adebayo to a self-contained flat within the care home premises, which was being refurbished and her decision was not further challenged.

It was acknowledged by all that the one-to-one support in the care home was not sustainable but there was no evidence that the care home were independently looking for alternative options nor were they applying pressure for Adebayo to move. Care home staff may have become tolerant to the aggression and its impact on other residents underplayed. **This is discussed in Finding 2.**

On 27 February Adebayo was in the sitting room and Lucy was in the kitchen. Adebayo stood up and was told to sit down but he ignored staff and moved too quickly for them to intervene. Adebayo punched Lucy who became upset and cried; she was helped to her room. Adebayo was redirected to his room and PRN medication was given. The police were called and when they arrived Adebayo was asleep so all agreed for him not to be disturbed. The care home manager made the decision that Adebayo should move to the flat the next day, which was now ready for occupancy. A safeguarding alert was raised. It was appropriate that the decision was taken to move Adebayo as soon as possible and acceptable that was completed in the morning as both Lucy and Adebayo were now asleep.

On 28 February the care home manager contacted the police again to request their presence while Adebayo was moved to the flat. The police attended and although keen to play a direct role in moving Adebayo, they took advice from the care home staff and remained outside while care home staff move Adebayo, and were not required to intervene. It was good practice for the police to attend as at this point they were not attending for a criminal reason but to support the care home staff. This illustrates good practice in working together with other professionals and utilising a proportionate response with adults at risk.

The decision to move Adebayo to the self-contained flat was the right decision and it was also timely in that the flat had become ready for occupancy a couple of days before. This allowed Adebayo to be moved but continued to be supported by the same staff.

4 Findings

Summary of Findings

The Review Team has prioritised **four findings** for the SAB to consider:

Findings	Category
Finding 1: Professionals across the partnership are not using historical information to inform and influence their decision making for adults with learning disabilities who have challenging behaviour. The result is that each incident is responded to individually and the accumulative risk is then not recognised.	Patterns of multi-agency working in longer-term work
Finding 2: Professionals are desensitised to aggressive behaviour which results in the minimisation of the impact of violent behaviour by and to people with learning disabilities and the potential safeguarding implications.	Innate human biases (cognitive and emotional biases)
Finding 3: Police are not routinely invited to adult safeguarding strategy meetings or seen as part of the multi-agency safeguarding partnership due to other professionals viewing their role as being solely crime-investigation focused. (This is also links with Finding 2).	Patterns of multi-agency working in longer-term work
Finding 4: Professionals do not fully understand the role of statutory advocacy services in supporting adults at risk in key decisions affecting their well-being, with the result that adults at risk are left without their wishes and feelings known/articulated.	Patterns of multi-agency working in response to incidents/crises

Findings in detail

This section represents the main learning from this case review for the SAB and partner agencies. Each finding is set out in a way that illustrates:

- How does the issue feature in this particular case?
- How do we know it is not unique to this case?
- What can the Case Group and Review Team tell us about how this issue plays out in other

similar cases/scenarios and/or ways that the pattern is embedded in usual practice?

- How prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern?

- How widespread is the pattern? Is it found in a specific team, local area, district, county, region, national?

- What are the implications for the reliability of the multi-agency safeguarding system?

The evidence for the different 'layers' of the findings comes from the knowledge and experience of the Review Team and the Case Group, from the records relating to this case, other relevant documentation and from relevant research evidence.

Four priority findings were chosen because they represented areas of practice which were significant in how this case was managed, but which also reflected wider patterns of practice and the systems that underpin that practice.

Finding 1:

Professionals across the partnership are not using historical information to inform and influence their decision making for adults with learning disabilities who have challenging behaviour. The result is that each incident is responded to individually and the accumulative risk is then not recognised.

As part of any in-depth, thorough assessment, historical information is gathered and analysed. This information should then be actively used to inform future planning.

How did the issue manifest in this particular case?

Historical information regarding Adebayo's previous violent behaviour towards both residents and staff in two previous settings was known and included in the comprehensive assessment that was completed by the care home as part of the placement request process. A decision was taken by the care home that they could meet Adebayo's needs.

Despite the fact that information was available its relevance wasn't recognised when Adebayo assaulted Lucy on the first and subsequent occasions.

Each incident should have triggered a reassessment, drawing all the information available including the pattern of historical behaviour. This pattern, in addition to the pattern that was emerging, now should have informed the new risk assessment and the intervention that needed to take place. The care home staff were looking for triggers for each individual incident which appears to have prevented them recognising a pattern of repeated assaults.

In addition the risk assessment process for individual residents did not look at the potential risks from the perspective of the other residents. In this situation Lucy's behaviour changed once the assaults started and she became withdrawn, spending more time in her room and looking anxious as she moved around the home. The information regarding Lucy's change in behaviour wasn't part of the decision making discussions.

What makes it underlying rather than a particular issue

The Case Group and Review Team are all aware of other cases where historical information is not always taken into account when making decisions and discussed this as part of this review process.

How widespread and prevalent is it

There is a large body of evidence from statutory reviews that demonstrates that the issue of not taking account of/or the lack of awareness of historical context as part of assessments/analysis of present situations is a feature of almost all statutory reviews (Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews etc.). The issue as it presents in this case is also known to be present for adults with mental health problems and older adults signifying a potential substantial issue nationally.

In addition we can also transfer knowledge from research in children's work looking at prediction of behaviour and the use of historical context. Munro emphasised the importance of this in 2008 when she highlighted that "the best guide to future behaviour is past behaviour".

It is likely that practice in Waltham Forest will reflect practice nationally with mean that a substantial proportion of assessments nationally do not include historical context.

A Waltham Forest joint children and adults multi agency audit on parents with learning disabilities highlighted lack of historical context which further supports the suggestion that this is widespread.

What are the implications for the reliability of the multi-agency adult safeguarding system

Given the political context of the Winterbourne View Inquiry and subsequent moves out of institutional units to smaller community units for life, there will increasingly be the potential for a cohort of service users who are the most difficult to place and thus the potential for conflict and compatibility issues to increase.

Care settings are always going to have residents that are placed by different authorities.

The care home staff are the only professionals that have access to the information on all the residents and can make the appropriate risk assessment. Therefore if they do not ensure that historical information influences decision making once a resident is living in the placement there is the potential for the needs of the resident to be misunderstood and the implications for other residents to be missed.

As part of the pre-admission assessment and risk assessment process, challenging behaviours and patterns of behaviour should be identified. There should then be a risk management plan for an immediate response and a longer term strategy that identifies previous patterns of behaviour and notes the possibility that because this has happened in the past it may happen again in the future. The risk management plan should also include reference to the impact of this behaviour on other residents/staff and a plan for how this could be addressed but not presumed in order to avoid labeling.

Finding 1:

Professionals across the partnership are not using historical information to inform and influence their decision making for adults with learning disabilities who have challenging behaviour. The result is that each incident is responded to individually and the accumulative risk is then not recognised.

It is important to recognise that people are capable of change at any point in their lives. Past behaviour can also be an indication of future behaviour and where this may have direct implications for the support an individual needs and an impact of those living with them, the information should form part of the context of the assessment and behaviour plan. This case evidences how the relevance of historical information was not recognised until considerable harm had been suffered.

Questions and issues for all the board members and agencies to consider

- In what ways does the Board think that pre-admission/risk assessments can be improved to ensure that behaviours that may negatively impact on other residents are included?
- How can the Board support the commissioning and contracts process to embed good practice regarding use of historical information and use of a compatibility assessment tool when appropriate etc.?
- How will the Board assure itself that practice has improved?

Finding 2:

Professionals are desensitised to aggressive behaviour which results in the minimization of the impact of violent behaviour by and to people with learning disabilities and the potential safeguarding implications.

For some people with autism and other learning disabilities displays of challenging behaviour are not uncommon and this can include physically aggressive behaviour. All behaviour has a function and for people with autism who may have an over sensitivity to their environment and difficulties in communicating their needs, this can then lead to anxiety, anger and frustration. This is turn can lead to an outburst of challenging behaviour (National Autistic Society, 2016).

This results in a situation where physical aggression is more common place in residential settings for people with autism and learning disabilities. Understanding the possible context for the behaviour however does not mean it is not assault/potential crime nor the response to it should be lessened/different.

How did the issue manifest in this particular case?

Lucy was assaulted a total of six times before the perpetrator Adebayo was removed from the care home they shared with two other residents.

By the third assault, staff at the care home recognised that Lucy was avoiding Adebayo but it was not until the fifth assault that there was recognition by the care home and Adebayo's SW that Lucy

was being targeted by Adebayo. Lucy's SW was alone up to this point in perceiving the assaults to be targeted at Lucy.

If Lucy's 'story' was told replacing her and Adebayo with adults who are not at risk, actions to remove Adebayo would have been taken sooner, suggesting that it was the nature of their disabilities that influenced professionals' thinking.

The approach taken by the partnership was largely one of behaviour management of Adebayo which was appropriate but there was not a robust safeguarding approach running alongside this for Lucy. Following each assault Adebayo's behaviour plan was reviewed but this was done in isolation of other incidences rather than being contextual or accumulative, meaning information from previous assaults was not taken into account. Risk management plans were not updated contemporaneously and, when looked at subsequent to the assaults, appear to have been downgraded on one occasion.

A single safeguarding alert was raised for a number of events rather than separate ones for each assault which is not acceptable practice. This was not good practice as alerts should have been raised for all occasions. The cumulative nature of the events was not highlighted either, rather it was a presentation of a series of unrelated events.

What makes it underlying rather than a particular issue

Although we were not able to identify national research in this area to support this, the Review Team and Case Group know from their own experience that minimisation and desensitisation can occur in units for people with learning disabilities and/or mental health needs and for older adults and that violence may then be seen as normal behaviour.

Examples of this were given by the Head of Safeguarding who identified multiple occasions where residential settings do not record unwanted physical contact as safeguarding and it is only when this behaviour escalates and past records are viewed that the minimisation of the unwanted physical contact becomes apparent.

How widespread and prevalent is it?

The Francis Inquiry and Winterbourne View Inquiry were both in response to organisational abuse of adults at risk; the Winterbourne View Inquiry specifically in relation to people with learning disabilities. Although there is no suggestion of organisational abuse in this case, both reports highlight that whistleblowers did attempt to raise the profile of what was occurring and this was not recognised by the authorities they alerted, which the Review Team recognised as a result of desensitisation.

There is no national data that details how prevalent this is, however, there is nothing to suggest from the above reports that the poor practice identified was specific to the localities of the institutes. Therefore, this review is confident that desensitisation is a Waltham Forest and national issue.

What are the implications for the reliability of the multi-agency adult safeguarding system?

There is a pattern of under reporting the severity and frequency of aggressive behaviour. If this is not recognised, then the appropriate safeguarding process/framework is not put in place, leaving victims at risk for longer.

Due to the assaults not being seen in the context of safeguarding, the behaviour is minimised and the recording of the person's needs are not accurately documented. Procurement decisions on placements are therefore based on incomplete information.

People who are assaulted in these situations do not receive the same human rights and access to natural justice afforded to people involved in a similar incident in a non-care setting or between people who are not adults at risk.

Perpetrators can also be affected negatively if events are not recorded. For example, they are not able to access some forensic or other services that they might benefit from, nor is information recorded accurately to inform their future assessments and levels of need.

Finding 2:

Professionals are desensitised to aggressive behaviour which results in the minimisation of the impact of violent behaviour by and to people with learning disabilities and the potential safeguarding implications.

Professionals can be over-tolerant to levels of physical aggression that would not be acceptable in situations if the perpetrator did not have learning disabilities or mental health concerns. The impact for victims is twofold in that they are physically and emotionally affected by the assault, and, when it is not recorded or recognised as a crime they do not have access to the justice system and/or recourse to available compensation.

It also impacts negatively on the perpetrator in that if events are not recorded they are not able to access some forensic or other services that they might benefit from, nor is information recorded accurately to inform future assessments.

Questions and issues for all board members and agencies to consider

- How could the Board develop a zero tolerance approach regarding violence for staff and residents?
- How can the Board promote an approach and understanding that all unwanted physical contact must trigger a recorded discussion and decision about whether to initiate safeguarding procedures in care settings?
- How can the Board support staff to recognise and manage violence against staff or service users?

Finding 3:

Police are not routinely invited to adult safeguarding strategy meetings or seen as part of the multi-agency safeguarding partnership due to other professionals viewing their role as being solely crime-investigation focused. (This is also links with Finding 2).

The London Multi-Agency Safeguarding Policy and Practice Guidance 2015 outlines the role of the police, naming them as one of the three core organisational members of a local safeguarding process. It also places a responsibility on staff to report a crime if they witness it, or if they are

made aware of it, either through supporting the adult a risk to do this or making a best interest decision to do so.

How did the issue manifest in this case?

The police were not engaged as a partner in multi-agency meetings or as part of the safeguarding processes. The police were not contacted or invited to:-

- Four out of the six occasions when Lucy was assaulted
- The safeguarding strategy meeting on the 6 February
- The review meeting on the safeguarding strategy meeting on the 23 February

The police were contacted on two occasions (the second time followed the sixth and final assault when the decision was made to move Adebayo) but they were not engaged in further discussion regarding the situation and their advice and support was not requested. The Review Team felt this was a missed opportunity for the police to intervene in a more constructive way. For example they could have spoken to Adebayo about why his behaviour was unacceptable and the possible consequences, which may have contributed positively to the outcome. In developing a proportionate response to a crime the police take into account public interest as well as individual concerns and this affords them some flexibility in approach.

On the two occasions the police attended the care home their report noted that they felt the care home should be doing more to safeguard both residents. Despite this the police did not request to be part of the safeguarding process nor did they follow up or escalate their concerns, demonstrating a lack of understanding of their role and responsibilities, both general and specific to law enforcement.

It was not until the first Merlin was circulated that Waltham Forest staff were aware of all of the details of Adebayo's previous history of violence against staff and residents. In addition by not involving the police this denied Lucy access to justice as a crime had been committed against her.

What makes it underlying rather than a particular issue

The Review Team and Case Group perceived that police involvement in formal safeguarding processes is not yet embedded in safeguarding practice. This is evidenced by the lack of routine police involvement in safeguarding events and strategy meetings.

There was a perception in the Review Team and Case Group that staff could minimise or become desensitised to physical violence (Finding 2). Additionally it was suggested that staffs' determination of whether a crime has been committed is affected by their interpretation of the capacity of the service user; in this case the service user had a learning disability, and some staff took the view that as there was no intent then no crime had been committed. (Although an assessment around Adebayo's capacity to understand intent was not formally completed or recorded). It was mentioned that the CLDT had previously had access to a nominated Community Safety Unit officer who offered support and advice, this had been extremely helpful but had at some point ceased.

The police in the Review Team report that they are aware that they are not routinely invited (across London) to adult safeguarding strategy meetings in the same way as they are to children safeguarding strategy meetings. Whilst it is acknowledged that if they have capacity, adults may choose not to have the police involved, they should still be invited to the strategy meetings.

Review Team and Case Group members reported that when police are contacted with a report of physical violence between residents they would always attend. However, on arrival the approach taken is very inconsistent and the issue of capacity and consent may make it difficult for officers to proceed with an investigation. The Review Team believes that practice across London and nationally is inconsistent. It is possible that staff felt there would not be additional value by contacting the police because of this inconsistent approach.

How widespread and prevalent is it?

Anecdotal evidence from other SABs and the police suggests that the involvement of the police in strategy meetings and safeguarding processes in general is inconsistent and their role is not clearly understood. However to date, due to the new nature of SARs, there is only a very limited body of published knowledge and insight into practice on record and this does not yet include police involvement.

Due to the relatively new statutory nature of adult safeguarding procedures and practice it is anticipated that consistent practice and understanding of roles and responsibilities of all partners will take time to develop and mature. It was suggested by the Review Team and Case Group that if a crime had been committed and a person did not have capacity there should automatically be a strategy safeguarding meeting, and that the individual should automatically receive advocacy support.

The Review Team and Case Group are confident that the issues raised regarding police involvement are national as well as local and that this will eventually be identified and evidenced more broadly in other statutory reviews.

What are the implications for the reliability of the multi-agency adults safeguarding system?

The London Multi-Agency Safeguarding Policy and Practice Guidance 2015 is clear that safeguarding adults is a partnership endeavor and specifies the roles and responsibilities of organisations.

The role of police in safeguarding adults is not consistently understood by all partners. If the police are not seen as essential/statutory partners in safeguarding practice this results in cases where there is a lack of:

- Police expertise and knowledge regarding possible options
- Potential historical, relevant information gained through police checks
- Opportunities to utilise police discussion with the perpetrator to emphasise the unacceptability of the behaviour and possible consequences

- Historical context of incidents recorded by the police on a person's record for future information. This could ultimately result in a service user being denied access to the correct forensic support which is only available to people with certain behaviours.
- natural justice for people who lack mental capacity

Finding 3:

Police are not routinely invited to strategy meetings or seen as part of the multi-agency safeguarding partnership as other professionals associate their role as being solely crime-focused. (This is also links with Finding 2).

Multi-agency partners are not routinely involving police in safeguarding processes, and are viewing the role of the police as one of enforcing law and order and not drawing upon the wider value that police can bring to a safeguarding issue. The Care Act 2014 emphasises the importance of making adult safeguarding personal; it is important to ensure that where a person has capacity that their wishes about police involvement are respected, however, for those without capacity they should have the same access to the justice system as others.

Questions and issues for all board members and agencies to consider.

- How can the Board evidence that the statutory role of the police in safeguarding practice is understood by all partners, including the police, and that practice is consistent and this is reflected in local guidance?
- How can the Board support all partners to value police involvement in safeguarding in addition to the enforcement of law and order?
- How can the Board evidence that staff in care home settings will recognise assault as a crime and ensure service users have appropriate access to the justice system

Findings 4:

Professionals do not fully understand the role of statutory advocacy services in supporting adults at risk in key decisions affecting their well-being, with the result that adults at risk are left without their wishes and feelings known/articulated.

The Mental Capacity Act (2005) ensures independent advocacy services has a key role in ensuring that those who lack capacity have their wishes, feelings and beliefs considered in decision making processes. This can avoid the distress and frustration caused by unnecessarily restrictive care packages as well as empowering people to enjoy as much freedom of choice and movement as possible. It states that if an individual does not have an appropriate person to support and/or represent them (usually a friend or family member) then an IMCA must be appointed for the following decisions:

- Change of accommodation
- Serious medical treatment
- Applications under the Deprivation of Liberty Safeguards

Additionally they may be appointed for:

- Safeguarding decisions
- Care reviews

The Care Act also references access to advocacy for people when they do have capacity and when there are significant decisions to be made which they may find very difficult.

How did the issue manifest in this case?

Both Lucy and Adebayo were unbefriended; family members were not able to advocate on behalf of either of them. In Lucy's case her mum had mental health needs and Adebayo was in contact with his family less regularly than usual.

Staff were aware that, following the assaults, Lucy increasingly stayed in her room and appeared cautious when Adebayo was around, indicating that she was fearful of him. Statutory advocacy however, was not sought for Lucy until after three assaults had occurred and when the referral was made there was confusion around the necessary requirements for a referral which further delayed the advocate visiting until the 5 March. The advocate visited Lucy once and attended the safeguarding meeting on 6 March. The advocacy report had still not been received by Lucy's SW on the 17 April but was not robustly chased. The report when received was unclear and did not provide value or insight to the situation. Outside of the referral and the report there was no communication between the advocate and the SW. This demonstrates a lack of shared understand of the process, role and purpose of an IMCA.

In addition to this the Review Team noted that neither the advocate nor the staff involved considered involving Lucy's mum in the process as the person who knew Lucy the best. Although Angela was not in a position to advocate formally for Lucy she could have provided valuable input. There were conversations between Lucy's SW and the care home staff about discussing with Angela what was happening but this was discounted in the short term as staff did not want to cause her additional anxiety. At the time Angela had only just been allocated a social worker for herself so there was no established route in to a potentially difficult conversation with her.

It was not considered at any stage that Adebayo might benefit from advocacy, resulting in no exploration of how much he understood about the impact of his actions, or how he was feeling and any future decisions about his placement. This information could have influenced the risk management solutions put in place by staff.

An advocate could have been considered at any time after the first assault for both Lucy and Adebayo to determine:

- For Lucy, what she wanted going forward in relation to her proximity to Adebayo, what staff could do to provide her with more security and safety.
- For Adebayo how aware he was of his actions and their impact and how this would inform future risk management and behaviour management plans.

What makes this an underlying issue?

Conversations with the Case Group confirmed that practitioners were not clear when an advocate should be called and what could be acceptable; the differences between statutory and non-statutory advocacy were also not fully understood. They felt that some extra guidance on the use of advocates would be helpful.

What is known about how widespread or prevalent the issue is?

The local Waltham Forest data on referrals for IMCA services is extremely low with a total of seven referrals of which adult protection was only two.

National data for the use of advocacy for adults at risk shows that use is increasing, however, this is primarily for older adults and is related to dementia. The Department of Health (DH) report *'The 7th Year of the IMCA service'* provides analysis from data from all IMCA services. It highlights that although there is a growing use of advocacy, particularly in cases where safeguarding is an issue, the degree of involvement is far less than would be expected given the number of safeguarding referrals. Nationally safeguarding only constitutes 13% of referrals.

In an as yet unpublished SAR, a similar issue arose in relation to advocacy for an adult with a learning disability. The findings from the report also identify the lack of independent advocacy to a young woman with learning disabilities and queries if there is sufficient access to and understanding of IMCA services.

What are the implications for the multi-agency safeguarding system?

Like the Mental Capacity Act 2005, the Care Act 2014 focuses on person-centered care, making it the responsibility of the local authority to involve people in their care and support assessment, planning, review and safeguarding processes. The statutory requirement for the provision of independent advocacy under the Care Act is to support that involvement where the person would otherwise have substantial difficulty being involved and has no one appropriate to support them.

If professionals are not clear when and how to involve advocates it is likely that those without capacity or those who would have substantial difficulty being involved and have no one appropriate to support them will be left without a voice when dealing with significant life changing events such as safeguarding issues, placement moves etc.

This may mean that decisions are then taken on behalf of people that are not the right decisions which then create further difficulties and complications as a result.

As the definition of when an advocate should and can be used includes those with difficulties as well as those without capacity the demand for advocates should be significantly more and this may have implications for local providers.

Finding 4:

Professionals do not fully understand the role of statutory advocacy services in supporting adults at risk in key decisions affecting their well-being. This results in the wishes and feelings of adults at risk not being known or articulated.

Professionals (for example key workers and social workers) can sometimes see themselves as having an advocacy role and the boundaries between the statutory and 'non statutory' advocacy role can be confused. This can result in adults at risk not having access to statutory advocacy, or this not being at a sufficiently early stage in the process for their involvement to be meaningful. Within a safeguarding context it means that the person is not held central to the process. At an individual level this means the needs of adults at risk are not being heard. Collectively it results in less information available to inform future commissioning decisions at a micro and macro level.

Questions and issues for the all board members and agencies to consider:

- How can the Board assure itself there is a shared understanding of the value and requirements for statutory advocacy services and high quality consistent practice across Waltham Forest in accessing advocacy for adults at risk?
- How can the Board use monitoring information from IMCA providers to improve the quality of service provided to Waltham Forest adults at risk who lack capacity?
- What information needs to be available to the Board to ensure that the growing demand for statutory advocacy services is met?

5 Learning completed already

The agencies involved in these events took the opportunity to review their practice, learn lessons and make changes in the weeks following the conclusion of events. This learning took place before this review started and so it is important to reference this.

The following statements have been provided by the agencies themselves.

NELFT Community Learning Disabilities Team:

There have been several significant changes since the time of this case which has bought improvement to the CLDT.

1) **The implementation and embedding of the integrated health and social care triage for all service users.** This has ensured that each service user is re-assessed within a holistic framework when making contact with CLDT (known and unknown). This has promoted joined up ways of working and has integrated further the practice within the team. It has ensured that all CLDT staff are being skilled up in recognising safeguarding concerns and ensuring that safeguarding processes are adhered to. All new cases that have been triaged are discussed at a weekly Multi-Disciplinary Team (MDT) meeting to determine what professional group will lead on coordinating their care. All safeguarding cases are tracked at this weekly meeting allowing for discussion and support around decision making and risk management.
2) **The appointment to the CLDT locality manager post**; which bought a period of stability, strong leadership and challenge to the existing practice, with a view to driving improvement. The locality manager also bought in two new senior social workers. This has ensured that there has been good oversight on both health and the social work practice within the service and there has been an improvement in the quality of safeguarding practice occurring in the team.
3) **The appointment of two permanent Consultant Psychiatrists** which has ensured that there has been good clinical leadership within the service and that discussion of complex cases is robust and occurs on a weekly basis.

The care setting provider

As part of a governance review following a number of safeguarding incidents, which were raised around the behaviour of one specific resident, the Provider senior management team have shared the lessons learned from these safeguarding incidents with all service managers within the Provider Group.

1. Accidents / incidents / potential Safeguarding of Adults at Risk have always been reported to senior managers, however, the development is that in the event of the same service users being involved in more than two safeguarding or potential safeguarding incidents over a period of four weeks these must be flagged to the Director of Operations within 24 hours of the most recent incident along with copies of the actual incident report, updated risk assessments and updated behaviour management plans. The Director of Operations will

then direct what additional action should be taken if necessary. Any such case is then discussed at the senior Operations Meeting chaired by the Director of Operations.

2. All risk assessments (for residents) that have been reviewed and updated as a result of instigating safeguarding procedures must be re-visited by the service manager within 48 hours after the change to ensure that it remains appropriate.

3. Home managers must follow up with safeguarding authorities what the status of any safeguarding alert is and whether there is a need for further actions. This confirmation from the safeguarding authority must be in written format not just verbally over the telephone.

4. The provider's safeguarding policy has been reviewed to ensure that staff call the police following a potential safeguarding incident even where the alleged perpetrator is another service user.

5. All service managers submit a monthly report to the Director of Operations with updated information regarding all active safeguarding alerts.

6. Where ongoing safeguarding alerts are active, the home manager must liaise with the allocated care manager / duty care manager to ensure that a referral to an IMCA is made where required.

7. Managers must consider the potential impact that known / historical behaviours of any new service user might have on existing residents. In addition, managers must consider whether existing residents' behaviours might change due to the introduction of a new resident. Under such circumstances a review of risks should be completed and documented. In the event that risk assessments indicate an increased likelihood of behaviours occurring then access to additional clinical support through psychology / psychiatry must be prioritised as a matter of urgency. The senior management team will review the ongoing placement if applicable.

Waltham Forest
Adult Social Care

Following the identification of the incident, the Head of Service for Safeguarding Adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) has worked with the local authority's IMCA service to better promote the service, which has included them attending Adult Social Care's (ASC) Best Practice Forums, and being a member of the Safeguarding Adults Board's "MCA and DoLS Steering Group".

Safeguarding processes have been modified to better capture the need to identify IMCA involvement.

The local authority has also adapted its processes to adhere to the principles of Making Safeguarding Personal, which are now enshrined within the Care Act 2014. This includes ensuring that the views and indeed wishes of the adult at risk are considered at the onset. This should include facilitation to better include people in the process, ie Makaton / PECS.

Appendix 1: Methodology

Introduction

The case review used the systems methodology developed by the Social Care Institute of Excellence (SCIE) called *Learning Together*[3]. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

The methodological heart of the Learning Together model has three main components:

- Reconstructing what happened – unearthing the 'view from the tunnel' and understanding the 'local rationality'
- Appraising practice and explaining why it happened through the analysis of Key Practice Episodes (KPE's)
- Assessing relevance and understanding what the implications are for wider practice – using the particular case as a 'window on the system'.

Using this approach for studying a system in which people and the context interact, requires the use of qualitative research methods to achieve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation from organisations.

Review Team

This review has been carried out by a review team led by an accredited Learning Together Lead Reviewer, internal to LBWF (Suzanne Elwick), Head of Strategic Partnerships and an externally commissioned trainee lead reviewer (Mary Burkett), who was in the process of being accredited whilst the review was undertaken. The Review Team received support throughout the process from the Head of Safeguarding who was also part of the Review Team. Supervision was provided by SCIE and administration support was provided by Diane Collings and Thom Foot, LBWF.

Collectively, the role of the Review Team is to undertake the data collection and analysis and author the final report. Ownership of the final report lies with the SAB as a commissioner of this SAR.

The Review Team was made up of seven senior representatives from six different agencies, most of which had been directly involved with Lucy. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development of the findings from the review.

[3] Fish, Munro & Bairstow 2009

Review Team Members

John Binding	Head of Safeguarding, MCA and Dols, LBWF
Bernice Solvey	Head of Assessment and Care, LBWF
Darren Newman	Head of Service Design & Contract Management, LBWF
Phillipa Galligan	Assistant Director for MHS & Learning Disability - Waltham Forest, NELFT
Janice Cawley	Specialist Crime Review Group, Met Police
Russell Pearson	Specialist Crime Review Group, Met Police
Helen Sargent-Dar	Interim Deputy Director of Safeguarding, WFCCG Left her post after the second review team meeting.

Support from SCIE was provided in the form of case consultation, supervision and quality assurance.

Specialist Advice

The Review Team sought specialist advice from the Head of Clinical Psychology at NELFT in relation to any published evidence supporting the statements that professionals involved in the support of people with learning disabilities and mental health made to highlight that professionals in this role can normalise any violence that occurs and become desensitised to it.

Structure of the Review Process

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings between the Lead Reviewers, Champion, Review Team and Case Group members.

Initially there was a meeting between the Lead Reviewers and the Review Team, to explain the SCIE Learning Together model and the role of the Review Team in the process. This was followed immediately by a meeting with the Case Group so they could meet the Review Team. The Review Team then left and the Case Group had an introductory session about the methodology and their role in the review process was clarified.

It was agreed at the scoping meeting that due to the timeframe and level of activity not all staff involved would have an individual conversation. Some staff would have the opportunity to provide their input at the workshop sessions.

During the course of the review the Review Team met on four occasions. The Case Group met on three occasions: one for the introductory session and then for two half day follow-on workshops, where the emerging analysis was discussed and challenged. The Review Team were present at these meetings.

The review followed the process, and meeting structures, as outlined by SCIE with additional governance meetings arranged over the course of the review.

Timeframe and Mandate

In line with qualitative research principles, reviewers endeavor to start with an open mind in order that the focus is led by what they discover through the review process. This replaces the terms of reference (that have a specific focus on analysis before the review process has begun) which are a fundamental feature of traditional statutory reviews.

The timeframe for the review was drafted at the scoping meeting and confirmed by the Review Team. The timeframe covered by this SAR is 9th January 2014 to 28th February 2014.

Within the period under review, four KPEs were identified. These KPEs were then analysed in detail to provide insight into not only what happened with Lucy but also why things happened as they did. It was from this process of detailed analysis that the learning from the review (presented as findings) was generated.

The scoping meeting was held on the 8 February and the first meeting with the Review Team andCcase Group was held on the 15 March. The review will be concluded at the point the report is presented to the SAB on the 27 June 2016.

Sources of Data

The systems approach requires the Review Team to avoid hindsight bias and to learn how people saw things at the time – the ‘view from the tunnel’. Identifying and examining KPEs allows the Review Team to understand the way that things happened and explore the contributory factors that were influencing the Case Groups’ working practice. This is known as the ‘local rationality’. It requires those who had direct involvement in the case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

Data from Family Members

The lead reviewers met with Lucy’s mother, Angela to discuss her understanding and thoughts of what had happened and how well Lucy had been supported.

Angela was able to tell us a lot about Lucy as a person, her likes and dislikes etc and what they liked to do when spending time together.

Angela was aware of how Lucy's behaviour had changed during the time of the assaults and was relieved that since Adebayo had moved Lucy has started to come out of her room again more and her confidence is growing.

Angela spoke of her wishes to be more involved in Lucy's life in the home including helping her decorate her bedroom and go on holiday with Lucy and the care home staff.

Angela was aware that she was not told initially about the events and understood why but said she is stronger now and wants to be there to advocate on behalf of Lucy and wanted re assurance she would be informed going forward of anything significant**.**

Data from Practitioners

Information was provided by members of the Case Group who were directly involved with the family through a process of individual conversations. They were invited to share their experiences of working with Lucy and Adebayo in the context of their knowledge, systems and practice at that time. A total of four conversations were held with individual practitioners, all of whom were part of the Case Group for the review. Both lead reviewers were involved in each conversation.

Data from Documentation

In the course of the review the Review Team members had access to the following documentation.

- Safeguarding meeting documentation
- Assessment of Adebayo as part of the placement process
- Commissioning and contracts polices and framework
- Risk assessments from the care home
- Police Merlins
- Safeguarding investigation report
- Email exchanges between the care home and Lucy's SW.

Methodological Comment: Participation of Professionals

Case Group

Throughout the review Case Group members were provided with the opportunity by the Review Team to reflect on their professional practice with Lucy and Adebayo and the services provided by the agency they represented.

Throughout the process the willingness of practitioners to be involved, and make themselves available for conversations and meetings has been impressive. At each stage of the process, Case Group members have repeatedly shown their commitment to engage in the learning, both in terms of systems and reflecting on their own of practice.

The Lead Reviewers and the Review Team have been impressed throughout by the professionalism, knowledge and experience the Case Group have contributed to the review, and their capacity to reflect on their own work so openly and thoughtfully.

Both the Review Team and Case Group members have remarked that it has been a positive experience to take part in the review process and that it has contributed to a deeper and richer understanding of what happened and why, as well as allowing the learning presented in this report to be captured. Anxieties in the Case Group about being part of the review were largely allayed which facilitated open and honest discussions.

The Review Team

The Review Team has provided invaluable information and expertise in relation to local practice and understanding of the complex issues of supporting people with learning disabilities in care homes.

The Review Team members supported and welcomed the use of the Learning Together methodology and commented on using aspects of the approach in their everyday work to enhanc reflection and trouble shooting.

The Review Team together with the lead reviewers facilitated and led discussions and exercises with the Case Group. The Review Team members actively contributed to all aspects of the review process and ensured it was collaborative process with both the lead reviewers and the Case Group.