Safeguarding Adult Review "B"

In Rapid Time (SAR-IRT)

-Systems Findings-

Background

"X" had no history of offending prior to the first offence. There were four incidents (Sexual offences) in quick succession all in the same area of Southend around where he lived. "X" reoffended soon after release from custody on two occasions. "X" was convicted of the offences and spent some time in jail. On release he was placed in a Residential Care Home and did not reoffend for several months.

"X" is on the Violent and Sex Offender Register and is monitored by the police, his risk grading is HIGH. "X" had a probation worker who visited him and settled into the home well.

"X" sexually assaulted a vulnerable resident "B". "B" is entirely dependent on care. She is bedbound and none-verbal.

LOW LEVEL CONCERNS BY MORE THAN ONE AGENCY

Systems finding

Agencies come into contact with people as a result of need. When that need is low level, it is often a single contact that includes referrals to other available support. Agencies often have a different view of support required. In this case, the East of England Ambulance Service referred to the Local Authority who referred to their Doctor (GP) some two years previous; at which point contact was lost as the person did not follow up available support. A person's failure to engage with a provider's referral can cause the identified need to develop into crisis intervention. There is a daily tension between professional responsibility, professional curiosity and resources.

Learning Opportunity

- A referral mechanism that adopts a 'fire and forget' approach might not deliver the support required.

A HOLISTIC CARE PACKAGE

Systems finding

When agencies engage with a person who is at risk to themselves and others, they should have sufficient information (from other Agencies) to ensure their engagement is appropriate. This includes all information that impacts on the shape of the care they offer. In this case there was uncertainty (even during the SAR-IRT) about assessments completed and outcomes, the role of Deprivation of Liberty Safeguards (DoLS), and engagement with referrals. This case also demonstrated some excellent inter-agency working, where practitioners worked together to overcome unconnected and complicated issues.

Learning Opportunity

- The use of regular and frequent multi agency meetings improves communication, information sharing and development of professional relationships.

OFFENDERS WITH COMPLEX NEEDS RELEASED FROM CUSTODY

Systems finding

If Agencies believe a person will re-offend if arrested, charged and released on bail, such measures should be put in place to prevent that re-offending. If any agency believes that it is the responsibility of a different agency to put those measures in place, and they are not, they should escalate the issue. In this case the person was released more than once with the (proven correct) belief that they would reoffend quickly. When a person charged with an offence is released from custody by the Court there is not always sufficient time to plan to protect the person, those who care for them and the general public. This is further complicated, and the number of agencies involved increases, when the person has complex needs. A person can be released by the Court immediately, even if found guilty, indicating 'time served' on remand to be sufficient. The sentence is within the gift of the Court and so all potential outcome needs to be planned for. Agencies report that there is not capacity to plan for every potential outcome of a court hearing, but release often requires significant planning.

Learning Opportunity

- The approach to planning (resources, timing) for release from custody should be impacted by appropriate risk assessments more closely.

ENSURE AGENCIES WORK TOGETHER

Systems finding

Ideally all Agencies have agreed methods and routes for contact, and well used processes for the passage of timely and appropriate information between each other. These interactions follow an agreed path, timeline and format. This process would facilitate a confirmation / check that appropriate control measures are in place if a person is a risk to themselves, carers or public. In this case some agencies found it difficult to gain access to the person (not helped by COVID), did not have information that might have changed their service offer and were frustrated by a perceived lack of progress by other Agencies.

Learning Opportunity

- All practitioners should have an address book of Agency Contacts.
- Agencies should encourage challenge or escalation if Partners actions are not thought to be sufficient.

INAPPROPRIATE SEXUAL BEHAVIOUR (ISB)

Systems finding

ISB is a relatively common and potentially disruptive form of behaviour in people with dementia. Staff in care homes should be aware of the presentations of sexuality in dementia and how to manage (risk assess and design and implement control measures) the issue. In the case in question a history of sexual offending was not linked to dementia but considered by a number of professionals.

Learning Opportunity

- Care staff must recognise the difference between a sexual offence and ISB caused by a medical condition.
- Care staff must be aware of the potential change dementia, as it progresses, might make on ISB. (*future harms*)

ACCOMMODATION FOR SEXUAL OFFENDERS WITH COMPLEX NEEDS

Systems finding

An offender, released from custody with complex mental or physical needs should be placed in accommodation that has the facility to keep them, their staff and the public safe. Risk Assessments should consider all appropriate risk and identify those at risk; and control measures put in place (physical, training, reporting etc.). In this case accommodation was found with no previous experience of providing this support. A risk assessment was completed that inappropriately highlighted risk only to females under 16; leading to control measures that were not appropriate.

Learning Opportunity

- We do not have sufficient facilities to place elderly people with complex needs, including a history of sexual offending.

SAR-IRT-B Noteworthy Good Practice

1. *There was significant evidence of practitioners in both Probation and the Local Authority (Adult Social Care) making every effort to make suitable arrangements for accommodation and care needs. These arrangements were frustrated by the lack of capacity in the marketplace.*
2. *The Care Home and Probation Services built an excellent relationship. Probation Services provided significant advice and support to the Care Home.*
3. *HMP Chelmsford managed inmate preparation for release through a particular difficult pandemic. Even with tough restrictions (visiting) agencies were accommodated as much as reasonable possible.*

Links

- *Social Care Institute for Excellence, Safeguarding Adult Review in Rapid Time: https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time*
- *Suffolk – SAR-IRT (https://suffolksp.org.uk/assets/Working-with-Children-Adults/Safeguarding-Adults-Reviews/2021-05-14-SAR-in-Rapid-Time-Systems-finding-report-FINAL.pdf)*
- *Sexual incidents in adult social care; Evidence Review briefing (SCIE) (March 2022)*
- *Systems Thinking: From Heresy to Practice (Zokaei, K. Seddon, J.) (2011) (Palgrave Macmillan)*