S1

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity around multi agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

S1 was residing in a private residential care home when S2 was moved in. An incident occurred between the two men which could not be verified but circumstances suggested that a sexual assault was committed by S2 against S1. The adults involved both have learning disabilities and challenging behaviour.

Circumstances of, and challenges faced by the individual

S2 moved into the care home on 1 February 2014. The panel placing him there considered whether the environment would be suitable for him. They did not consider information about his history of aggression and sexually harmful behaviour and how this could impact on other residents. S1 had been in residence in the care home since 2010 and appeared well suited to the environment.

Frequent staff turnover may have diluted the effectiveness of initial training to implement the Personal Behaviour Support Plan (PBSP) for S2.

There was no clear protocol for staff response to the bedroom door alarm nor for responding to S2's sexualised behaviour.

The incident occurred outside of office hours when senior management were unlikely to be on the premises. This was seven months after S2 had moved in.

Staff on duty on the night of the incident did not provide adequate supervision of the residents, including S1 and S2. The staff did not respond promptly to the bedroom door alarm.

Staff on duty promptly reported to management and management to the police.

Forensic and medical care of S1 was delayed as there was no clear pathway to address the medical needs of someone lacking the capacity to give informed consent, which was presumed to be the case for S1. This was a judgement based on the circumstances instead of a person-centred assessment. The lack of such an assessment created confusion between the police and the care manager for S1.

Family did not feel that they had been informed of the outcome of the investigations into the incident.

What happened?

In July 2014, an incident occurred between the two men which could not be verified but circumstances suggested that a sexual assault was committed by S2 against S1. The nature of the assault could not be verified due to the delay in S1 receiving health care and forensic medical attention.

Why it happened?

It was recognised that where adults have learning disabilities there may be a tendency to mitigate the motivation for sexually harmful behaviours and thus minimise them.

This may have created an environment where staff supervision was not alert to the possibility of sexually harmful behaviours. This was underlined by the lack of adherence to the PBSP for S2 due to staff turnover and the relaxing of senior management support during "out-of-office" hours.

Report recommendations

1. Placement panels to include the care managers of the current residents as well as the care managers of the proposed new resident and other key personnel.

2. A robust system of accountability for Personal Behaviour Support Plans (PBSP) to be introduced, to include ownership and maintenance of the plan. Escalation process should be explicit, staff members to be trained on PBSPs at regular intervals to mitigate against staff turnover. Responsibility lies with the care provider.

3. A Quality Assurance Framework for all residential care homes, allowing for measurable improvements where needed, through monitoring, accountability and also preventing insularity.

4. Police training for officers around vulnerability and capacity.

5. A police and health agreed pathway to address the health care and forensic medical examination needs of adults with learning disability and issues of capacity.

6. The Specialist Behaviour Team to introduce a more forensic approach to the risk assessment of sexualised behaviours in adults with learning disabilities and challenging behaviour.

7. Family members need clear and open lines of communication during investigations and at their conclusion. Practitioners need to ensure that the family have a clear understanding of what they (the practitioner) believes has been communicated to them.

8. An advocate was involved in the best interest meeting concerning S1. Organisations should share this example of good practice with their staff and encourage the use of advocates.

NB: As a vulnerable adult, S2 would have a right to a responsible adult/advocate supporting his rights throughout any police procedures. Police action taken as a result of the investigation is not detailed in the report.

Citation

Warrilow T. (2017) Concise adult practice review: re: WBA N2 2016. 9/2017. [Western Bay]: Western Bay Safeguarding Adults Board

www.safeguardingboard.wales/2018/06/19/western-bay-concise-adult-practice-review-22016/