Adult Practice Review Report

Western Bay Safeguarding Adults Board
Concise Adult Practice Review

Re: WBA N2 2016

Brief outline of circumstances resulting in the Review

A Concise Adult Practice Review was commissioned by the Western Bay Safeguarding Adults Board on the recommendation of the Quality & Performance Monitoring Management Group in accordance with the Social Services and Well-being Act 2014; Working Together to Safeguard People (vol 3 Adult Practice Reviews). The criteria for this review are met under Section 6.1 of the above guidance namely;

6.1 A Board must undertake a concise adult practice review where an adult at risk who has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

(a) died; or

(b) sustained potentially life threatening injury; or

(c) sustained serious and permanent impairment of health.

Circumstances Resulting in the Review

This review concerns two vulnerable adults with learning disabilities and challenging behaviour who were living in a privately managed residential care home. An incident occurred in July 2014 which triggered this review. Due to the individuals' vulnerabilities the exact nature of the incident is unknown but circumstances suggest that a sexual assault was committed by one of the men (S2) against the other (S1).

Time period reviewed and why

The period under review is 1st February 2014 until 31st March 2015. S1 was residing at the care home from 2010 and the timeframe was agreed by the panel to include the period from when S2 moved in to the care home to when the final strategy meeting was held under the Protection of Vulnerable Adults process.

Practice and organisational learning

1. Before S2 was admitted to the private residential care home a placement panel was held which only considered information about the proposed new resident and whether the home was a suitable environment for him. The panel did not consider information about his history of aggression and sexually harmful behaviour against the vulnerabilities of the other residents, including S1, and their interests were not represented except by the management of the private residential care home. This is in contrast to the process adopted when vulnerable adults are admitted to supported accommodation when the Care Managers for all residents are included in the placement panel and can contribute to safer decision making.

2. A thorough Personal Behavioural Support Plan (PBSP) was developed by the Health Board for S2 prior to his placement but the responsibility for ongoing ownership of, accountability for, and maintenance of the plan was unclear.
Whilst there was recognition that thorough initial training occurred prior to the placement of S2 in the private residential care home around his PBSP, there was doubt as to whether staff on duty at the time of the incident were adequately trained in managing his behaviour and the risk he posed. Frequent staff turnover and transfer of experienced staff to new establishments acquired by the same owners are believed to have diluted knowledge of how to manage S2's behaviour. In particular there was no clear protocol on how staff should respond to the bedroom door alarm or how they should respond to S2's sexualised behaviour.

3. At the time of the incident there was no robust system in place to assure commissioners that providers of private residential care homes consistently deliver care of a good standard. Care Managers had no concern about the care provided at the home involved in this review but their visits occurred during office hours when managers were on duty. The incident occurred out of hours when there were no senior managers present.

4. The private residential care home in question is a 'family business' and the senior management team are related to one another. They have had years of experience in the public sector and thus are qualified to provide in-house expertise, which means that services such as the Behavioural Support Team and the community nursing team do not need to visit the home to see residents. Whilst commissioners may see this as an advantage, it also results in fewer visits to the home by independent professionals who could provide some informal oversight of the care provided there.

5. The staff on duty on the night of the incident did not provide adequate supervision of the residents including S1 and S2 and did not respond promptly to the bedroom door alarm. Once discovered, the incident was promptly reported by care staff to management and by the managers to the police. However, there was confusion as to what had occurred. This coupled with the presumed rationale that the vulnerable adults involved lacked capacity meant that the 'Golden Hour' for securing evidence was lost.

6. Following the presumed sexual assault the forensic and medical care of S1 was delayed as there was no clear care pathway to address the health care and forensic medical needs of those who may lack the capacity to give informed consent. There was confusion between both police and S1's Care Manager.

7. The Specialist Behaviour Team recognised that where vulnerable adults have learning disabilities there may be a tendency to mitigate the motivation for sexually harmful behaviours and thus minimise them. They have since recognised the need to undertake robust risk assessments and analyse these behaviours in a more forensic manner to inform the PBSP.

8. Family did not believe that they had been informed of the outcome of the investigations into the incident whereas practitioners confirmed that meetings had occurred where this information was offered.

9. Following the incident a Best Interest meeting was held in relation to the placement of S1. Due to differing opinions the Case Manager involved an advocate from 'Your Voice' in order to ensure that S1 had optimal representation. This resulted in S1 accessing a new placement which his family now acknowledge as better suited to him.

Improving Systems and Practice

1. It should be a contractual obligation that placement panels should include the Care Managers of all current residents as well as the Care Managers of the proposed new resident and other key personnel. All relevant information should be shared with the whole panel when assessing the risk residents may pose to each other. This would be particularly relevant when placing out of county residents. The outcome of this placement panel could reduce the likelihood of risk of harm to other residents.

2. A robust system of accountability for PBSPs should be introduced. The rationale underlying the PBSP, ownership and maintenance of the plan and an escalation

process, including thresholds for behaviours of concern, should be explicit. Care home staff members need training on individual residents' PBSPs and this should be repeated at regular intervals in order to allow for frequent staff turnover and loss of experienced staff to other establishments and organisations. The responsibility for this training lies with the care provider.

3. The Western Bay Safeguarding Adults Board has developed a Regional Quality Framework which should be embedded in practice to provide assurance about the standard of care delivered in all residential homes. This will allow for measurable improvements where needed.

4. There is a need to guard against insularity for any care home, and commissioners should ensure that providers are adequately monitored and held to account for the services they deliver.

5. The police have already acted to improve the training their officers receive around vulnerability and capacity as well as expanding their Vulnerable Adults Team.

6. There is a need for police and health to agree a clear care pathway to address the health care and forensic medical examination needs of vulnerable adults following alleged assaults including sexual assaults.

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

8. Family need clear and open lines of communication during investigations and at their conclusion. Practitioners need to ensure that family have a clear understanding of what they believe has been communicated to them.

9. An advocate was involved in the Best Interest meeting concerning S1. Partner organisations in the Western Bay Safeguarding Adults Board should take this example of good practice back to their staff and encourage the use of advocates when appropriate.

Statement by Reviewer(s)			
REVIEWER 1		**REVIEWER 2 *(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	

I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference
Reviewer 1 *(Signature)* *pp.* **Name** *(Print)* Sian Ivens **Date** 29.09.17	**Reviewer 2** *(Signature)* **Name** *(Print)* Dr Lorna Price **Date** 29.09.17

Chair of Review Panel *(Signature)* **Name** *(Print)* Terri Warrilow **Date** 29.09.17	

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the SAB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

An Adult Practice Review Panel was established in May 2016 chaired by Terri Warrilow, Safeguarding and Quality Manager, Social Services and Well Being Directorate, Bridgend County Borough Council. The reviewer was Sian Ivens, Quality Manager, Wales Community Rehabilitation Company with support from Dr Lorna Price, National Safeguarding Team, Public Health Wales.

The Panel consisted of representatives from South Wales Police, Corporate Safeguarding Abertawe Bro Morgannwg University Health Board (ABMUHB), Neath Port Talbot County Borough Council (NPTCBC) Adult Services, Mental Health Services AMBUHB and Vale of Glamorgan Adult Services.

A practitioners' Learning Event was held in March 2017 and was attended by members of staff from the following agencies; South Wales Police, ABMUHB, Vale of Glamorgan Adult Services and NPTCBC Adult Services. The management of the private residential care home where S1 and S2 lived at the time of the incident were contacted but neither they nor any of the staff from the home attended the Learning Event.

The reviewers met with the families of S1 and S2 at their homes to discuss the process of the review and to gather their thoughts and feelings about the care their loved ones had received and the circumstances surrounding the incident. The parents of S1 indicated their positive relationship with all professionals involved in the care of S1 apart from the staff on duty on the night of the incident in the private residential care home. The family of S2 were also satisfied with the support they received except from the management and staff of the private residential care home.

Following the completion of the review the Chair of the panel and the Safeguarding Board Business Manager met with the residential care provider to give feedback on the identified learning points. It was explained that the report had been signed off by WBSAB and so amendment would not be possible. However, the provider wanted it noted that, although invited, they were unclear about who could attend the learning event and so nobody did. It was acknowledged that this was possibly a missed opportunity and with hindsight it was recognised that they could have attended and

provided a valid contribution from the care home's perspective.
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads ……

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	