social care
institute for excellence

Staffordshire and Stoke-on-Trent
Adult Safeguarding Partnership Board
Abuse must stop

A Safeguarding Adult Review commissioned by Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB)

Following the assault on Elsie by a fellow resident Frank at the nursing home where both were living Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board has decided to arrange for the conduct of a Safeguarding Adult Review (SAR). In this case the statutory criteria were met for conducting a Safeguarding Adult Review in order to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again' (Care Act 2014).

The SAB is collaborating with the Social Care Institute for Excellence to develop a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

What is a SAR In-Rapid-Time?

A SAR in Rapid Time aims to turn-around learning in an approximately 3–6-week timeframe, following the Set-Up meeting. The Set-Up meeting is held after the decision has been made to progress with a review. An outline of the process is captured below.

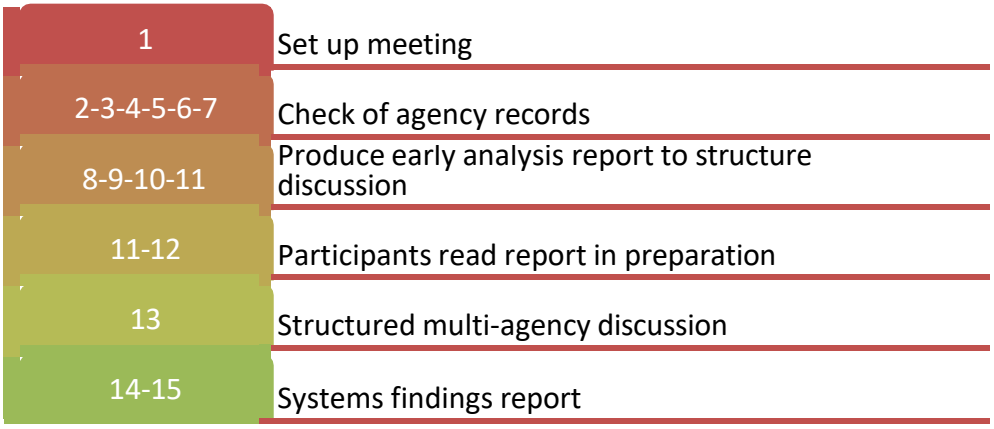
The learning produced through a SAR in Rapid Time concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

Standardised processes and templates support an analysis of a case to identify systems findings in a speedy turnaround time. The process is supported by remote meeting facilities and does not require any face-to-face contact.

This document

This document forms the final output of the SAR in Rapid Time. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on social and organisational factors that will make it harder or easier to help someone in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

Figure 1: Outline of a SAR In-Rapid-Time (in days)



In order to facilitate the sharing of this wider learning the case specific analysis is not included in this systems finding report. Similarly, an overview of the methodology and process is available separately.

The facts and focus of this SAR are explained below, followed by the systems findings.

Each systems finding is first described. Then a short number of questions are posed to aid SABs and partners in deciding appropriate responses.

Focus of this SAR In- Rapid -Time

This SAR takes the case of Elsie and Frank as a 'window on the system' through which to understand:

'What is helping and hindering achievement of sexual safety of residents in care home settings, including the management and mitigation of risks related to aggressive and/or sexualised behaviour of residents?'

Elsie was not the only resident to be exposed to harm from Frank during his time in the nursing home. This review does not focus on her situation, rather it considers how Frank came to be in a position where he had access to her and other vulnerable residents in the home. We looked at how Frank came to be in the nursing home in the first place, and at how agencies understood and communicated about the risks he posed to others during his time at the home.

Frank was evicted from a nursing home in a neighbouring local authority and admitted to the nursing home in Staffordshire on the same day. The nursing home wanted Frank's removal because they could no longer cope with his behaviour.

Four months after admission he carried out a sexual assault (non-consensual). The police did not bring charges. Further investigations were made under the safeguarding umbrella. These concluded with Frank's referral to mental health services. The intervention by mental health services concluded when Frank's sedative medication was increased, and the home reported him to be 'settled'. Frank became fixated on Elsie shortly after her arrival in the home. There were further incidents of non-consensual sexual activity, which were not reported to safeguarding. On 21.06.21 Frank was witnessed raping Elsie. This incident led to the referral for a SAR.

Looking beyond this case

The SARs In Rapid Time methodology distinguishes between the case findings, and systems findings. Systems findings are the underlying issues that helped or hindered in the case and are considered systemic rather than one-off issues. Each systems finding attempts to describe the barrier or enabler to good practice. This requires that we think beyond Frank and the assaults in this case to the wider organisational and cultural factors. It also requires that we hold off at this stage from solutions or articulating what is needed, to specify first what the current reality of barriers/enablers is, that the SAR process has helped us understand.

Systems findings:

What are the key barriers/enablers we have learnt about that make it harder/easier for good practice to flourish and that need to be tackled in order to see improvements?

Systems finding 1

SYSTEMS FINDING 1.

Staffordshire safeguarding policies and procedures recognise sexual abuse as a category however there is no local policy or procedure about how sexual safety can be maintained specifically in residential care settings, including how to respond to incidents, assess and manage risk. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common. This leaves disparate and sometimes contradictory efforts by different agencies to support the individual and protect others, with no effective multi-agency working or effective oversight of risk management within a home, or of placement decision making, whether routine or in emergencies following evictions.

Discussion

The Care Act and associated Code of Practice focus on adults who are experiencing or at risk of experiencing abuse or neglect and encourages a personalised response. Very little is specified about the management of adults with care and support needs who pose a risk to other adults. This gap has not been addressed fully in Staffordshire.

In safe practice there will be clarity and agreement across agencies on how vulnerable individuals who pose a risk to others are included in multi-agency adult safeguarding processes. Risk will be assessed and mitigated through processes agreed between safeguarding partners, including care providers. In the complex and difficult area of assessing and reducing risks posed by individuals with significant cognitive impairment joint working and information sharing are essential.

In discussion with practitioners, it became evident that in practice the safeguarding adults team may identify such individuals as ‘sources of risk’ in their recording systems but no robust process for risk assessment and management follows on from this. In practice individual residential care providers rate risk and develop management plans according to their own perspectives and understanding. Where other agencies rate the risk more highly than the provider, there is no obvious arena where evidence around

this can be reviewed and evaluated, or the adequacy of the mitigations objectively considered. Where an individual is identified as a 'source of risk' this is shown in relation only to the individual who is the focus of the safeguarding enquiry. There is no system for identifying high risk individuals who pose a risk to groups of people (residents, staff, visitors) as they move around the care system, and no easy way to discern patterns of behaviour, or any escalation in risk.

In this case it was evident that evaluations of risk Frank posed to other vulnerable people were not always arrived at objectively, or based on evidence, or shared. There appeared to be other priorities in play, whether to secure speedy removal from one care situation to another, to minimise unwanted scrutiny of failing care arrangements, or simply because processes required decision makers to look only at needs, not risks, and questions could be satisfied with blanket statements that 'all needs were met'.

In discussion with practitioners, it was easy to see how time pressures, Covid pressures, lack of support, paucity of options, financial pressures, lack of scrutiny, lack of knowledge and understanding, lack of transparency, led to a situation where a person displayed high- risk behaviour and found himself in a setting with access to extremely vulnerable people and minimally effective risk reduction strategies in place. Although Covid pressures have receded, others remain. This case demonstrates the need to counterbalance everyday pressures to act without due consideration of patient safety with objective safeguarding oversight of individuals known to pose a risk to others through their sexual behaviour.

Questions for the SAB and partners

- Is there agreement across partners that some policy and procedure development would be useful in this area?
- How might private providers be involved?
- Is there potential for a jointly agreed format for risk assessment and individualised care planning for such circumstances?
- Would such development be adequate to achieve effective oversight of the management of sexual safety issues, including by private providers of residential care services?
- How would the SAB know if there had been improvement in this area?

Systems finding 2.

SYSTEMS FINDING 2. Staff in residential care are not adequately equipped to distinguish consensual sexual activity from sexual assault, based on an assessment of an individual's capacity to consent. This is reflected in unclear language to describe sexual activities and increases the chances of downplaying both the risks an individual may pose, and the needs of others for protection.

Discussion

In relation to sexual behaviour, there is a common assumption that having a broad cognitive impairment equates to 'not knowing what they're doing' rendering adverse behaviour unintentional and harmless. In consequence, risk is downplayed, and protections not put in place, even where such behaviour is based on firmly held if delusional beliefs, does not occur randomly but appears to be guided by the beliefs, and follows a clear and predictable pattern.

In safe practice, instead of such assumptions, there is a shared and consistent understanding that for any sexual activity to be consensual individuals must have capacity to consent to the activity. Where decision

making capacity is likely to be impaired (delusional beliefs are a clear indicator of this) staff must know how to use the guidance in the Mental Capacity Act to reach a conclusion about this, or to recognise where more specialist help is needed. All staff need to understand that in the absence of capacity to decide about taking part in sexual activity, the activity is non-consensual and is an assault.

In the workshop it was clear that in consequence of a lack of shared understanding of the relationship between mental impairment, decision making capacity and risk, terms such as 'disinhibition' and 'sexually inappropriate' and were used euphemistically by agencies to convey the sense that Frank 'didn't really mean' his actions. This hampered agencies in reaching shared and consistent agreement around the risks of sexual harm posed by Frank. It also contributed to the difficulties agencies appeared to have in understanding that the behaviours were not 'one offs' but likely to be driven by a mental condition with no prospects of improvement and hence highly likely to be repeated.

In the discussion it emerged that high staff turnover and use of agency staff affected the development of shared understanding of sexual safety and how to maintain it in residential and nursing homes This may have improved with the reduction of Covid restrictions. For the future, robust policies around mental capacity, linked to development of sexual safety policies in residential and nursing care, will provide some assurance that staff will be supported in safe practice in this sensitive area.

Questions for the SAB and partners

- Where can training on assessment of mental capacity specifically regarding decisions about the ability to consent to sexual activity be sourced?
- What other factors need to be addressed in order to make it easier for staff to put such training into practice?
- How can the workforce across Staffordshire be enabled to engage with the definitions available in recent CQC guidance on sexual safety for social care and mental health? Can other definitions for example, those used in the criminal justice system, be better understood across all agencies?
- Is there a role for the SAB to support understanding and adoption of the CQC guidance language and definitions?
- Do, or should, local authority and health contracts with care home providers include a requirement for sexual safety policies to be in place?

References

- Joint Multi-Agency Safeguarding Adults Policies and Procedures
- Section 42 guidance: https://www.adass.org.uk/media/7326/adass-advice- note.pdf
- Resident-to-resident harm in care homes and residential settings | SCIE
- Loss of inhibitions and dementia | Alzheimer's Society (alzheimers.org.uk)
- Microsoft Word - 20190110 Sexuality in Care V0.09 Clean for approval_PUBLICATION.docx (cqc.org.uk)
- Older People Relationships | Publications | Royal College of Nursing (rcn.org.uk)
- https://www.cqc.org.uk/sites/default/files/20180911c_sexualsafetymh_report.pdf
- https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf