Vulnerability Knowledge & Practice Programme

# Learning for the police from Safeguarding Adult Reviews: Quarter 4 briefing

This briefing contains learning for strategic and operational police practice in England and Wales

Released January 2020

# INTRODUCTION

This briefing, produced by the Vulnerability Knowledge and Practice Programme (VKPP)[1], is the fourth in a series which examines police practice in statutory reviews, and is the first to focus on Safeguarding Adult Reviews (SARs). SARs became a statutory requirement for Safeguarding Adult Boards (SABs) under the Care Act 2014, which states that SABs must arrange a SAR when an adult in its area dies or suffers serious harm as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult[2]. This briefing also covers Adult Practice Reviews (APRs), which became a statutory requirement for Welsh SABs under The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.

Between July 1st and September 30th 2019, 330 unique published SARs and APRs were scanned for inclusion. This briefing is based on 45 of these which fit the criteria for inclusion (see Appendix B for a full account of the methodology). Cross-cutting themes identified and presented here relate to multi-agency working and information sharing, auditing and recording, risk assessment, investigation, pursuit of perpetrators, and engagement with vulnerable adults and their families. Self-neglect is featured as a special theme to identify specific learning for police in working with adults with complex needs arising from this issue.

**CONTENTS**



[1] This programme operates under the auspices of the National Police Chiefs' Council Lead for Violence and Public Protection. You can read more about this programme here: https://whatworks.college.police.uk/Research/Pages/Vulnerability.aspx

[2] Department of Health & Social Care (2018) *Care and Support Statutory Guidance*. London: DHSC. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

## SNAP SHOT OF CASES

**Police forces**

- Twenty police forces covering 9 regions, are represented in these 45 SARs

**Police involvement**

- **Police initially became involved with the adult subject to the review in the following ways:**
  - *17 call outs from or about a vulnerable adult*
  - *10 responses to an offence committed against a vulnerable adult*
  - *8 responses to a family incident*
  - *4 responses to a missing adult*
  - *3 'other' (1 adult making multiple calls to the police; 1 adult making complaints about neighbours; 1 call out due to concerns about the adult's home conditions)*
  - *2 responses to a vulnerable adult committing an offence*
  - *1 involvement with the perpetrator of incident*

**Categories**

- The 45 SCRs relate to: **42 deaths (93%)** and **3 (7%) cases of significant harm**

**Deaths**

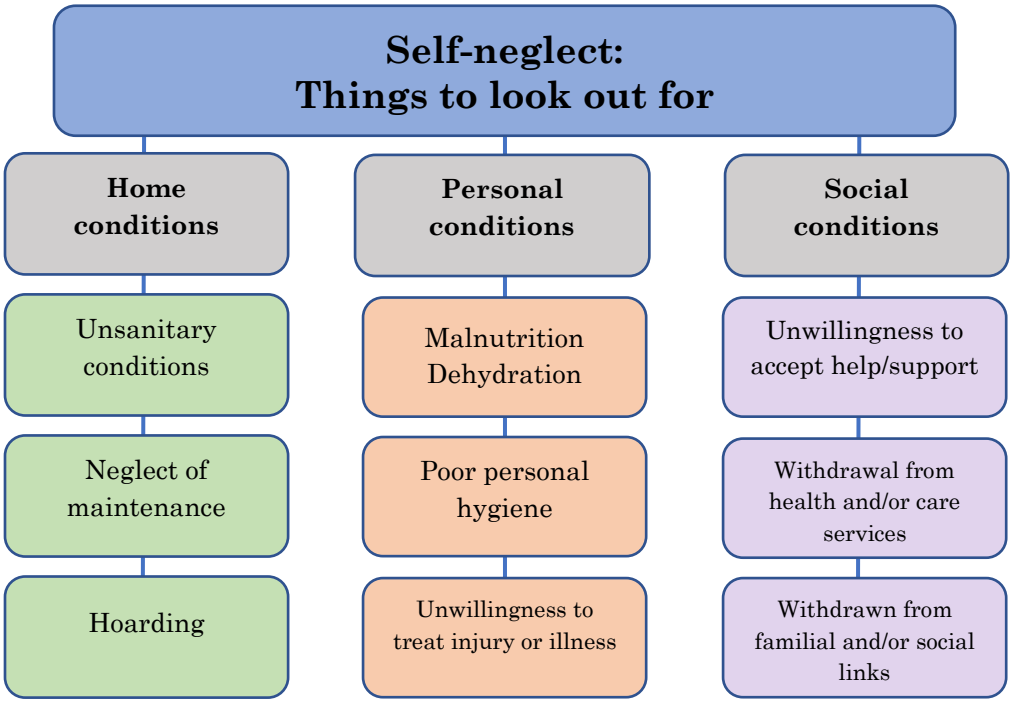
- ***The 42 deaths related to:***
  - *10 cases of homicide*
  - *5 deaths in a house fire*
  - *5 suicides (1 related to maltreatment/abuse)*
  - *2 unclear*
  - *20 'other', most commonly in relation to ill health but also substance abuse, traffic collision, and one death in an explosion*

**Significant harm**

- ***The 3 cases of significant harm related to:***
  - *1 neglect*
  - *2 physical assaults (1 due to domestic abuse)*

## SPECIAL THEME: SELF-NEGLECT

Self-neglect is described by care and support statutory guidance as covering 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings' (Department of Health and Social Care, 2018). By neglecting to care for their own needs, an individual increases risk to their own wellbeing, and also creates difficulties for agencies seeking to mitigate any risk of harm to them. The difficulty in cases of self-neglect, is that often the individual does not wish to engage with such support services, and is deemed to have the capacity and autonomy to make that decision. This leaves many practitioners with ethical and legal dilemmas, as Braye, Orr and Preston-Shoot (2015) describe, whereby the balance must be struck between their duty of care, and the individual's right to a private life.




Self-neglect, despite being an issue most commonly associated with health and social care, does present significant issues for policing. Namely, the issue at the forefront of dealing with self-neglect is that the individual refuses support or any other action to change their condition, yet their condition often presents a high level of risk (Social Care Institute of Excellence, 2018). Due to the reluctance of the individual to co-operate with the support available to them, the options available to the police and other practitioners are often perceived as being limited. Despite this perception, Preston-Shoot (2019) highlights a model of best practice developed from the analysis of SARs related to self-neglect which can be found here.

Significantly, the incidents which led to the reviews in this sample were not always overtly self-neglect related, but instead related to an incident connected to the individual's wider vulnerability, which was often caused or amplified by their self-neglect. Whilst the upcoming examples are specific to individual cases and contexts, they provide valuable insights into the issues presented by self-neglect, and the way in which the police can more effectively approach cases where it is present.

In this review of SARs, **17 cases were identified** to have significant themes of self-neglect and relevant police involvement within them. Of the 17, **all related to the death of the subject of the review.** There were **9 reviews focused on male adults and 7 focused on female adults**, the gender of the remaining individual was not given in the review. **The majority (11) of the adults were aged over 55, with 4 under 55** and the ages of the remaining 2 adults were not given in the review.

## Recording vulnerabilities

The vulnerability of adults who self-neglect is often difficult to interpret, with the adult physically able to take care of their own needs, but reluctant to do so. **In one case, it was highlighted how the police had dealt with each incident involving the individual in singularity and did not record their vulnerabilities appropriately.** Whilst the reasons for this issue were not made clear within the review, substance and alcohol misuse played a major factor in the individual's life and may have influenced the perception of their vulnerability. The disjointed approach meant that it was difficult for practitioners working with the individual to appreciate the whole picture of their vulnerability, and develop a suitable management plan for their care. **For the police to work proactively in reducing the risk of harm to vulnerable adults, it is important that an individual's vulnerabilities are appropriately recorded in order to fully understand the complexities of their needs.**

## Appropriate referrals

Self-neglect can often come with specific risks for the individual. Hoarding for example, a prominent feature of self-neglect, can increase the risk of fire within the home. In one case, the police had noted the condition of the adult's home, their self-neglect and use of an open flame to cook food in their bedroom. The police had referred this to adult social care, as expected. However, **this was an opportunity to involve the fire service at an earlier stage**, who could have provided the adult with fire safety guidance around their cooking arrangement and hoarding behaviour**. It is important that the police refer specific risk such as this to the individual agency, rather than relying on other agencies to identify risk and share appropriately.**

## Co-ordinating multi-agency responses

In five of the cases related to self-neglect, there were issues around the co-ordination of multi-agency arrangements to safeguard the individuals. In these cases, the police had multiple interactions with the individuals and had some degree of understanding of their vulnerability and self-neglect. However, in all cases the reviewer highlighted how there was a lack, or insufficiency, of a co-ordinated multi-agency effort to approaching the needs of the individuals in question. **It is important that cases of self-neglect are not approached in isolation, but are subject to strategic and co-ordinated efforts by all agencies involved in the care of an individual, ensuring that a full picture of their vulnerability is discerned and can be managed appropriately.**

## Approaching self-neglect

Self-neglect has clear implications for policing, and it is important that forces are aware of the issue and have a clear strategy for dealing with cases in which it is a factor. The following are conclusions for practice developed using SCIE (2018) guidance for approaching self-neglect and the analysis of self-neglect related SARs in this briefing:

- The police should **work with other agencies** at both a strategic and operational level **to co-ordinate responses to self-neglect.**
- Whilst it is important to work jointly, it **is important that the police do not rely on other agencies**, such as adult social care, **to refer cases to the appropriate agency where there is a specific presenting risk.**
- Whilst a person who has capacity is able to refuse offers of support, **other ways of reducing the risks posed to the individual should be considered**. The police should consider all legal options and alternative courses of action should they be required. Alternative courses of action may include introducing another agency which the individual is more prepared to work with, or consideration of whether family or friends are able to assist.
- It is important that a **clear record is kept** around an individual's **condition, decisions made** about their care and the **rationale** behind the decisions.
- **Officers should be supported in developing their understanding** of the complexities of self-neglect, **and their knowledge of how to approach cases** where it is a factor.

## CROSS CUTTING THEMES

The themes presented below offer universal messages for police practice across a range of case types. The messages are drawn directly from SARs where police practice either did not meet standard expected practice or missed important opportunities for intervention. It is structured roughly according to the flow of an investigation for ease of reflection, and the themes within each section are classified by the likely explanations for the missed opportunities. In some reviews, it is not possible to glean information about why missed opportunities occurred. A matrix listing the 45 SARs and the themes associated with each can be found in Appendix A, where interested readers can go directly to the SAR by clicking on the title link.

### Multi-agency working and decision-making

**Knowledge, awareness or attitudes as barriers to effective multi-agency working**

*Recognising vulnerability in adults*

Adult vulnerability is often complex and unlike child vulnerability, not widely assumed. It is important therefore, that agencies involved with adults are vigilant and work to identify characteristics, conditions and environments which may increase vulnerability. In one SAR reviewed, **the police showed a lack of awareness of the individual's vulnerability, and as a result were disengaged from multi-agency discussions about them**. However, in the same review, it was highlighted how the police responded quickly and appropriately to the potential vulnerability of a child. Had the adult's vulnerability been recognised in the same way, **the police could have engaged more meaningfully** with the development of a multi-agency response to their needs**.**

*Knowledge of processes*

In two of the SARs reviewed, there was **a lack of knowledge around the process of multi-agency working to support a vulnerable adult.** In one of the cases, **the police were unaware of their responsibility beyond submitting a risk assessment**, with the assumption being that their responsibility stopped there. Such an assumption **may lead to an over-reliance on partner agencies to respond appropriately**, and risks the dilution of the risk should the other agency interpret it differently.

In the second case**,** the police had submitted a form which was **considered a referral for support by Adult Social Care (ASC), but had been intended as a referral for safeguarding by the police.** Because a referral for support requires the consent of the individual, and the adult in this case did not consent, **ASC were unable to respond how the police had intended.** It is important that the police are aware of agreed processes for partnership working to avoid misunderstandings such as this which devalue the level of response required.

*Addressing the safety of individuals with mental health needs*

**Cases in which mental health is a factor require an effective multi-agency response**. It is important that the police understand their powers under the Mental Health Act 1983 and the Policing and Crime Act 2017, and are aware of other courses of action available to them, so that they can respond accordingly. In one case reviewed, the agencies involved had

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| | difficulty in deciding the best course of action to address the individual's mental health crisis. With the individual in a place considered to be his abode**, the police deemed section 136 of the Mental Health Act to be unavailable to them, and with the individual seemingly compliant the police considered it appropriate for the case to be dealt with by the Ambulance Service.** The Ambulance Service were concerned that the individual was at risk of absconding, despite their compliance, and called for the police to use section 136 whilst the individual was in the ambulance. The police had deemed this course of action to be unethical, despite the Ambulance Services' concern. With the benefit of hindsight, and appreciative of the s136 being unavailable to the attending officers, the option of escorting the ambulance service and the vulnerable individual to hospital should perhaps have been considered in this case. The Ambulance Service demonstrated clear concerns around the risk presented to the individual, and the negative outcome of this case **highlights the importance of dialogue and trust between agencies in making collaborative decisions about an individual's care.** |
| **Procedural or systemic barriers to effective multi-agency working** | In a further mental health related case, it was noted by the reviewer how the police response to the adult's vulnerabilities was 'disjointed' and 'episodic'. **The police had avoided arresting the individual in order to preserve the individual's best interests**, however it was noted that there was a **lack of multi-agency process for dealing with the mental health needs of those who are not subject to arrest under criminal law.** This meant that the individual received a far less robust response to their needs and vulnerability. The absence of agreed processes or systems limit the safeguarding capability of multi-agency partnerships. |
| **Unknown barriers to multi-agency working** | **A number of examples show that the police sometimes do not initiate multi-agency discussions around long-term solutions for managing an individual's case**, despite having frequent involvement. Without an understanding of the specific reasoning in each case, it is difficult to identify the precise issues, however it is **important that the police are aware of their responsibility in identifying the need for, and initiating the process of, joint working.** |

## Information sharing

**Knowledge, awareness or attitudes as barriers to information sharing**

*Understanding of referral services and processes*
In three of the SARs included in this review there were information sharing issues caused by a lack of knowledge of the relevant referral services and processes:

- In one example, the police had attended the adult's home on multiple occasions and had **identified circumstances which increased the risk of a fire on the premises**. It is noted that all agencies had missed opportunities to refer the case to the Fire and Rescue Service for a fire safety assessment, with **front line staff having limited knowledge of the availability of the service and of the criteria for referral.**
- In another, the **police had been deterred from submitting further concerns** about the individual's welfare **because of the absence of feedback** from ASC on previous referrals. Police staff **did not fully understand the referral process and the steps thereafter**, which meant that they did not submit any further concerns.
- The third example where the understanding of referral processes proved problematic for information sharing was in a case where **the individual, who was a care leaver, had transitioned from childhood to adulthood**. The police involved were unclear around the responsibilities of Children's Social Care (CSC) and ASC, and as a result **did not share information with CSC as required**.

*Knowledge and understanding of vulnerability*
Five of the SARs in which information sharing was an issue featured a lack of knowledge or understanding of adult vulnerability and circumstances which might contribute to an individual's vulnerability:

- Two of the reviews highlighted how there was a **lack of understanding around the vulnerability of an adult present in a household with domestic abuse and of coercive control** respectively. In both cases the **absence of related policy and legislation** at the time was highlighted as contributing to the lack of knowledge and awareness.
- In a third domestic abuse related SAR, **the police did not recognise or understand the vulnerability** of the individual and failed to share an adult come to notice (ACN) report with ASC, **despite the individual reporting an incident of domestic abuse.**
- In the remaining two cases which related to an issue of knowledge and understanding the police showed a lack of appreciation of the vulnerability caused by **mental ill health and self-neglect**, failing to share information in these cases.

It is clear from these cases that **domestic abuse, mental health and self-neglect remain key areas of problematic knowledge and understanding.**

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| **Procedural or systemic barriers to information sharing** | At times, procedures and systems may present barriers to effective information sharing between partner agencies. In one case, the police had submitted a Public Protection Notice (PPN) related to an incident within the family home and had included information about a vulnerable adult who was present. A locally agreed process meant that because the individual **was not listed as the main subject** on the PPN, **information regarding them was not accepted by health or social services.** This element of the process has since been adapted, but in this case was a clear barrier to information sharing. It is **important that there is a clear process in place to share information with partners, and that officers themselves are aware of the correct procedures and systems for sharing information** about a vulnerable individual, to ensure that partner agencies can take appropriate action.<br><br>One case highlighted an issue with information sharing procedures and the police understanding of their role. In this case the police had submitted an ACN report to ASC, and because of this **had assumed that their responsibility had been fulfilled**. In this case however, the individual's **behaviour had escalated, signalling an increase in vulnerability** and therefore the **need of continuous dialogue** between the police and partner agencies to ensure that decisions were made based on the full picture of their vulnerability.<br><br>In a further review it was the **absence of a formal process between agencies which created a barrier** to effective information sharing. In this case, there was no formal process in place for the force in question to share information with the Probation Service, unless Probation themselves requested information on an individual from the police. **This meant that the police were reliant on the partner agency to initiate any sharing of information.** The force has since updated its information system to include Probation as an 'interested party', so that an individual known to Probation services can be flagged and information sharing can be initiated. Similarly, a second review highlighted issues with information sharing brought about by the lack of a formal mechanism, **this time citing the implementation of a Multi-Agency Safeguarding Hub as remedying the issue.** |
| **Unknown barriers to information sharing** | SARs do not always uncover, or provide detail about, why information sharing was not effective. Some examples show that:<br><br>• The police sometimes fail to share information about **individuals who are present, but not directly related to the callout**, even where potential vulnerabilities are clear.<br>• At times, the **police rely on partners to share information** with the relevant agencies, instead of sharing information themselves.<br>• Information sharing between forces can also be an issue. |

## Auditing and recording

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| **Procedural or systemic barriers to effective auditing and recording** | The wider management of information and intelligence recording can impact the way in which the police engage in the safeguarding of individuals. In one SAR reviewed there were a number of issues with recording, which were attributed to an issue with the daily management of missing person found reports. Firstly, the officers had completed a found report upon coming into contact with the individual, who was behaving in an increasingly risky manner. It was noted that there were other options available to the officers, such as the **ACN and Misper reports**, which would have **included follow up risk assessment processes and intelligence gathering on the individual**. The individual was then found in another potentially risky situation, and officers added information about the new incident to the previous form. It is noted by the reviewer **that a new incident involving a vulnerable individual should not be added to a previous report**, and in this instance should have resulted in a new ACN report. The addition of new emerging information to the existing form **may have masked the emergence of new issues and risk** related to the individual, **impacting the effectiveness of information sharing and intelligence gathering**, and hampering efforts to establish a better understanding of the individual's vulnerability. |
| **Unknown barriers to effective auditing and recording** | The cause of any issues with auditing and recording are not always made clear in SARs. Within this analysis of reviews, there were a number of cases where there were clear issues, but there was no detail provided of the causes:<br><br>• In one case, the **police did not formally record the history of violence between two individuals**, and this history was therefore not picked up in any later contacts.<br>• In two cases, the **police did not record the vulnerability of the individuals in question**, meaning that anybody dealing with those individuals at a later date were not aware of the full picture of their vulnerability.<br>• In one case, the police decided to take no further action after an individual made **threats to kill**, based on the advice of a mental health practitioner. This incident was then **not recorded properly** on the relevant systems. |

## Risk assessment

**Knowledge, awareness or attitudes as barriers to effective risk assessment**

It is important that officers understand issues which may increase the risk faced by vulnerable persons, in order to ensure that these risks can be assessed and properly managed. In two SARs a lack of understanding around domestic abuse created barriers to effective risk assessment. In the first case, **the police failed to recognise the risk posed to an individual, who was a victim of domestic abuse, and their parent with whom they lived**. The police in this case **failed to recognise the pattern of coercive and controlling behaviour**, and did not understand the **risk posed to the parent**, because **they were not part of the intimate relationship.**

Similarly, in the second case, the police **did not assess the risks posed to a vulnerable individual who had moved accomodation** because the relationship with their new housemate was deemed **not to be familial or intimate**, and therefore did not meet the definition of domestic. Had the police exercised some professional curiosity and looked into the risk of the move, they would have uncovered **previous allegations of domestic abuse** made against the new housemate.

*Mental Health and the Mental Capacity Act 2005*
There were also issues noted around the understanding of the risk posed by mental health vulnerabilities, which included the understanding of the Mental Capacity Act and vulnerabilities caused by alcohol dependency. In one review, the police did not fully understand their role in applying the **Mental Capacity Act** whilst dealing with an **individual who presented as troublesome, but did not have capacity to make decisions to keep themself safe**. Because the individual presented more so as troublesome than vulnerable, and the police lacked an understanding of the individual's capacity, the risks posed to them could not be considered in the context of their actual vulnerability.

In the second review, the individual had issues with alcohol dependency and their mental health. The reviewer in this case highlights how the police did not assess the risk faced by the individual well, and importantly suggests that **alcohol dependency is often viewed as a long-term support issue, but often presents very serious short-term risk to the individual.** The reviewer suggests that an individual **with alcohol dependency issues should not be considered less at risk based on the premise that they are known to be regularly intoxicated alone.** It is important that the police make a **dynamic risk assessment based on the presenting factors, rather than what they believe they know about the individual.** Officers should follow the national decision making model to take action that is **proportionate, necessary and justified under the circumstances**.

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| **Individual error as a barrier to effective risk assessment** | Within the SARs reviewed there were two instances of individual error which proved to be a barrier to effective risk assessment. In one case there was a **missed opportunity by an individual officer to submit an adult protection form** about an individual who had threatened to commit suicide.<br><br>In the second case, a police control room operative failed to exercise professional curiosity whilst dealing with another individual who had threatened suicide. The operative directed them to approach their parents to take them to hospital, **whereas if they had investigated the case further they may have recognised the risk the individual posed to both themselves and their parents**, and the call could have been dealt with more appropriately. **It is important that a course of action is informed by the potential risk posed to both to the individual in question, and those around them.** |
| **Multi-agency barriers to effective risk assessment** | Despite the importance of good inter-agency working in managing the risk posed to vulnerable individuals, it is **important that the police do not become overly reliant on other agencies** to take action in scenarios where they are also able to act. For example, in one case reviewed, the police did not submit a Single Combined Assessment Risk Form (SCARF) concerning an individual who had threatened suicide and was presenting clear mental health vulnerabilities. The reasoning behind this was that the **police believed the hospital would inform ASC** about the incident. The reliance on the hospital to make the referral **meant that it may not have been made or details may have become diluted** and the risks posed to the vulnerable adult may not have been fully understood. |

## Investigation and charging

### Knowledge, awareness and attitudes as barriers to effective investigation and/or charging

*Assessing capacity*
In one SAR reviewed, the police officers involved deemed the individual in question unfit for interview because at the time, they were a recently discharged mental health inpatient. The reviewer in this case highlights how **being a mental health inpatient does not necessarily mean that an individual is unfit for interview**, and that the police action in this instance suggests a lack of understanding around capacity informing the investigation. Whilst it is true that in some instances an individual with mental ill health may need an appropriate adult present to assist with communication and/or to ensure that the person is not overly influenced by the authority of the officer, there are instances where this level of support is not required and each case needs to be considered individually.

*Adult safeguarding*
In another case, there was an evident lack of understanding of adult safeguarding issues which led to problems with the investigation. The officers in this case, **did not recognise the significance of financial abuse**, and this led to no further action being taken. The police, who submitted evidence as part of the review, acknowledged the deficiencies in their approach and suggested that an officer would now be deployed to investigate such concerns.

### Unknown barriers to effective investigation and/or charging

In some of the cases under review, there were issues with the police investigation presented, though the causes of these issues were not made clear. These issues included:

- The police took an **informal approach** to investigating one case, and **did not achieve a full picture of the vulnerability** of the individual as a consequence.
- Officers did not interview a suspect after they were discharged from a secure hospital, despite knowing their home address.
- Allegations against a carer were not properly investigated, **putting the victim and other potentially vulnerable individuals at risk.**

## Pursuing perpetrators

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| **Knowledge, awareness and attitudes as barriers to effectively pursuing perpetrators** | Two cases presented missed opportunities to pursue perpetrators which related to the knowledge and understanding around the vulnerability of individuals who were potentially being abused and coerced. In one of the cases, the individual who was subject of the SAR did not wish to pursue action against those who had assaulted and financially exploited them. The issue in this case, was that **it was not considered whether this decision was made under duress, with the individual in the case vulnerable to coercive and controlling behaviour**.<br><br>A similar issue presented in the second case, where the police had been alerted to concerns about an individual whose nephew had allegedly withheld their medication. The police in this **case did not understand the vulnerability of the individual, and as a result did not question the role of the two men** found with them at the time of incident. **Had the police looked into the role of these men, they would have uncovered allegations that they had been perpetrating abuse** against the subject of the review. |
| **Multi-agency barriers to effectively pursuing perpetrators** | Often it is professional partners who hold valuable information about perpetrators, and multi-agency working therefore becomes vital in their disruption and pursuit. In one case, it was highlighted that **the collaborative effort for working with adult victims and their perpetrators was lacking** in comparison to child victims. The reviewer highlighted that there were not mandatory requirements for joint working for adult cases in the area at the time of review, whereas **child related cases benefited from statutory guidance and a related local framework.** Although the police alone cannot be responsible for producing statutory guidance and establishing a local framework for adult safeguarding, they are a key partner in decision-making relating to safeguarding and must take an active role in ensuring that measures are in place to protect vulnerable adults, through Community Safeguarding Partnerships and Safeguarding Adults Boards, for example. |
| **Unclear barriers to effectively pursuing perpetrators** | In one case the police had not effectively pursued a perpetrator who had been threatening the individual subject to the review via text message. The police in this case decided that the **individual could be easily led** and was therefore not a good witness, so **instead decided to warn the perpetrator about their future conduct**, which the victim agreed to. This visit did not take place however, and it is unclear from the review why. Having agreed a course of action with the victim, **it is important to follow through with the action to help support the victim and also prevent the future behaviour of the perpetrator.** |

## Supporting vulnerable individuals

**Unknown barriers to supporting vulnerable individuals**

There were two cases where **a lack of prompt action led to breakdowns in communication, and eventually the disengagement of the victims**. In the first case, a change in who was managing the case led to a nine-month gap in contact with the victim, leaving them open to possible coercion from the perpetrator. It was not made clear why, even with the change of case management, there was such a gap in communication. Similarly, the second case involved a three-week period between initial complaint and the arrest of the perpetrator, who was subsequently bailed. The reviewer highlights how the pursuit of the case would have increased the risk posed to the individual, and how they had disengaged as a consequence. **Both cases highlight the need of continued support and engagement with vulnerable individuals who are victimised.**

# Conclusions

### Improving multi-agency working and decision-making

- It is vital that the police are able to recognise that adults have the potential to be vulnerable, and where vulnerabilities are recognised in an individual, the police must engage with wider multi-agency responses to that individual's needs. This includes the police identifying the need for, and initiating the process of, joint working.
- Where the police are involved in multi-agency safeguarding arrangements, it is important that they recognise their role within the arrangements, and do not rely too heavily on other agencies to act on their behalf. This includes understanding the referral processes and procedures, and making these referrals where relevant.
- When making multi-agency decisions, it is important that police consider the standpoint and relevant reasoning behind the decisions of other agencies, and work towards an agreed shared plan, rather than delegating planning to other agencies.

### Improving information sharing

- Adults are not widely assumed to be vulnerable by nature, therefore it is important that officers are given the opportunity to develop their understanding of the circumstantial and situational factors which may increase vulnerability, in order to ensure they are alert to these factors when interacting with the public.
- Officers should also be aware of the vulnerability of individuals who are present at a call for service but may not be the main subject. Information should be shared with the relevant agencies, if any concerns are identified.
- When dealing with a vulnerable adult it is important that the police understand what referral routes are available to them, the processes for the referral, and the expected outcomes of said referrals. It is particularly important that the police are aware of direct referral pathways where there is a specific presenting risk, rather than relying on a single route of referral into Adult Services.
- The lack of a formal information sharing arrangement between partners can severely hinder the capacity of co-working. Forces should ensure that there are formal information sharing arrangements in place with safeguarding partners in their area.

### Improving auditing and recording

- An accurate record of police interactions with an individual can help develop a full picture of their vulnerability. Therefore, it is important that officers are aware of the correct procedures for recording information, and ensure that any information pertaining to an individual's vulnerability is properly recorded.

### Improving risk assessment

- Officers should be supported in developing their awareness and understanding of the patterns of coercive and controlling behaviour which are symptomatic of domestic abuse, for consideration during risk assessment procedures.
- The statutory definition of domestic abuse may limit the focus on certain individuals. Officers should be aware of the potential risk posed by non-intimate or non-familial domestic

arrangements. This includes the risk posed to individuals residing in a home where there is domestic abuse, and to those living with non-intimate or non-familial housemate(s).

- Whilst dealing with individuals who may present as troublesome, or who engage in risky behaviours, it is important that the police consider the capacity of the individual to make choices to keep themselves safe whilst assessing any risk posed to them.
- In cases where alcohol or substance related vulnerabilities are evident, the police should be aware that individuals who are regularly intoxicated should not be considered less at risk purely because of the frequency of their intoxication, and any immediate risk associated with their intoxication should be factored into decisions made about their care.
- In cases where the police are involved with other partners, officers should ensure that they are not overly reliant on other agencies to assess the risk of the situation. A reliance on the actions of other agencies, particularly those who are not present at the initial incident or call for service may mean that details are lost or the severity of the risk is diluted in their communications.

### Improving investigation and charging

- It is important that officers understand that being a mental health inpatient or being mentally unwell does not automatically deem individuals unfit for interview. In order to better understand when an individual may be charged, it is important that officers are supported in developing their understanding of the Mental Capacity Act.
- Where allegations are made against an individual in a position of trust, it is important that officers are deployed to investigate in order to reduce the risk posed to potentially vulnerable individuals whom they might have contact with.

### Improving the pursuit and disruption of perpetrators

- Where an individual refuses to pursue action against an alleged perpetrator, it is important that officers consider whether it is possible that this decision was made under duress, particularly where the individual displays signs of vulnerability.
- It is important that police work with partners to identify, pursue and disrupt perpetrators of abuse and other crime against adults, as is the approach to perpetrators against children.
- In cases where a course of action is agreed with a victim, it is important that the agreed action is carried out, particularly if it relates to disrupting the actions of the perpetrator in the case.

### Improving support for vulnerable individuals

- It is important that police support vulnerable victims through the reporting of a crime as well as through subsequent criminal justice processes in order to ensure their safety and ongoing engagement.

# Next steps

There will be one final review of a sample of Domestic Homicide Reviews, produced by the VKPP. A meta-analysis considering findings from across all reviews will also be produced and published in March 2020. We will be considering the challenges and benefits of learning from reviews in this way, and make recommendations for future projects that can help the police to learn more quickly and comprehensively from statutory reviews. If you would like to be in touch, please email us at vkpp@norfolk.pnn.police.uk.

# APPENDIX A: SAMPLE OF SAFEGUARDING ADULT REVIEWS AND RELATED THEMES

| Case review title and link | SAB | Review focus | Themes present |
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| Safeguarding Adult Review - Jack | Barnsley SAB | Death of a 68-year-old male with safeguarding concerns around self-neglect. | Multi-agency working and decision making<br><br>Information sharing |
| Bath & North East Somerset Local Safeguarding Adults Board Safe Guarding Adult Review: Jane | Bath & North East Somerset SAB | Death of a 66-year-old female in sheltered housing with focus on self-neglect | Information sharing |
| Bedford Borough & Central Bedfordshire Safeguarding Adults Review: Case A | Bedford Borough & Central Bedfordshire SAB | Death of a 35-year-old female whilst an inpatient at a registered care home. | Multi-agency working and decision making |
| Bexley Safeguarding Adults Review Mrs BA | Bexley SAB | Suicide of a 42-year-old female involved with mental health services. | Multi-agency working and decision making |
| Bexley Safeguarding Adults Review Report and Findings known as Ms AB | Bexley SAB | Death of 45-year-old female with many vulnerabilities. | Risk assessment |
| Safeguarding Adult Review and Domestic Homicide Review: Harry | Bournemouth and Poole SAB | The murder of a 22-year-old male with learning disabilities. | Multi-agency working and decision making<br><br>Investigation<br><br>Disruption, diversion, pursuit of perpetrators |
| Safeguarding Adults Review using the significant incident learning process of the circumstances concerning Kamil Ahmad and Mr X | Bristol SAB | The murder of Kamil Ahmad whilst in supported accommodation for mental health needs. | Information sharing<br><br>Investigation |
| Report into the death of Mr A who was found dead on | Calderdale SAB | Death of 70-year-old male suffering from dementia. | Multi-agency working and decision making |

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| the 15th August 2017 | | | |
| Cardiff and the Vale Safeguarding Adults Board Extended Adult Practice Review Apr 02/2017 | Cardiff & Vale SAB | Death of a female with a high level of care and support needs. | Information sharing<br><br>Auditing and recording |
| Cardiff and Vale Safeguarding Adults Board Concise Adult Practice Review Apr 04/2017 | Cardiff & Vale SAB | Death of a 59-year-old female with concerns around self-neglect | Information sharing<br><br>Auditing and recording |
| Safeguarding Adults Review of the circumstances concerning Mrs Y | City & Hackney SAB | Death of an 84-year-old female with concerns around neglect | Information sharing |
| Learning from the circumstances surrounding the death of Adrian Munday (link unavailable) | Devon SAB | Murder of a 51-year-old male with long-term mental health issues | Information sharing<br><br>Risk assessment |
| Safeguarding Adults Review following death of "Mr A" - an adult at risk | Enfield SAB | Death of a 70-year-old male in sheltered accommodation in contact with a number of agencies. | Auditing and recording<br><br>Risk assessment |
| Learning from the circumstances of the life changing injury to Z | Gloucestershire SAB | Significant harm to 36-year-old female in a residential care home for learning and physical disabilities. | Information sharing |
| Safeguarding Adult Review: Ms Taylor | Haringey SAB | Death of a 71-year-old female with complex needs living in supported housing | Information sharing<br><br>Risk assessment<br><br>Investigation |
| Multi-Agency Partnership Review into the death of Ms M in December 2015 | Hertfordshire SAB | The murder of a 23-year-old female by a man under the care of mental health services. | Information sharing<br><br>Auditing and recording<br><br>Investigation |
| Safeguarding Adults Review for Hillingdon SAB: AA and BB | Hillingdon SAB | The murder of BB by AA who was under the care of mental health services. | Information sharing<br><br>Auditing and recording<br><br>Investigation |
| Safeguarding Adults Review - Howard (8th July | Isle of Wight SAB | Death of a 53-year-old male with | Multi-agency working and decision making |

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| 1963 - 21st March 2017) | | concerns of self-neglect. | Information sharing<br><br>Auditing and recording<br><br>Risk assessment<br><br>Disruption, diversion, pursuit of perpetrators |
| Safeguarding Adults Review: Mrs D | Kent & Medway SAB | Death of a 68-year-old female under the care of mental health services. | Information sharing |
| Safeguarding Adult Review: Mary | Barking & Dagenham SAB | Death of an 83-year-old female known to adult social care services. | Information sharing |
| Safeguarding Adults Review: Michael Thompson LSAB-SAR-002-2016 | Lewisham SAB | Death of a 60-year-old male known to mental health services. | Multi-agency working and decision making |
| Adult AB: Safeguarding Adult Review | Manchester SAB | Manslaughter of a 56-year-old through neglect and abuse | Auditing and recording |
| Adult CA: Safeguarding Adults Review | Manchester SAB | Death of 22-year-old known to mental health services | Information sharing |
| Independent Overview Report into the deaths of 'Lynn' and 'Natalie' | Merseyside SAB | The murders of a 54-year-old female at risk and a 29 year old female. | Multi-agency working and decision making<br><br>Information sharing<br><br>Auditing and recording<br><br>Risk assessment<br><br>Disruption, diversion, pursuit of perpetrators<br><br>Supporting and communicating with vulnerable adults |
| The Death of Lee Irving: Safeguarding Adults Review | Newcastle SAB | The murder of a 24-year-old male with care and support needs. | Risk assessment<br><br>Investigation |
| Safeguarding Adult Review: Case E | Norfolk SAB | Death of a 95-year-old female living in a residential care home. | Multi-agency working and decision making |
| Extended Adult Practice Review Re: APR 3/2015/Conwy | North Wales SAB | Death of male in 40's with concerns of self-neglect | Multi-agency working and decision making |

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| Safeguarding Adult Review: Adult C Overview Report | Oxfordshire SAB | Death of a male in their 40's with concerns for mental health | Risk assessment |
| Joint Safeguarding Adult Review and Independent Mental Health Homicide Investigation Mrs A and Miss B July 2019 | Royal Greenwich SAB | Murder of Mrs A by Miss B, both known to mental health services | Information sharing<br><br>Auditing and recording |
| Learning Review in the Case of Mary | Salford SAB | Death of an 85-year-old female with concerns of neglect. | Information sharing<br><br>Risk assessment<br><br>Investigation |
| Safeguarding Adults Review - Andy (25th October 1985 - 24th April 2018) | Salford SAB | Death of a 32-year-old male with concerns of self-neglect | Multi-agency working and decision making<br><br>Information sharing<br><br>Risk assessment |
| Safeguarding Adult Review Report: John | Solihull SAB | Significant harm to a male in his 30s with care and support needs | Information sharing |
| Safeguarding Adults Review Executive Summary: Rachel | Solihull SAB | Death of a 20-year-old vulnerable female. | Information sharing<br><br>Disruption, diversion, pursuit of perpetrators<br><br>Supporting and communicating with vulnerable adults |
| Safeguarding Adults Review: Nightingale Homes | South Gloucestershire SAB | Review of external agency responses to incidents within the residential care homes. | Information sharing |
| Adult D: The response of partner agencies to severe self-neglect | South Tyneside SAB | Death of a male in his 50's with concerns for self-neglect. | Investigation |
| Safeguarding Adults Review: Adult B | Southwark SAB | Death of 50-year-old female with mental health and self-neglect concerns. | Information sharing |
| Safeguarding Adults Review in the case of Elizabeth | Stockport SAB | Death of a female in her 80's with concerns of neglect and abuse. | Risk assessment |

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| Report of Learning Together Safeguarding Adults Review: Honor | Swindon SAB | Death of a female in her 90s with concerns of neglect and abuse. | Multi-agency working and decision making<br><br>Information sharing |
| Safeguarding Adult Review: Adult Andrew | Walsall SAB | Death of a 33-year-old male with mental health concerns. | Multi-agency working and decision making<br><br>Information sharing |
| Safeguarding Adult Review: Mr I | West of Berkshire SAB | Death of a male with concerns for self-neglect | Multi-agency working and decision making<br><br>Information sharing |
| Safeguarding Adult Review in Respect of Adult F | West Sussex SAB | Death of a 23-year-old male in the care of mental health services. | Risk assessment<br><br>Investigation |
| Safeguarding Adult Review Concerning 'Peter' | Wigan SAB | The murder of a 61-year-old male known to services. | Auditing and recording<br><br>Disruption, diversion, pursuit of perpetrators |
| Safeguarding Adult Review using the Significant Incident Learning Process of the Circumstances Concerning Adult B | Wiltshire SAB | Death of a 72-year-old male with dementia | Information sharing |
| Safeguarding Adult Review Using the Significant Learning Process of the Circumstances Concerning Adult C | Wiltshire SAB | Death of male known to mental health services. | Multi-agency working and decision making<br><br>Auditing and recording |
| Learning Briefing Safeguarding Adults Review: Adult D | Wiltshire SAB | Death of a 40-year-old male with recent contact with services. | Risk assessment |

# APPENDIX B: OVERVIEW OF METHODOLOGY

## *Identifying Safeguarding Adult Reviews for inclusion*

Unlike Serious Case Reviews, there is no comprehensive site that collects together all published Safeguarding Adult Reviews[3]. The VKPP team searched every Safeguarding Adult Board website and downloaded/ logged all SARs or associated documents relating to SARs that could be found. Using the NHS Safeguarding Adults digital statistics compiled on notifications of SARs, we found approximately 50% of all statutory SARs produced between April 2015 to March 2018.

## *Inclusion criteria*

Cases were included where they fit the following criteria:

1. Any published SAR in England produced under the statutory requirements of the Care Act 2014 (these began to be published from April 2015). Any published Adult Practice Review in Wales (where the Care Act does not apply) published from April 2015.
2. Police were involved with the vulnerable adult/ their family pre-incident, within the timeline of the review; if police were only involved post-incident, but learning for police practice was identified during the investigation, this was also included.
3. There is explicit reference to police practice within the review; this could be either omissions in practice or good practice identified.

SARs were excluded from this analysis where:

1. The SAR was published pre-Care Act 2014
2. Police were not involved in the case at all
3. Police were only involved in investigation after the incident, and no detail about police practice within the investigation was identified
4. No learning was identified by the reviewer in relation to police practice.

## *Number of SARs included in the analysis*

A total of 330 SARs were reviewed, 45 of which fit the criteria for inclusion for analysis. Table 1 details the number and percentage included, or excluded, and the reasons for this. The second column details the number in each category identified from the repository, from forces or from LSCB websites.

[3] The Social Care Institute for Excellence received funding to produce a library of SARs, but this library currently does not hold a full collection of SARs.

**Table 1: Number of SARs considered for this review, and their inclusion status**

| Inclusion status | Number (%) |
|---|---|
| Included | 45 (14%) |
| Excluded: Post incident involvement only[4] | 36 (11%) |
| Excluded: Date unclear | 12 (4%) |
| Excluded: Out of date[5] | 122 (37%) |
| Excluded: No learning relevant to policing practice[6] | 33 (10%) |
| Excluded: Too brief to extract any useful learning about police practice | 31 (9%) |
| Excluded: No police involvement in the case[7] | 47 (14%) |
| Excluded: Police involvement unrelated to the case[8] | 4 (1%) |
| | **330 (100%)** |

## *Timeframe of reviews*

Of the forty-five cases included for analysis, one review was published in 2015, three were published in 2016, eleven in 2017, twenty in 2018 and the remaining ten in 2019.

[4] In these cases, the police were only involved with the vulnerable adult subject of the SAR (or their family) post-incident usually through an investigation; but no learning was provided about the quality or detail of police involvement post-incident.
[5] In these cases, the review was published pre-Care Act 2014 and was therefore excluded from the analysis
[6] In these cases, police were involved with the case prior to the incident that triggered the SAR, but the SAR reviewer identified no messages for practice for the police within the body of the review or within the recommendations.
[7] In these cases, there was no involvement by the police with the vulnerable adult/ family prior to the incident that triggered the SAR, and the result of the incident did not include a crime that the police would investigate – therefore there is no specific police practice identified in the SAR.
[8] In these cases, the Police were involved with the individual or the family, but the involvement was unrelated to the incident which led to the review.

## Appendix C: References


Braye, S., Orr, D. & Preston-Shoot, M. (2015) Learning lessons about self-neglect? An analysis of serious case reviews. *Journal of Adult Protection*, 17 (1), pp3-18. Available at: http://sro.sussex.ac.uk/id/eprint/53039/.

Department of Health & Social Care (2018) *Care and Support Statutory Guidance*. London: DHSC. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

NHS England (2018) *Safeguarding Adults: England, 2017-18, Experimental Statistics*. Available at: https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf.

Preston-Shoot, M. (2019) Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice. *Journal of Adult Protection*, 21 (4), pp219-214. Available at: http://uobrep.openrepository.com/uobrep/handle/10547/623309.

Social Care Institute of Excellence (2018) *Self-neglect at a glance*. London: SCIE. Available at: https://www.scie.org.uk/self-neglect/at-a-glance.