Vulnerability Knowledge & Practice Programme

Learning for the police from Safeguarding Adult Reviews:

A second briefing concerning SARs produced by the VKPP

August 2021

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Introduction

In its first year of operation, the Vulnerability Knowledge and Practice Programme (VKPP)[1] established a process for drawing out learning for the police from statutory reviews. The associated briefings and reports can be accessed here. The VKPP continue to build on the evidence base by identifying the practice issues as they emerge in reviews.

This is the second briefing from VKPP analysis of Safeguarding Adult Reviews (SARs) and Adult Practice Reviews (APRs). 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 (see full definition below)[2].

We acknowledge the challenges raised by policing around adults at risk who meet the criteria of the Care Act 2014 and the challenges of signposting and supporting those adults who do not meet the criteria but police still have concerns for. Rather than create any updated policing policy, this briefing aims to draw out learning from specific cases which may be useful when managing such challenges locally. However, the VKPP encourages professionals to assess local system issues and gaps within strategic partnerships to explore commissioning and emerging needs.

The Care Act 2014:

Adults considered to be at risk of harm under the Care Act (2014) are defined as:

- 18 years or over
- Who need care and support (whether or not the local authority is meeting those needs)
- Is experiencing or at risk of abuse or neglect
- Who as a result of those care and support needs is unable to protect themselves from either the risk of or experience of abuse or neglect

This includes someone with physical, sensory and mental impairments and learning disabilities, whether present from birth or due to advancing age, illness or injury. Also included are people with a mental illness, dementia or other memory impairments, and people who misuse substances or alcohol (where this has led to impaired physical, cognitive or mental health). [3]

[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]The relevant legislation can be found here and the associated Care and Support statutory guidance here

[3]The Mind Safeguarding and managing risk (adults) guidance can be found here

This briefing is based on 21 SARs reflecting 22 separate adults at risk which fit the research criteria for inclusion (see Appendix B for a full account of the methodology).

The purpose of this briefing is to create a national picture of the policing-specific local learning published within such reviews, including gaps in knowledge and practice, and the identification of promising work. The learning is presented in line with the following themes, linked to the 'perennial issues' framework developed by the College of Policing:

- Identifying and managing risk

and

- Evidence and investigation

'Collaborative working' is a perennial issue within the College's framework, but crosscuts the themes above and will be considered where relevant within them. These themes are also aligned to actions contained within the National Vulnerability Action Plan (NVAP) V2, providing a helpful benchmark for strengthening practice.

These themes, based upon the perennial issues facing policing, are also supported by a special theme of substance and alcohol misuse.

It is acknowledged that there is continuous activity within police forces to improve and clarify responses to vulnerability. The learning in this briefing may, therefore, reflect practice that has since advanced in some forces in response to new guidance and toolkits. However, force progress in this area—as in other areas of policing—varies and may still be relevant and evident in some force approaches.

Useful Resources:

Eligibility criteria under the Care Act 2014: https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria

Care and Support statutory guidance- Chapter 14: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Useful guidance for frontline practitioners and managers who work with adults who have care and support needs and who may be at risk of abuse or neglect: https://www.scie.org.uk/safeguarding/adults/practice/questions

Snapshot of cases

Forces and regions

Cases identified came from 10 forces and 8 police regions

Case types

Cases relate to 20 deaths, and 2 incidents of significant harm.

Case contexts

- 15 cases involved self harm or there was no perpetrator directly identified
- 3 cases involved familial abuse, violence or neglect towards adults
- 2 cases involved an institutional or care context
- 1 case involved intimate partner violence
- 1 case involved peer to peer violence or abuse

Death classification

Of the cases involving death:

- 7 were related to illness
- 5 were through suicide
- 2 were accidental
- 2 were in house fires
- 2 were a result of overdose
- 1 was related to a homicide
- 1 individual died after the death of a carer

Harm classification

Of the cases involving significant harm:

- 1 related to a physical assault
- 1 related to an overdose

Special Theme: Alcohol and substance misuse

Adults at risk of harm may be more challenging for officers to respond to appropriately where the vulnerability-related risk is associated with a perceived 'lifestyle choice'. The first VKPP SAR briefing contained a special theme on self-neglect. The findings revealed that agencies struggled to manage and support individuals who self-neglect because the individual is seen to have the mental capacity to make their own decisions about how they live. Similarly, alcohol and substance misuse may be recognised and described by officers as a 'lifestyle choice'. Where officers take these views, it may negatively influence decision-making and increase the risk of harm. What is important to acknowledge however, is that alcohol and substance misuse is contextual to the individual, and that underneath there may be evidence of a history of trauma and mental health vulnerability (Bailey, 2019; Bellis *et al*., 2018). For example, research has found that victims of childhood abuse face an increased risk of issues with alcohol and substance misuse (Enoch, 2011) and a joint report by DrugsScope and the London Drug & Alcohol Network (2013) also highlighted the links between experiences of domestic abuse and subsequent substance misuse issues. Organisations such as Rethink Mental Illness (2018) also highlight the links between drugs, alcohol and mental health, suggesting that some may use alcohol and substances to try and deal with the symptoms of their illness. Some individuals may also be predisposed to addiction, with research evidence suggesting that addictive disorders are caused by a combination of environmental and genetic factors (Mayer and Höllt, 2005).

Police are not expected to be experts in supporting those with alcohol and substance misuse issues, however, officers should use professional curiosity and take appropriate action to support those who are at risk of harm due to their substance use. In order to support officers to take appropriate action, there needs to be a system built locally to enable officers to identify the best place to find help. Officers need to know this system exists, where to find it and how to use it. It is, however important to note that referral to local services is likely to be insufficient to assist certain individuals to modify their drinking behaviour. Alcohol Concern (2014) make particular reference to 'change resistant' drinkers, defined as individuals who are alcohol dependant but who lack the internal motivation to change. Sometimes people make choices that will end in their death or serious harm. Policing should, however, take every opportunity to divert people from harmful behaviour, particularly by referring to organisations who can support them. Practice at the individual level should involve consistent signposting at every encounter, because there may be a point at which an individual will accept the help offered. A multi-agency approach triggered by an adult safeguarding referral may also need to be considered. Repeat encounters create significant demand on the whole local system and in light of this, strategic leaders should be effectively identifying and monitoring demands on the service and considering ways to address the demand. An example of promising practice, which has helped reduce demand on the police service and strengthened the multi-agency response to change resistant drinkers is the Blue Light Project which can be found here.

The use of professional curiosity is emphasised in the Risk Guidelines produced by the College of Policing and the objectives of 'appropriate action' are detailed in Action 2.2.1 of the National Vulnerability Action Plan (2020).

In this sample of SARs, substance or alcohol misuse was evident in over half of the cases (13 out of 22). In many of these cases, the adult at risk of harm had presented to the police both as requiring support and also presenting risk to themselves and those around them. One example related to an individual described as aggressive towards family members and engaging in risky behaviours whilst under the influence of alcohol. The police responded to numerous incidents involving aggression in the family home and threats from the individual to harm themselves. There was some recognition of the risks caused by the individual's alcohol misuse, and also of their risk of harm related to this and their mental health. The police referred the individual into mental health related support; however, the reviewer noted that the police might have also recognised the multiple vulnerabilities present in the household and made a safeguarding referral for the children who were witnesses to and victims of the adults aggressive and risk-taking behaviours. The VKPP's meta-analysis identifies this kind of 'tunnel vision' as common in both child and adult reviews, and the findings of this case signify the importance of recognising the risks faced by those who misuse alcohol and substances and those around them.

In another, the individual had presented as homeless with alcohol and substance misuse issues, and had been in contact with the police frequently. In this case it seems that the assessment of risk was static, perhaps informed by the repetitive nature of the individual's presentation. As was highlighted in the previous SAR briefing, risk is dynamic and should be assessed and approached based on the information presently available and not purely on presumptions or an over reliance on what is already known about an individual. As noted above, a repeated pattern of contact and vulnerability should be effectively identified and a multi-agency response may be required. To support individual officers, the College of Policing are currently developing guidelines for recognising and responding to vulnerability related risks, which recognise the potential for officers to experience compassion or empathy fatigue (for example responders may become desensitised to the risks faced by vulnerable people because they have seen similar situations so often). Due to be published in 2021, the guidelines also highlight both the issues with existing risk assessment tools and systems and the importance of the police engaging with the wider safeguarding network to identify and manage risk.

In several of the cases which involved alcohol and substance-related risk, self-neglect was also a feature. Previous research has highlighted the connection between self-neglect and alcohol misuse, and discussed the impact of the refusal of services. Alcohol Change UK (2019: 14) discuss how the perception of self-neglect as a 'lifestyle choice' by practitioners prevents a 'deeper analysis of the underlying causes and precluded attempts to address them'. The related recommendation put forward by the organisation reads: 'All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers'. This is understandably a complex issue for policing, though the belief that self-neglect and substance and alcohol misuse are 'lifestyle choices' or occur through 'free choice' reinforce the stigma around the issues and also hamper attempts to address the risks faced by those who experience them. Instead, self-neglect and substance and alcohol misuse should be considered as both symptomatic of underlying issues, and also as heightening vulnerability and the risk of harm (Alcohol Change UK, 2019). Policing should continue to support these individuals and seek the support they need even when it has been refused before. An individual refusing support at one point in time may take up the offer of support at a later time.

Perceptions of alcohol dependency as a free choice can further lead to some individuals being incorrectly perceived as having capacity. Alcohol Change UK (2021) make particular note of the Mental Capacity Act (2005) and its relevance to dependent drinkers, arguing that dependent drinkers may fail both stages of a capacity assessment. Issues of fluctuating capacity are likely to be particularly important, and may lead individuals to be considered to have capacity when they are less intoxicated and to not have capacity when they are more intoxicated (Alcohol Change UK, 2021) Challenges in assessing capacity thus highlights the need for the police to develop familiarity with the Mental Capacity Act (2005), Care Act (2014) and the Mental Health Act (1983, amended 2007), or know who in their force they could contact if they need advice and guidance.

Considerations for practice for the Police

Strategic systems level	Operational frontline officers
Are force systems built to support officers to identify the best places locally to find help? NVAP Action 2.1.3 'Access to services' advises forces to promote awareness of local provision to support appropriate signposting and referrals.	Are frontline officers knowledgeable about where in their force, and how, they can access this information? NVAP Action 2.1.3 also advises officers to develop good relationships with local services where possible to promote good information exchange.
Are officers supported to recognise the cumulative impacts of alcoholism, drug dependency and mental ill health? These vulnerabilities, taken together, result in significant increased risks of harm. (NVAP action 2.1.1 - Recognition and response and action 2.1.2 Mental health)	
Are assumptions around 'lifestyle choice' regularly challenged within force, in recognition of the underlying causes of alcohol and substance misuse in adults? (NVAP action 2.6.2 - Officer norms)	
Do forces recognise that officers may become 'normalised' to certain aspects of criminality/ vulnerability, therefore potentially missing risks, and have processes in place to monitor and 'reset' that normalisation? (NVAP action 2.6.2 - Officer norms)	
How do forces, through supervision, encourage review and reflection to promote fresh perspectives? NVAP Action 2.5.2 recognises this to be essential in building resilient staff.	Do officers, as a matter of routine, apply reflective models of practice to reappraise new information that that may lead to a change in response?
Are forces engaged in multi-agency arrangements to ensure holistic support for individuals who are at risk of harm through alcohol and substance misuse? (NVAP action 2.6.1 - Multi-agency hubs)	

Cross cutting themes

Identification and management of risk

NVAP ACTIONS: 2.1.1, 2.1.2, 2.2.1

The findings in this area relate to the NVAP actions concerning 2.1.1 Recognition and response, 2.1.2 Mental health and 2.2.1 Appropriate action

Recognising self-neglect

Several SARs within this sample demonstrate good officer identification of neglect (by others) and self-neglect in adults-at-risk. Whilst traditionally viewed as a health and social care issue, self-neglect may significantly increase the risk of harm and exploitation faced by an individual, signifying the relevance of self-neglect to police. One review also demonstrates that carers who self-neglect may also pose a risk of harm to those they are caring for. **Care and support statutory guidance** (2020) notes that self-neglect 'covers a wide range of behaviours including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding' (Department of Health and Social Care, 2018). While self-neglect, and corresponding neglect of others, was effectively recognised by officers and appropriate action was taken to refer adults at risk to adult social care in some cases, in other examples, further support is required to ensure officers are equipped to take appropriate action. Some of these examples are featured in this section.

The self-neglect features recognised by officers included home conditions that were dirty or in disrepair, an absence of basic provisions such as food, and the physical presentation of the individual. Noticing carers' treatment of adults-at-risk also helped to identify potential emotional abuse. The officer used clear, straightforward language to describe the conditions which promotes clarity of description of risk and vulnerability.

Recognising 'mate crime'

Within the 21 SARs considered for this briefing, only one case involved a missed opportunity to identify risk. The case highlights specific learning about 'mate crime' (discriminatory abuse) and the essential role of professional curiosity in recognising a crime which can be very difficult for professionals to spot. Mate crime, according to the Safety Net project (Association for Real Change), happens when someone 'makes friends' with a person and goes on to abuse or exploit that relationship. The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a pattern of repeat and worsening abuse. Victims may not report to the police because they do not recognise it as abuse or because of their relationship with the perpetrator. Professionals may lack confidence in responding, particularly where adults at risk are deemed to have mental capacity. A recent national analysis of SARs (Preston-Shoot et al., 2020) identifies a critical national gap in policy and practice related to mate crime.

The featured review concerns a 50 year old male with care and support needs relating to his mental health, who was found murdered in his home, having been beaten and robbed. In addition to mental health needs, he was described as living a chaotic lifestyle, misusing substances and alcohol, had limited support from family, and as a result, self-neglected. On a range of occasions, the victim reported concerns about physical and financial exploitation to services who were supporting him, some of which were passed onto the police although the police had no record of these. (Continued on the next page…)

Cross cutting themes

Identification and management of risk

According to the College of Policing Evidence-based risk guidelines, professional curiosity involves not taking things at face value, enquiring more deeply and exploring what happened in order to build a better picture. It is important that Police recognise that adults at risk may be reluctant to support police action when it relates to someone known to them, potentially leaving them vulnerable to further abuse or crime.

Police were involved with the victim on various occasions, responding to mental health crises and a domestic abuse incident where he was recognised as the victim. Police took appropriate action by raising a safeguarding concern with adult social care. At a later time, the victim contacted the police to report a street robbery by someone known to him. He did not wish to support a police investigation, however, and the matter was closed with no further action. The reviewer reflected that had police recognised his potential vulnerability related to the known suspect, further questioning may have proved valuable in identifying the robbery as well as wider concerns related to potential cuckooing. The case also emphasises the importance of *recording* information so that Police are equipped to understand the wider picture. Sometimes the Police need to take action against the wishes of the victim, in the public interest. Officers may wish to consider evidence-led prosecutions where relevant.

Appropriate action

There were three examples of ineffective risk management that provide useful points for reflection. The first example concerns the death (by fire) of an adult male (of unknown age) in supported living with an extensive history of setting fires, and significant mental health needs. Following multiple responses due to this adult going missing, police appropriately submitted multiple safeguarding notices to adult social care identifying concerns. The police management report identified that additional safeguarding referrals could have been submitted concerning this individual. Importantly, however, the reviewer also identified a need for consistent follow up. Adult social care had no record of any of the referrals made by Police, and indeed none of the referrals triggered an adult safeguarding enquiry or any form of multi-agency response. There is no evidence in the review that Police followed up with adult social care about those referrals that had been sent.

Appropriate action through further safeguarding referrals may have helped agencies develop a better understanding of the pattern of risk facing the individual. The case also demonstrates the importance of Police following up on referrals made to ensure appropriate action has been taken.

The second example concerns an adult male aged 55 with significant mental health needs who was known to local mental health services and attempted suicide history, eventually dying of suicide by hanging. There was clear evidence of escalation of risk. At a point at which this individual was disengaging with services, increasing his alcohol consumption, taking steps to identify ways to kill himself, having increasing contact with emergency services including the police, and exhibiting increasing aggression and threatening behaviour to his wife and family, no adult safeguarding referral was made. Eventually, the fire service identified the need for a safeguarding response and made a referral; neither the Police nor the ambulance services recognised the need for appropriate action. The reviewer hypothesised that the Police did not make an appropriate referral because the case was being coordinated by a National Interagency Liaison Officer, a specialist role within the Fire and Rescue Service providing support and guidance to incident commanders and liaising with partner agencies.

In line with statutory safeguarding responsibilities, forces should ensure their officers are submitting their own concerns even where other agencies are taking action.

Cross cutting themes

Identification and management of risk

The final case to feature relates to two adult females aged 95 and 61 (a mother and daughter) who resided together, with the daughter acting as a main carer to her mother. The daughter developed depression and anxiety and suffered from back pain which limited her ability to live an active and full life. Sadly, following a concern by a neighbour, the Police and ambulance services found the daughter deceased and her mother upstairs, alive, but in a severely dehydrated state. In an earlier visit to the home following a concern from a neighbour, the responding officer appropriately identified cause for concern, in particular that the mother may have been physically neglected. The officer recorded the house as being dirty and untidy, the mother's bed was soiled and observed the daughter shouting at her mother, suggestive of emotional abuse. The officer also noted potential self-neglect in the daughter.

> The Mental Capacity Act (2005) is 'little understood across policing in the United Kingdom and few patrol officers have received any training in its application' (Quote of reviewer)

Despite an absence of structured safeguarding guidance to help officers reach a risk grading, the officer risk assessed the incident as 'high', defined as 'a person in need of immediate protection from significant harm'. The officer was aware this would trigger a notification to the Partnership Team, who would alert adult social care. It took a full day for this alert to occur, and a further week for adult social care to respond. Adult social care reported being unable to reach the Police for further information, and the Police did not actively follow up on the referral. The reviewer advised that there was force guidance that recommended the attending officer to contact the emergency duty team directly, where a risk was graded as high, however the officer did not do so, concerned that ASC would not respond. There is no mention in the Police management review whether the officer considered the mother and daughter to have capacity to make the decisions they did. Because Police attendance at the home gave rise to a concern about the daughter's mental health, the reviewer advised that it would have been appropriate to assess the daughter's mental health capacity at that point. However, the attending officer was deemed, by the reviewer, to be ill-equipped with the knowledge or skills to complete a mental capacity assessment, or to know that one was required. This may have progressed if the officer had contacted the emergency duty team to discuss the case. The CoP suggest that 'the MCA is most likely to be necessary in emergency situations when officers are faced with someone lacking mental capacity, whose life may be at risk or who may suffer harm if action is not taken'. Use of the MCA allows the police to make decisions related to the care and treatment of an individual who the police reasonably believe is not currently able to make decisions in their own best interests. Essex Police have published a resource related to the police application of the Mental Capacity Act, which can be found here.

Cross cutting themes

Identification and management of risk

Collaborative working

There were a number of ways in which limited, or absent, appropriate action by the Police intersected with collaborative working. Some of these issues have been seen in previous briefings, for example:

- *Following up the outcome of a referral by Police to Adult Social Care*: There were more examples in this sample of SARs where this issue was observed. Reviewers found that had Police followed up in these cases, it would have become clear that the referrals had not been recorded or actioned within Adult Social Care.
- *Absence of an information sharing process between Police and hospital Emergency Departments*: Another review in this sample of SARs also found a lack of a process for Police to share information with hospital staff about an adult at risk who is not being accompanied by the Police under the Mental Health Act. Police are not required to remain with the adult in these contexts, but leaving without sharing information with clinical staff undermines appropriate action and collaborative working with partners.
- *Raising concerns about repeat or escalating risk with multi-agency partners:* Further examples in this sample of SARs highlight that repeating patterns of behaviour or incidents that Police respond to may negatively influence consistent involvement of partner agencies possibly due to compassion fatigue or lack of knowledge about how to appropriately respond to persistent risk of harm. Concerns held by Police must be consistently recorded and submitted to relevant agencies, with additional follow up with partners to discuss escalating concerns in the absence of a satisfactory response from partners.
- *Inconsistent attendance at strategy meetings:* Common in our previous briefings on Serious Case Reviews, there was further evidence of Police non-attendance at strategy meetings for adults at risk with whom Police had previous contact. Resourcing tends to be a common systems issue preventing officer attendance at all meetings, but this should not get in the way of sharing information that can protect adults at risk.

> A triage nurse, within one learning event, said she was exploring the development of a basic form for the Emergency Department receptionist to give to a police officer to provide summary information or a telephone number so they can be contacted to provide the background information if they need to leave quickly.

Reflections for forces:

- How are forces supporting officers to develop their understanding of mate crime? MenCap offer a helpful overview of this crime, and the Safety Net Project by the Association for Real Change offers resources for professionals and people with learning disabilities, their families and supporters to help them identify mate crime and know what to do if they have concerns. Check your force's capability to respond to mate crime using this checklist, produced by Association for Real Change for their Safety Net Project.
- Professional curiosity is essential for helping officers to identify mate crime which is often hidden from view. The College of Policing's Evidence-based guidelines for recognising and responding to vulnerability-related risk is a useful resource for supporting the development of professional curiosity in officers.
- Does your force have, or is your force working with the local Safeguarding Adult Board(s), to ensure there is guidance for officers that would assist them in gathering the necessary information to make high quality referrals?
- Does your force have a process in place to effectively share basic information about an adult at risk with hospital emergency staff?
- As a key partner within multi-agency arrangements, are police forces embedded and engaged within local responses to safeguarding adults? This includes attending multi-agency strategy meetings, involving partners in safeguarding responses and supporting partners where appropriate. Where officers find it difficult to attend all strategy meetings, there may be alternatives such as the use of technology to join meetings remotely.
- Have forces considered establishing a system that can notify referring officers when a referral has been received by ASC?

Cross cutting themes

Evidence and investigation

NVAP ACTION 2.4.2

Action 2.4.2, Evidence and investigation, is to develop competent front line police and staff responders who use professional curiosity to ensure that the early investigation is maximised to gather best evidence.

Professional curiosity and evidential thresholds

A THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement, Prevention and Intervention) approach helps officers identify the key considerations for assessing a given situation, and may have helped identify the contradictions between the adult's presentation and the family's explanation of their injuries.

Following a safeguarding referral from a district nurse, an elderly individual was brought to hospital with multiple, unexplained injuries on her face and body, later dying from natural causes (sepsis and pneumonia), as reported by the Coroner. The Police had taken the lead in the investigation but appears they were unduly influenced by the Coroner's report which led to a conclusion by the police (and supported by other agencies) that there should be no further criminal investigation. This was in addition to a focus on evidence which met the threshold for conviction, rather than a more open approach based on THRIVE, which meant that the investigation was ended without properly exploring the possibility that the injuries were caused by anything other than a fall. Police and other practitioners within the learning event agreed that there would have been a different response had the individual been a child. In this locality, following the unexplained death of a child, families should be visited by police and health staff within 24-48 hours to establish medical or child protection factors related to the death. In this case, because the case was closed to investigation, this multiagency review did not occur. Had it, a more robust challenge of the family's explanations could have been made and resulted in a fuller post-mortem report.

Disrupting perpetrators with civil orders

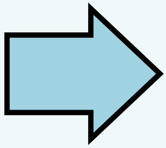
The VKPP's previous analyses of reviews found little reference to disruption methods used with perpetrators. One example within this sample of SARs, however, highlights specific learning for the use of Domestic Violence Prevention Notifications and Orders (DVPOs). The case related to a 30 year old woman who died of cardiac arrest following a diagnosis of pneumonia, health problems that likely stemmed from a long history of substance misuse. She was known to be a victim of domestic abuse by her partner, ex father in law and others, and also to perpetrate physical violence against her partner and others. She was also extensively involved with services over a long period. There was a period which featured escalating contact with the Police; including reports by the adult subject of this review of violence and thefts by others, and reports by others about her violence against them. The case was considered in local MARAC arrangements, with the subject of this review identified as the perpetrator and her partner the victim. Police were also managing the couple through stringent bail conditions to keep them apart. Appropriate civil protection orders such as DVPOs were not considered however. These 'allow the victim a degree of breathing space to consider their options with the help of a support agency', and may be considered by forces.

The review highlights that there were further options available to the police, in order to manage the behaviour of the partner and the risk of further domestic abuse. These options included the use of Domestic Violence Prevention Notifications and orders, which would have provided sanctions that could have kept the couple apart.

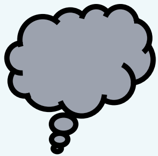
Reflections for forces

- In investigations relating to potentially vulnerable individuals, do officers remain professionally curious and apply principles such as THRIVE, which support decision-making? This extends to seeking the voice of the victim and challenging where there may be inconsistencies in discussion/wishes and presentation.
- There are a number of civil orders which can help protect victims, including DVPNs/Os. See the College of Policing APP Guidance and government guidance for further information.

Next steps



There will be a forthcoming briefing concerning police learning from Serious Case Reviews. The VKPP are also planning their strategy for continuing to learn from reviews for the 2021-2022 year ahead. All previous VKPP briefings can be accessed here.



We also encourage feedback or questions about the briefing. Please e-mail us at: vkpp@norfolk.pnn.police.uk.

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APPENDIX A:

Overview of cases

Case review title	SAB	Review focus
Safeguarding Adults Review Paul March 2020	Bexley	Death of a 55-year-old man by suicide.
Safeguarding Adults' Review for GH	Bracknell Forest	Death of a 62-year-old man by an overdose of prescription drugs.
Learning the lessons from the death of GB	Bradford	Death of a 65-year-old man in a house fire.
Safeguarding Adults Review Adult L	Buckinghamshire	Death of a 23-year-old man with care and support needs, after a suicide attempt whilst remanded in prison.
Safeguarding Adult Review David	Bury	Murder of a 50-year-old man.
Report of a safeguarding adults review: Paul	Cornwall and the Isles of Scilly	Death of a 70-year-old man who had been in a long-standing dispute with neighbours.
Report of the discretionary safe-guarding review regarding adult B	East Sussex	Death of a 94-year-old woman who had suffered unexplained injuries be-fore her death.
Learning from the circumstances of the death of Martin	Lambeth	Death of a 51-year-old man related to alcohol abuse.
Overview report: Adult G	Lancashire	Death of a 51-year-old man by suicide.
Overview report Adult J	Lancashire	Death of a 41-year-old man by suicide.
A report commissioned by Norfolk Safeguarding Adults Board into the cases of Ms F and Mr G, two unre-lated residents at the same care home in Norfolk	Norfolk	A case related to physical assaults between residents of a residential care home.
Adult 2	Rochdale	Death of a woman with care and support needs, in a house fire.
Safeguarding adults review - EE (5th February 1957 - 1st March 2018)	Sutton	Death of a man with mental health support needs, who had set fire to him-self.
Safeguarding Adults Review - Josh	Teeswide	Serious harm of a man in his late twenties who overdosed on prescribed insulin.
Learning lessons review - Adult C	Teeswide	Death of a 30-year-old woman who had experienced DA
Summary report into circumstanc-es surrounding the death of Adult E	Telford & Wrekin	Death of a 43-year-old man known to misuse alcohol and self-neglect.
Ms H and Ms I - Thematic Safe-guarding Adult Review	Tower Hamlets	Deaths of two women aged 33 and 52 known to misuse substances.
Safeguarding Adult Review in re-spect of Ryan	Trafford	Death of a 30-year-old man who had an epileptic seizure.
Safeguarding Adult Review Susan and Anne	Trafford	Case related to the serious harm of Susan (mother) who was found se-verely hydrated after Anne (daughter) had died at home.
Safeguarding Adult Review of Paul	West of Berk-shire	Death of a man with care and support needs.
Safeguarding Adults Review in re-spect of MS	West Sussex	Death of a 90-year-old woman, who had fallen at home.

APPENDIX B:

Overview of methodology

Identifying Safeguarding Adult Reviews for inclusion

Unlike Serious Case Reviews / Child Practice Reviews, there is no currently active, comprehensive site that collects together all published Safeguarding Adult Reviews / Adult Practice Reviews. Between 1st June and the 31st July 2020, the VKPP team searched every Safeguarding Adult Board website and logged and downloaded all SARs or associated documents relating to SARs that were not already within our existing database.

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 adult at risk/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 70 SARs were reviewed, 21 of which fit the criteria for inclusion for analysis.

Timeframe of reviews

Of the twenty-one cases included for analysis, one review was published in 2016, two were published in 2018, thirteen in 2019 and the remaining five in 2020.