Executive Summary of the Serious Case Review in respect of Adult A

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Acknowledgements

The Tameside Adults Safeguarding Partnership (TASP) would like to thank all those who contributed to this Review and particularly to Adult A's mum and Adult A's brother. In spite of the difficulties they experienced, they were generous in their praise of those who had done their best to try to protect the family. They also made it clear that many people who knew Adult A described him as 'a gentleman'. He had many good times in his life and liked to enjoy himself.

Contents

1. Introduction

1.1 This Report provides a summary of the circumstances and findings of a Serious Case Review (SCR) set up in April 2010 by the Tameside Adult Safeguarding Partnership (TASP) following the death in March 2010 of Adult A.

1.2 It also sets out in full the recommendations, from which agencies can develop an action plan to enable the lessons learnt during this Review to be used to improve the safeguarding and wellbeing of vulnerable adults in the future.

1.3 The holding of a SCR is considered as a good practice response to the death or serious harm of a vulnerable adult[1] when there are questions to be considered about the circumstances of that death and/or where concerns have been expressed about the adequacy of the response of relevant agencies in working together to safeguard the vulnerable adult.

1.4 A SCR is not intended to attribute blame but to reveal and collate the lessons to be learnt from the review of the circumstances and to make recommendations. The objective is to improve practice in safeguarding and hopefully prevent future deaths or significant harm to vulnerable adults.

[1] Association of Directors of Social Services (2005) Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work.

2. The background and circumstances that led to the decision to undertake this Serious Case Review (SCR).

2.1 Adult A died on the evening of 10th March 2010. He died suddenly as he cleared papers young people had scattered in his garden. His death was found to be from natural causes. The Pathology Report refers to a combination of a heart attack and a small cancerous tumour at the junction of his oesophagus and stomach[2].

2.2 Adult A and his family, experienced taunting, harassment, and damage at the family home during the day and in the evening of his death. The pathologist stated that the stress of the harassment could have exacerbated the medical issues but he could not confirm that was the case.

2.3 Adult A was a man of White British origin, originally brought up in the Manchester area, but from his early 20s he lived with his parents and older brother in a housing association rented house in Tameside. At the time of Adult A's death his mother was aged 88, had mobility and other health problems and had been a widow since 1987. Adult A's brother was 67 years old.

2.4 Adult A had some learning disabilities[3] from birth and his speech could not always be understood. He was generally described as having a moderate learning disability, though no formal assessment appeared to be available on agency records. In spite of his disability he was very active, had been in paid or voluntary work for a number of years, and he travelled independently. He had rarely seen a doctor and his underlying health conditions identified after his death were not diagnosed.

[2] The exact cause of death is listed as ischaemic heart disease and adenocarcinoma of the oesophagus.

[3] The definition provided in the government strategy document, 'Valuing People' (Department of Health, 2001), describes people with a learning disability as having:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with:
- A reduced ability to cope independently (impaired social functioning); and
- This started before adulthood, with a lasting effect on development.

The presence of a low Intelligence Quotient (IQ) is not sufficient in defining people with learning disability. There are disputes about classification but professionals tend to use 4 classifications of disability: mild, moderate, severe and profound.

2.5 Adult A's brother also has some 'learning difficulties'; so all three members of this household could be described as vulnerable, due to their age and/or intellectual disability and there is considerable evidence to confirm that they were 'adults at risk from abuse'[4].

2.6 Some of the events on the day Adult A died were, sadly, not unusual for him or his family; they had endured many similar days and nights. Adult A's mum said incidents took place almost as soon as they moved to their house in Tameside in 1971. Detailed chronologies of events from January 2007 to March 2010, prepared by a number of agencies as part of this review, indicate that there were over 90 recorded incidents of, burglary, harassment and general anti-social incidents at Adult A's home; or tormenting, theft and assault against him when he was out in his local community.

2.7 During that three year period, 26 named young people, mostly young men, were identified as being involved in these incidents and two thirds of these were identified as having had some contact with the Youth Offending Service. A small number were subject to Acceptable Behaviour Contracts (ABCs), 3 received Anti-Social Behaviour Orders (ASBOs) and at least 1 was given a custodial sentence. Not all their behaviour/offences focused solely on Adult A and his family. There were also other unknown people, including some thought to be as young as 5 years old, whom agency staff and neighbours witnessed harassing Adult A.

2.8 Although a number of young people are believed to be involved in nuisance/harassment on the day of Adult A's death, only one, who at that time was living on the same road as him, was charged with harassment. He pleaded guilty and received a 4-month custodial sentence in September 2010. At the time of this offence, he was already subject to a Community Order, managed by the Probation Service, for an offence not related to Adult A.

2.9 Adult A and his family were in contact with a number of public agencies and some voluntary sector agencies in the years prior to his death and had some contact with police and staff from the local Neighbourhood Office on the day of his death.

2.10 The substantial evidence gathered during this review indicates that staff from some of these agencies tried extremely hard to meet Adult A and his family's needs, often working well beyond their job description and showing great determination to seek solutions to the problems.

2.11 A small number of these staff raised the question of disability Hate Crime or hate incident[5] on several occasions during the 2007-10 timeframe covered by this report. The Housing Association did complete a Multi Agency Hate Crime

[4] "No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse". (2000) DH

[5] See section 5 of this report for definition and discussion-page 29

Report in June 2007. However, Hate Crime does not appear to have been a key consideration in the minds of those agencies involved with Adult A or in the sentencing of the offender[6].

2.12 There was only one occasion, in April 2007, when concerns about Adult A were referred to the (Local Authority based) Adult Safeguarding Team. The formal process of a strategy meeting, investigation and case conference began to be followed and protection plans were put in place. However, the process was not systematically invoked to respond to further incidents of abuse.

2.13 In an interview with the author of this report, Adult A's mother, made no criticism of any agency and has consistently described some people as 'very good' in the support they provided over the years.

2.14 However, given the circumstances of Adult A's death and the extensive multi-agency involvement with him and his family, Tameside Adult Safeguarding Partnership (TASP) decided that they would carry out a review with the purpose of understanding what lessons could be learnt from his death and the events leading up to it so that preventive measures might be put in place to avoid a similar outcome for other vulnerable people.

2.15 At the time of writing this Summary Report an inquest into Adult A's death has been adjourned and an enquiry by the Independent Police Complaint's Authority (IPCC) was about to report on its findings.

[6] Adult A's vulnerability was referred to in court without specific reference to 'Hate Crime'.

3. Information about Adult A and his family, and their contact with agencies.

3.1 Much of what we have learnt about Adult A, the person, comes from an interview by the Report author with his mother and older brother at the bungalow they moved to following Adult A's death. Further information was contained in the reports following Individual Management Reviews (IMRs) and some from the psychologist who met all members of the family and attended a SCR Panel interview.

3.2 Video footage broadcast on television news programmes after Adult A's death has shocked many people as it shows him outside the family home looking agitated, helpless, and biting his fist as some young people torment him.

3.3 Adult A Senior died in 1987. There is only one other family member mentioned in any reports, who was noted in police records in 2004, as being contacted when Adult A's mum was in hospital. Adult A's mum also described this relative as being very helpful following her son's death.

3.4 Adult A's mum said Adult A had some 'learning difficulties'[7] and his speech was unclear. He attended an adult training centre as a child and young adult. When he left, he got a job in a local shoe factory and worked there for 13 years until it closed down. He loved the shoe factory as he worked with lots of women who, according to his mum, cared for him. She said she knew some of them and they always commented how polite he was; "Adult A was a gentleman". She also observed that, "There never seemed another job that suited him".[8]

3.5 She encouraged him to be independent and he went errands and did all his own personal care. He couldn't read but "knew his money". He liked to smoke, go to the bookies, fill in his football pools, watch football, play snooker, and get out and about with his bus pass. He was a loving son and was always concerned to protect her. He worried that she would be hurt by people throwing things at the window. She believed that he would find it difficult to be away from her as he felt he was needed to protect her.

3.6 An entry in one of the agency chronologies confirms some of his behaviour was designed to protect his mum. At a meeting in April.2007 a neighbour described how, "*the local kids taunt him mercilessly, threaten him, steal from him, and abuse him. He has endured it for years and was now beginning to retaliate in his own limited way*". She observed*, "Adult A often stays outside*

[7] Learning disability and learning difficulties are often used interchangeably, though professional understanding is that a difficulty tends to be specific to a particular skill deficit, whilst a disability is more pervasive.

[8] The IMR from Adult Care states Adult A was made redundant in 1998 and did have another paid job for a year but then went into voluntary supported employment.

because he sees it as protecting his mum; he walks away from his home to take the kids away with him in order to protect the house".

3.7 Adult A could get very upset and frustrated over the harassment he and the family experienced, particularly as he thought some of his tormenters were his 'friends'. He would get agitated, shout and bite his hands until they bled.

3.8 The family moved to the Tameside area in 1971(Adult A would be in his 20s) as part of slum clearance from a rented house near Belle Vue in Manchester. His mum said they always loved their new house and the area, which was near to shops but also had good views and had generally good neighbours. She said she never wanted to move from the house in spite of the harassment from local youths that began very soon after they moved to the area.

3.9 Teasing and taunting of Adult A started very soon after the move. He liked to be friendly with people and he would give them a packet of cigarettes even if they only asked for one. Youths started to throw things at the windows and ask him for money and ask him to get some from his mum.

3.10 Youths tended to congregate outside the family house as the original wall was just the right height for sitting on and other walls were higher. Other neighbours also had problems from time to time. Youths threw eggs and tomatoes at the windows and would shout for Adult A to taunt him or hassle for money/cigarettes. From time to time, it went quiet but his mum said that the harassment behaviour seemed to get passed down to the next generation.

3.11 Individual Management Reviews (IMRs) report occasions when neighbours and people in the shopping area complained about Adult A's shouting and his apparent 'egging on' of some of his tormenters.

3.12 Adult A's mum reported that at one stage, she was told her son needed to see a psychiatrist. The information in the Individual Management Reviews (IMRs) and the Panel's subsequent interviews with IMR authors suggest that the psychiatrist was probably the psychologist Adult A saw with his mum on 3rd November 2008. He had another appointment, which he attended with his brother on 27th November and then the psychologist visited the family home on 19th February 2009 though he was out. The psychologist noted that his mum said she was at the end of her tether due to her failing health. There was a discussion about Adult A spending some time away from home. His mum was said to be keen on the idea of him trying out an adult placement but believed he would be reluctant as he felt he needed to be at home to protect her.

3.13 The psychologist described the Adult A she met and shared with the Panel some of her insights into the dynamics of the family relationships. She found him difficult to engage, as he seemed to think he was being brought to see her to be told off, and he became very distressed when the harassment issues were discussed. Adult A did make it clear that he did not agree with his mum's view when she said that the incidents of harassment had decreased. His mum also said he was losing his temper sometimes at home and it had

got worse since he had been at home all day. She said she and his brother had been trying to stop the harassment by keeping him in the house.

3.14 The psychologist also witnessed a high level tension between Adult A and his brother on the occasion she saw them together. She was very concerned about the tension in the family home. She felt that before she could do any work with Adult A he needed to feel more secure and to have some time away from the family and neighbourhood.

3.15 In the IMR provided following an interview with the GP and surgery staff, there is a statement that the IMR author was told, “He was always regarded as well behaved and mannered. There were no concerns over the patient’s behaviour or attendance at any appointments or home visits”.

3.16 Adult A’s brother is a slightly built man. The family GP Practice had his brother’s name on their Learning Disability Register, but Adult A’s name was not on the Register. There is no explanation for that.

3.17 His brother was mugged by local youths about 4 years ago (he could not identify the youths so there was no prosecution). He said in interview with the Report author that some youths had tried to harass him over the years but he never encouraged them by giving them cigarettes as he said Adult A had done, so they mostly left him alone.

3.18 Adult A’s mum has poor mobility and gets around the house by holding on to the furniture. She has a mobility scooter for outside use.

3.19 There is evidence to suggest that Adult A’s mum was keen that others saw her as ‘a coper’. She asked for very little support in caring for him from external agencies, other than to support him with employment/daytime activities.

3.20 Adult A’s mum said most neighbours were good, though she recalled one man saying to her when she was in the garden with him, “He should be in a home”. She once went to see one mother of one of the lads who was tormenting them but she regretted going, as the woman was very abusive.

3.21 On the day of Adult A’s death (Wednesday 10th March) his mum said there were problems early in the day and she called the police who came out to the house but the youths had left. Some youths had returned and scattered papers from the blue recycling bin into the garden and thrown the bin at the house wall. Adult A and his brother had been watching football in the evening and he had gone out to put the papers back in the bin. He also went to lock the garden gate but his brother looked out of the window and saw him lying on the grass – he was found with his hand on his chest.

3.22 Adult A’s mum was generally not critical of any of the agencies who had been in touch with the family over many years. She felt the police had done all they could. In the early days they didn’t respond very quickly and said things like ‘lads will be lads’ but she observed that they didn’t seem to have the

manpower to respond and weren't happy about filling in forms for things that weren't serious. She said there was a change of attitude and more contact about 4-5 years before her son's death. They put up CCTV cameras and responded more quickly. Some lads were taken to court but only 1 convicted (he had other non related offences), as there was not enough evidence.

3.23 She described one police officer and a police community support officer as particularly good – one coming to sit with them in the evenings to see if he could catch people harassing them and doing damage at the house, and both officers helped them out with the house move and other matters.

3.24 She said they hadn't had much contact with Social Services. Adult A had been attending some drop-ins and the 'Friday club'. He was given a support worker to take him out once a week. He liked the last support worker very much and she took him to play snooker and bowls[9].

3.25 Adult A's mum said he did not have much contact with health workers, as he was not ill very often. He had a few small accidents (accident to his thumb and ankle) but no hospital admissions and no signs of any heart problems.

3.26 Adult A's mum agreed there had been some contact with the Victim Support and Witness Service on at least one occasion when there had been an incident.

3.27 Adult A's mum said the Housing Association had asked her a number of times if she wanted to move but all three of them liked where they lived and didn't see why they should move - they were not the cause of the problems. Adult A's brother's view was "*Why should we be forced out by others?"* Information also came forward that an additional possible explanation about why Adult A's mum refused to consider moving from her home was she had been involved in community activity to improve the neighbourhood when she was younger.

3.28 Adult A's mum did ask to move shortly before her son's death. She was having problems with the stairs and they were on the list for a newly built bungalow, which was to be ready later in the year her son died (2010). After his death, they agreed to move to a 2-bedroom bungalow that had recently become vacant a few hundred yards from their previous home and moved in May 2010. This has gone well and they are very comfortable "*just sad that he is not able to enjoy it*".

3.29 It was clear that Adult A's mum didn't always know exactly which agency was in contact with her but there were named people from a number of agencies who she saw as friendly and supportive and she did not have a critical word for any of them.

[9] There is evidence that social workers from the Adult Assessment Community Care Team (AACCT) visited the family on several occasions and then Adult A was allocated a social worker from the learning disability team in April 2009. The supported employment/drop in and personal support worker were all commissioned by Adult Care (social services).

3.30 In discussion about how she thought future events like this might be prevented, she said she believed that it was important children learnt about disability in school so that they might not be quite so cruel to people who were different.

3.31 She thought the regular contact from the police was important and maybe there needed to be another telephone number where people could report concerns even if they were not quite serious enough for the police. She sometimes hadn't been sure whether to phone or not.

3.32 She has taken great comfort from all the letters and cards and flowers she had received from people all over the country. She said local people had also been wonderful in offering her help and telling her they had known him and what a "*perfect gentleman*" he had been and they could tell, "*He had been brought up well*". She said she had had a lovely letter from all the children at the local school.

3.33 She and his brother missed him but he had had a good life and she wasn't bitter – just sad about what had happened.

4. Information from the Chronologies and Individual Management Reviews (IMRs) in relation to the incidents and the details of agencies involvement with Adult A and his family from 2004-2010.

4.1 Although this section of the report is primarily a gathering together of the relevant facts and recorded incidents, it does include some commentary taken from IMRs and from the SCR Report author. These comments begin to identify some of the developing themes and learning points, which will be picked up in more detail in Section 5, Findings and Analysis, of this SCR Report.

4.2 The information gathered to produce the full Overview Report was very substantial 11 agencies produced Individual Management Review reports ranging in length from 34 pages (Police who had a lot of contact with Adult A and his family) to 3 pages (NHS Community Provider Services who had no direct contact with Adult A). The reports were generally well prepared, honest in their reflections on agency practice, and identified appropriate recommendations for improvement. The IMR authors also presented their reports to the Panel and were questioned on their findings and took part in discussion about the learning from their Reviews.

4.3 A number of agencies reported *and* recorded many incidents in the community and at the family home over the years. However, there are references to other incidents, certainly prior to 2007 that were not formally reported or recorded.

Pre 2004

4.4 The Individual Management Review (IMR) undertaken by Adult Services (Social Services) reports, “Involvement with Adult A commenced prior to 1985 when he attended the Learning Disability Day Service... Following redundancy from paid employment in 1998 ...he was assisted to obtain further employment. Adult A undertook some paid employment during the period 1999 until 2000 when he started supported voluntary work at a local Cemetery”. He remained involved with the work placement service until 2008, though contact became intermittent in the later period.

4.5 The IMR from the Police notes “The police have been aware of the family for many years before 2004 with several sporadic incidents involving members of the family as victims or witnesses being reported back to 1998, not all at the home address”

2004

4.6 Throughout 2004 Adult A worked at a local cemetery on a part time placement organised by Tameside Adult Services. Records of this period are patchy but he was visited on at least 3 occasions, though he only seemed to be present at work on one of those occasions. There are no references to any safeguarding concerns.

4.7 In May 2004 the staff at the local Neighbourhood Office witnessed an assault on Adult A in the local high street – a stone was thrown that hit him on the ear. The youths could not be identified from CCTV. The police were involved and his intellectual disability and communication problems as well as his distress and reluctance to be interviewed were recognised as barriers to getting information that could have led to a prosecution.

4.8 From chronologies, we learn that by 2004 CCTV had been installed at the back of the family's house supporting the view that problems had been taking place for some time.

4.9 In August 2004, the police respond quickly to a call from a neighbour, when windows have been smashed at the family home and find the two brothers are on their own as their mum is in hospital. The neighbour states *'youths have plagued them for three years".*

4.10 A referral to Adult Services results in a visit to carry out an assessment within 7 days. No further support is wanted by Adult A's mum. However, nothing appears to be recorded regarding the multiple vulnerability of this family: an 82 year old single parent with 2 disabled sons in their 60s; and no safeguarding alerts were made.

4.11 The focus is on Adult A's care needs rather than his need for protection. No alerts are made to the Safeguarding Team but a referral is made to the Victim Support Service[10] but the family did not take up this service. There is no record of what Adult A felt about his situation.

4.12 Adult A's level of understanding and capacity for decision making is unclear but police officers felt that, "*he couldn't grasp the concept that giving cigarettes and money to the youths was likely to cause problems*".

4.13 There is evidence that the local police officer is providing support to the family and decisions are being taken at a senior level, that it would not be in Adult A's interest to involve him in court proceedings.

4.14 There is also evidence that the police are actively dealing with one of the key young people involved in the anti-social behaviour and involving his parents.

[10] This service is now known as Victim Support and Witness Service

4.15 There is no evidence that the work placement provider service was recognising and reporting safeguarding issues for Adult A or even that he was attending his work placement on a regular basis.

2005

4.16 There are only 3 entries in chronologies for this year: 2 entries relate to monitoring/review visits by the work placement provider, noting Adult A is happy with his work at the cemetery but he 'chooses when to attend'. A third relates to a home visit made by a staff member from the work placement provider to Adult A and his mum, who raises concerns over local youths. Advice is given to talk to the Patrollers

2006

4.17 The combined chronologies record 7 separate incidents of nuisance, verbal abuse and damage to Adult A's home including a brick thrown through the window on 14th September 2006 and a report from his mum of a neighbour "who has barged into their home looking for his son and accusing Adult A of hiding him".

4.18 There are reports of other nuisance/anti-social behaviour incidents in the local area and on the shopping precinct.

4.19 Staff at the local Neighbourhood Office, located in the shopping precinct, which was quite close to Adult A's home, had witnessed abuse and assaults on him. They provided him with support, reported incidents to the police, and took him home on occasion.

4.20 On 14th December 2006, the escalation of anti-social acts in the locality and against Adult A and his family was discussed at a local multi-agency PACT meeting (Police And Community Together) –a forum that also includes some local residents.

4.21 The local Neighbourhood Office, proposed that staff should keep a written record of incidents where Adult A and his family were subject to harassment. This was to include "hearsay", record of incidents reported to staff by local residents.

4.22 The objective of this was to collect evidence that would demonstrate that the harassment experienced by Adult A and his family was persistent, rather than sporadic and isolated incidents. By collecting all possible evidence, it was hoped to use it to assist agencies to work together to agree and take action to resolve the harassment.

4.23 The Neighbourhood Office staff agreed the plan but "it was not formalised as an organisational procedure".

2007

4.24 The plan devised at the end of 2006 began to be put into practice in 2007.

4.25 Chronologies indicate a much increased recorded level of direct harassment, theft, burglary and assault on Adult A as well as targeting of the family home.

4.26 Given this concentrated approach and multi-agency involvement, it is not surprising that the number of *recorded* incidents increased during this period but it isn't possible to confirm this was a real increase rather than just a documented increase of incidents, which the family had been subject to in previous years.

4.27 Adult A's mum also said, when interviewed as part of this Review, that she felt agencies, particularly the police, began to take what was happening more seriously.

4.28 In all, during 2007, chronologies record 46 incidents involving Adult A and/or his family. Of these 46, 26 are incidents at the family home. These range from groups of youths gathering at the family house, begging money and cigarettes, using abusive and threatening language, damaging gates and fencing, committing burglary on 2 occasions, and throwing bricks through windows on 3 occasions.

4.29 The other 20 incidents are directed at Adult A and consist of taunting, breaking his glasses, assaults - including simulating a sex act, stealing his cigarettes and money and threatening him to get him to give them cigarettes and money. These crimes and abuses often took place in the shopping precinct area and staff at the Neighbourhood Partnership Office witnessed a number of these incidents.

4.30 These detailed records also demonstrate that agencies were trying to adopt a planned process and were working hard to deal with the problems being faced by Adult A's family and others in their neighbourhood.

4.31 There does seem to be a reduction in reported incidents at the family home towards the end of 2007 with only 5 of the 26 recorded incidents being reported in the later half of 2007; more young people had been identified and a range of actions undertaken; from early intervention letters to parents, involvement of the Early Intervention Group (EIG); to the issuing of Acceptable Behaviour Contracts (ABC); and warnings to parents about risk to their tenancy by the Housing Association.

4.32 The new names and involvement of younger children are, however, of concern as they herald the emergence of the next generation of potential tormenters of Adult A and his family.

4.33 The first adult safeguarding alert was made during this period. A Strategy meeting involving 11 key agencies takes place on 20th April, followed by a Safeguarding Adults Conference, 21st May. Plans are formulated and a decision made that, "the harassment issue would stay on the PACT agenda; there would not be another Safeguarding Adults meeting". A closer look at the

incidents and differentiation between incidents at the family home and abuse of Adult A in the community, might have led to a different decision.

4.34 The notes of the safeguarding meeting do not indicate that a lead agency was identified to co-ordinate the actions of the various agencies involved.

4.35 It is noted that Neighbourhood staff, the police, and other volunteers did some clearing up work at the family house so that the contractors would install central heating.

4.36 The role of the Advocacy Agency commissioned to work with Adult A is unclear. There are repeated issues of his unwillingness to be interviewed formally to provide the police with evidence to prosecute. This is in contrast to his willingness to tell people in the Neighbourhood Office what had happened to him. There does not seem to be any consideration of how that willingness could be used more effectively to give him the confidence to use support to take more control in seeking justice for himself.

4.37 A referral to the Psychology Service is made in May but because of staff shortages, no service is available to Adult A for the next 18 months and there doesn't appear to be any escalation of concern by Adult Services to seek swifter or alternative action. Adult Services continue to be involved, although it is sometimes unclear whether they regard him and his family, as an,' open' case for them as there are no requests for services to meet personal care needs made by Adult A or his mum.

4.38 Whilst incidents at the family home appeared to be reducing, detailed examination of the chronologies supplied as part of this SCR, do not support the view that harassment, thefts and assaults on Adult A were reducing: 9 of the 20 took place in the later part of the year with one assault in July resulting in him needing medical attention from his GP and another in September when he described being grabbed from behind by two boys who simulate sex with him. None of these incidents, many of them directly witnessed, lead to further safeguarding alerts.

4.39 Referrals begin to be made to the Victim Support Service, although on three occasions, they are given a different spelling for the family surname and it was not possible for their data system at that time to make connections with earlier referrals using different name spelling. The IMR from the Victim Support Service indicates that they had other referrals about Adult A's mum but again the information systems did not flag up the connections

4.40 The Neighbourhood staff develop as key players in getting others together as well as having very active day to day involvement with Adult A and his family.

4.41 There are 3 references to Hate Crime during this period:

- 18.6.2007- at a meeting of the Environment, Housing and Community Safety Theme Group it is suggested that the incidents should be regarded as Hate Crimes and this should be referred to PACT.

- 26.6.2007 - a Hate Crime initial reporting form[11] was completed by the Housing Association. This was posted to the local Police Office with a copy to a member of staff involved with the Hate Incident Panel. It is unclear what happened to these forms as both organisations have no record of receiving them so took no action; and

- 27.6.2007- the IMR for the Police notes that in reviewing a particular incident reference is made to consideration of it being a 'hate incident' as there is mention of Adult A's 'mental problems' and the fact that the youths had called him a 'paedo'. However, a decision is made that, "as there is no mention by the youths of Adult A's mental health problems it was not a hate incident".

4.42 There are no references to Hate Crimes/incidents as part of the adult safeguarding alert strategy meeting on 20.4.2007 and none at subsequent PACT meetings.

4.43 In the latter part of 2007 there seemed to be an increasing focus on Adult A's behaviour and how it makes a 'contribution' to his harassment problems. References are made to him 'egging lads on', taking retaliatory actions, shouting without provocation, urinating in the garden, following lads, looking through a window into a classroom. In April, he is banned from one of his favourite places, the local betting shop, and in September 2007, after a meeting with Housing Association he receives a letter, which to all intents and purposes is an Acceptable Behaviour Contract. This includes an agreement not to go out after dark. There are no assessments of Adult A's risk to others nor any suggestion that he has the capacity to understand an acceptable behaviour type of contract.

4.44 In spite of further incidents of abuse, there are no further alerts/referrals into the Safeguarding Adult Team.

2008

4.45 The first month of 2008 was relatively quiet in terms of reported incidents but by the end of the year, there are 31 reported incidents of causing nuisance and damage at the family home and 3 of witnessed abuse/assaults on Adult A away from the house.

4.46 In February there were 3 incidents, 2 reported by Adult A's mum and 1 by a neighbour and 2 incidents in March; all are about harassment at the family home. This includes 1 where his mum reports that one youth stated, "*He was going to kill Adult A*". His mum warns, "*The problems were becoming regular again".*

[11] The Police, having seen a copy of the form retained by Housing Association, confirms this was a Manchester form but that should not have stopped it being acted on.

4.47 There are at least 10 similar incidents in April. The police attend within the hour on all these occasions unless Adult A's mum has asked them not to visit. Community Safety Patrollers increased their patrols in the locality. There is another occasion (25th April at 23.00 hours) when his mum says youths are shouting to her "*give us some money and we will leave you alone*" and the "Call taker records that the caller appeared distressed and breathless and that she said this was because she was frightened". It does not appear that she receives a visit until the following day. The IMR author for GMP also expresses concern about why that happened.

4.48 CCTV footage is reported as continuing to yield inadequate quality images that cannot be used for perpetrator identification.

4.49 In June there is the first (for 2008) recorded incident of someone taking money from Adult A in the shopping precinct.

4.50 In July, Neighbourhood staff make an application under Part II of the Regulation of Investigatory Powers Act (RIPA) 2000 for authorisation to carry out directed surveillance in the area around Adult A's home. A private specialist contractor was engaged to conduct observations of the area in order to identify the perpetrators. It was not successful as no incidents took place during the period of observation.

4.51 The Advocacy Service continued their efforts to locate voluntary work for Adult A and were in regular contact with his mum to sort out his bus pass and clothing. His brother informed them that Adult A was still getting harassed by kids breaking windows. There is regular contact with the police.

4.52 In August, staff from Adult Services carried out another assessment over the phone with Adult A's mum, who said that she was coping. Adult Services' case notes record "we will take no further action at this point". It is reported that there was still no action from the Psychology Service.

4.53 There are 6 recorded incidents in August and on 5.8.2008, the police reported to a Community Safety Theme meeting that they had been talking to local people about issues in Adult A's locality. "The police proposed setting up a subgroup that will involve his mum to discuss ways forward as this was one of most longstanding issues on this beat". It is unclear how this relates to the work being 'led' by the Neighbourhood Office.

4.54 On 6.8.2008, the Neighbourhood Office calls a meeting with Adult A's mum, Police, and the Crime Prevention Officer. His mum said that she would like regular contact with a social worker for her Adult A. The meeting discussed housing options for Adult A and his brother when their mum is unable to support them.

4.55 There are several incidents at the house in August. 10 youths are stop checked and some reported to Community Support but no charges are made.

4.56 In September there are 5 recorded incidents including one on 11.9.08. A local resident had seen children shouting "paedophile, paedophile" towards the family's house. Neighbourhood staff made a written note of this report and a police officer attends the next day to view CCTV images but they are too poor in quality to identify anyone.

4.57 22.9.2008 the CCTV tape shows 2/3 youths shouting and demanding money with threats to attack Adult A's mum and to smash windows. Neighbourhood staff note evidence on CCTV tape and inform the police.

4.58 9.10.2008 an update at the Community Safety Theme Group meeting reported on Police trying to organise activities for Adult A. He reported closer working relationships with the Youth Service.

4.59 20.10.2008 – a group of 4 lads and 1 girl are reported as causing nuisance at Adult A's home. 1 of them is the young man who was involved on the day of Adult A's death and convicted of the harassment.

4.60 In November 2008, the clinical psychologist saw Adult A with his mum. The delay is recorded as "due to waiting list pressures caused by vacant post and also long term sickness in department".

4.61 The psychologist records "Mum reported that the harassment had lessened recently because she and Adult A's brother were managing it by keeping Adult A in the house and trying to stop him wandering the estate". His mum was concerned Adult A was losing his temper. Adult A was quiet but disagreed with his mum when she said things had got better with the harassment. "He was so distressed he walked out of the session when she (psychologist) asked him a question about the harassment…Adult A appeared to think he was in trouble."

4.62 The psychologist made a request for assessment from the Learning Disability Team to look into accessing day time activities for Adult A. This is followed up at the end of November after a meeting, which Adult A attends with his brother. The psychologist is so concerned about the level of tension between them that she sends an email immediately to the adult learning disability social work team leader expressing her concerns and asking if he is still on the list for social work allocation in the team.

4.63 The information from his contact with psychology is significant in that it paints a different and troubling picture of his relationships within the family home. The contact with the psychologist coincides with the period of attempts by his mum and his brother to keep him in and stop his wandering so that he didn't get into trouble in the local community.

2009

4.64 There are 14 (6 up to end of March and 8 after) recorded incidents in 2009, all at or near Adult A's house ranging from:

- Youths entering the house when Adult A opens the door and taking his mum's shopping trolley and throwing across the garden;

- 2 males (14-18yrs) throwing a brick through the rear window. A further call is received from a neighbour confirming the smashed window. The neighbour also states hearing a male call out to Adult A and he came out and started shouting at the offenders who shouted back "windows" before throwing the stone that smashed the window; and

- The young man involved on day of Adult A's death is referred to Community Safety team regarding a non recorded incident near to Adult A's address.

4.65 Adult A's mum expresses concern to her GP in March about finding "it hard to cope with two mentally handicapped adult sons". There is contact from the GP practice to Adult Services and following further assessment (by a specialist learning disability team social worker) a care and support package was identified for Adult A. He was supported to access daytime activities via a Direct Payment to pay a personal assistant. Adult Services also reported that incidents had reduced with continued interventions from the Police.

4.66 During 2009 until Adult A's death of March 2010, there were no further interagency meetings involving Adult Services and there appears to have been no direct contact with the GP from Adult Services.

4.67 The evidence seems to suggest that Adult A was enjoying a better quality of life in the later half of 2009. He was going out doing activities he liked with his support worker. There were no recorded incidents against him personally and incidents at his home appeared to have reduced.

4.68 However, some police officers speculated with the IMR author that one of the possible reasons why there were no incidents in the shopping precinct during this period was because Adult A was barred from the local betting shop so used to take a bus to Hyde to place his bets.

2010

4.69 The combined chronologies record no incidents until 23rd January, though other information about increasing concerns from agencies suggests that didn't mean nothing was happening. 2 incidents at the family home on 25th January frightened Adult A and his mum, though no offences were deemed to have been committed. A member of staff from the Neighbourhood Office said he wanted the issues considered in a multi-agency forum and he wanted the incidents to be discussed as Hate Crime, though there is no evidence that they were reported to the Hate Incident Panel or that any safeguarding alerts were made. He also contacted the Housing Association to try to sort out more external lighting around the house in an attempt to get better quality CCTV images.

4.70 On 27th January, Adult A is again distressed at the Neighbourhood Office and a neighbour reports several incidents at the house and says she has

difficulties in trying to report to the police. Police advised ringing 999 if she had problems.

4.71 Adult A's mum said at end of January that she wanted to move, though there seemed to be subsequent confusion about this as the social worker reported that she had told her she didn't want to move. In any event, a re-housing application was completed by the Housing Association on 24th February.

4.72 On 3rd February at the Community Safety Theme Group meeting, a local resident, suggested that the victimization of the family should be treated as a Hate Crime because the 2 brothers had learning difficulties. She also expressed her concern "*that if something wasn't done there would be a death in the family".*

4.73 There is more evidence of people working beyond their job description; for instance, the local PC was planning to organise a clear up at Adult A's house, as some improvement work was to take place.

4.74 Adult A is described as seeming more settled and enjoying activities with his Direct Payment support worker.

4.75 Some identified young people receive quick responses to try to prevent escalation of their behaviour but there are continuing issues over the effectiveness of the CCTV in identifying individuals.

4.76 There is evidence from the Probation Service that the young man, who was charged with harassment after Adult A's death, was a vulnerable young person, having lived with foster carers, become homeless, and was then sleeping on a friend's floor (possibly close to Adult A's house).

4.77 There is evidence that agencies showed appropriate concern for Adult A's welfare and responded quickly to the harassment incidents at the family home on the day of his death. Neighbourhood staff walked him home from their office, when he was upset at an incident of damage to his gate in the morning of the 10th March. The PCSO and a Housing officer attended and made some repairs. The police responded in 9 minutes to a call that evening about youths at the house and found Adult A lying in the garden.

5. Findings, Analysis and Learning

A long list of questions was developed in the SCR Panel meetings. These questions provide the structure for the findings and analysis section of the Report

Question 1: Were all the incidents of equal significance – should there have been a distinction made between assaults on Adult A's person and anti-social behaviour at his home? Would it have made any difference to outcomes for Adult A?

5.1 It would have helped in understanding the level of personal harassment and actual physical assault and its impact on Adult A if agencies had made a distinction between the two classes of incident. This information is highlighted in Section 4 of the Report setting out the facts of the incidents and the balance between personal harassment of Adult A in the community and the more general harassment at the family's home.

5.2 It is worth noting that Panel members were informed that, even now, anti-social behaviour continues in the vicinity of Adult A's former home even though the family no longer lives there. This suggests that some of the anti-social behaviour was not specifically targeted at the family.

5.3 There is evidence to demonstrate that Adult A's need for protection as an individual was, at times, clouded by the agencies focus on family and locality issues.

5.4 If Adult A's personal experiences of actual crime had been focused on consistently, then it is likely there would have been more safeguarding alerts and probable that he would have received priority for specialist learning disability service intervention sooner.

5.5 A narrower focus may also have illuminated that many of the incidents had the characteristics of Hate Crime and perhaps promoted a more urgent and escalated response to some incidents. This lack of urgency and need for escalation is identified specifically in the IMR from Greater Manchester Police. The issues of identifying behaviours as hate incident/crime are dealt with under question 4 of this section.

5.6 Earlier referral to a specialist social worker might have identified Adult A's needs for a very focused advocacy service that would work with him to assist him to protect himself and to assert his rights to justice when crimes were committed against him; to seek interventions to reduce his health and transactional risk factors by stopping smoking; and to identify the need for routine health screening and the development of a Health Action Plan (See question 5).

5.7 Consistently case managed/care coordinated social work support might have focused sooner on assisting Adult A and his family to appropriately separate from each other, so he could achieve greater independence and his mum could have some respite. He experienced a great sense of needing to protect his mum even though he did not have the capacity to undertake that role and in fact his behaviour sometimes put her at greater risk.

5.8 This approach might also have provided a platform to build a contingency plan for Adult A and his brother for the time when she died or was too frail for them to live with her.

5.9 More rapid access to a consistent care coordinator type of service might also have identified the extent and the persistency of the abuse Adult A was experiencing.

5.10 The information provided by the much delayed assessment, undertaken by the Psychology Service is important, in that it draws attention to the tensions in the family. These were probably exacerbated by his mum and her older son's attempts to 'manage' Adult A's behaviour and to limit his excursions into the community. There was no recorded plan to investigate these tensions or any solution other than to '*occupy*' him.

5.11 Concerns were raised during the Review about the impact of Fair Access to Care (FACs) and Adult A's eligibility for support. There certainly seems to have been some lack of clarity about whether Adult A's case was being actively managed, but there is evidence to demonstrate that he was seen as eligible, and did receive services commissioned/provided by Adult Services. There were a number of occasions when his family declined support other than for work/day support for him. It is less clear that he declined services, as his views do not come through strongly from assessment information.

5.12 The fact that there was only one formal safeguarding alert from any agency during his life is surprising and concerning. Whilst there are issues about how that was initially dealt with, it did galvanise greater multi-agency activity, though arguably its focus drifted to general concerns about the family and neighbourhood incidents rather than Adult A's protection.

5.13 This Report author speculates that there were so many people involved with Adult A that they each believed someone else would be doing something[12]. This was certainly illustrated in the interview with the psychologist who was concerned and reflective about her own expectation that something would be done urgently given that she had passed the information on to Adult Services. This could be regarded as an unreasonable expectation when set against the long waiting period for the Psychology Service to become involved with Adult A in the first place.

[12] See appendix 3 for a diagram of all the people/agencies involved in some way with Adult A and his family.

5.14 In both instances; delay by psychology and the learning disability social work service, Adult A was not well served and more urgency and a greater focus on alternative options to accessing support to keep him safe and to meet his personal development wishes needed to be pursued. Whilst this may not have made a difference to the timing of his death, it is likely to have reduced the level of misery that he regularly experienced.

Question 2: What role did/could consistent advocacy and communication support play in ensuring access to justice systems for Adult A and his family?

5.15 The Equality and Human Rights Commission concluded in their report about the safety and security of disabled people, "that the emphasis on help and protection underpinning much of existing policy and legislation should be replaced by a focus on justice and redress".[13]

5.16 Evidence suggests that the advocacy services Adult A received were more like support services to enable him to access the community more safely, rather than support him to access the Justice system. It is not entirely clear why he was so reluctant to identify offenders or give video interviews. A strongly held view is that his mum tried to deal with what was happening by playing down its importance and there was the undercurrent from family members and the local community that he brought trouble on himself. The pressure was on him to conform to family norms, but giving him support to exercise more control over his own life could have raised his self esteem. As the psychologist said, building up trust with him would have taken a long time but this did seem to be happening with his support worker (personal assistant) and all the evidence points to him having trust in a number of staff at the Neighbourhood Office, where he sometimes sought refuge.

5.17 There is no discussion in any IMRs about the possibility of Adult A accessing speech therapy or other communication support, in fact he appeared to make few demands on health or social care and a representational advocate may have applied more pressure and also supported Adult A to be his own advocate.

[13] Equality and Human Rights Commission (2009) "Promoting the safety and security of disabled people".

Question 3: Was Adult A's family in need of protection, and if the answer is yes, how did agencies try to protect them, and how could they have done that better?

5.18 This whole family had visible characteristics that identified them vulnerable as individuals and as a family unit. Agencies and individuals worked hard to put a variety of supports in place to protect them. These ranged from: trying to ensure perpetrators were caught and held to account/punished for their wrong doings; keeping Adult A out of the locality by finding 'occupation' for him during the day; offering the family the opportunity to move house; encouraging and supporting neighbours to report incidents; discussing the issues regularly at PACT (Partners And Community Together) neighbourhood meetings and setting some actions in place; and installing technical barriers to the targeting of the family home.

5.19 One of the key areas was installing extra lighting, CCTV, and building bigger fences and stronger gates. With hindsight it is easy to see that some of these interventions had unintended negative consequences and some of the equipment was not robust enough to fully protect the family.

5.20 In the author's discussion with Adult A's mum, she said when they first moved into the house there was a low front garden wall where young people used to gather to sit. Over time, this was replaced and during the relevant period considered by this SCR, there are a number of references to the regular efforts to get increased and improved fencing.

5.21 The IMR from the Neighbourhood Partnership describes (between June and November 2008), "contributing to the cost of improved, higher fencing at the house to improve the security and reduce the ability of local youths seeing over the fence and Adult A responding to them over the fence".

5.22 The back gate is regularly referred to as a target for the young people. Adult A's distress at the Neighbourhood Office on the morning of his death was because "*they've kicked my door in*" and, on examination, one of the staff describe the gate as having been '*attacked*'

5.23 It is unreasonable to criticise the motivation and efforts of agencies to provide more secure gates and higher fencing, particularly given that Adult A's mum did not want to move house. This is not a criticism of her. She loved where she lived, and quite rightly did not feel that it was fair that she should be driven out; and it also emerged that she had been very active in earlier years in developing her local community. She made it clear in interview with this Report author that she had been offered the opportunity to apply for a move on more than one occasion.

5.24 It is probable, though, that these efforts to provide greater security had some negative outcomes for the family. There have been comments from some who saw the TV footage following Adult A's death that the house looked like a fortress, possibly increasing its attraction to groups of young people

misguidedly seeing ‘a brick through the window’ as a greater challenge. Moreover, it potentially increased Adult A’s low self esteem as it physically emphasised his lack of control over his environment and his ability to protect his mother. The fact that it still wasn’t secure enough to keep the house from being attacked is likely to have added to that.

5.25 In the combined IMRs, there are at least 35 references to CCTV from August 2004 to the retrieval of the footage after Adult A’s death.

5.26 Although there is some evidence that there was some CCTV installed at the rear of the property in 2004, one IMR says that CCTV installation on12 April 2007 was agreed with Adult A’s mum in January 2007. The aim of this was to collect evidence of incidents at the house to assist with criminal prosecutions, or with the breach of civil orders, i.e. ASBOs, or Acceptable Behaviour Contracts.

5.27 The IMR from the Community Safety Service explains, “CCTV that is referred to is not linked into the council’s monitoring system and is part of a stand alone, neighbourhood system”.

5.28 The installation of more CCTV in 2007 was part of the plan to increase and refocus multi-agency efforts to protect the family. There are some suggestions that Adult A’s mum expressed some reluctance to having it installed but after some increasing incidents, it was installed ‘discretely’. Staff at the neighbourhood office were to regularly collect footage and ‘give to police for evidence’ so as to identify the perpetrators rather than simply act as a deterrent. It appears to have been targeted almost immediately, as a few days after installation it was knocked to face the wrong way and needed attention. Later that month following an experiment by the police, they confirmed that it did not capture images at night other than of reflective clothing.

5.29 In May 2007, footage was obtained of one of the more persistent offenders but the evidence was not strong enough to bring a prosecution. There were a number of other occasions when images could not be used as evidence.

5.30 In June 2007, following meetings organised by the neighbourhood office with local residents and elected members, Councillors agreed to install street CCTV. This was intended to provide coverage of Adult A’s home, a Children’s Centre and the newly built play space.

5.31 CCTV underwent a number of improvements in 2008 and its coverage was extended into the local area; particularly at the local SureStart Centre, though some issues of quality remain, as do discussions about which organisation should fund the CCTV.

5.32 The quality issues continued into 2010. On 27th January 2010, Neighbourhood Office staff noted a recent surge in incidents at the house and identified a need to improve the lighting to get usable CCTV images of perpetrators.

5.33 A member of staff at the Neighbourhood Office commented to the IMR author that, “Even CCTV failed as perpetrators simply pulled their hoods up to hide their faces”.

5.34 It is clear that, if technical and environmental solutions are to be useful in protecting vulnerable adults, they need to be ‘fit for purpose’ and their potential for negative impact recognised and reviewed at regular intervals using a risk management process, and involving all agencies.

5.35 The staff of a variety of agencies were in regular contact with Adult A’s mum. She described a number as very helpful and one person even came and sat in the family home to try to catch the perpetrators

5.36 Some staff, including young people on a youth project, helped with family clear ups when renovation work was taking place at the family home. Referrals were also made to organisations like Age Concern, which assisted with some work in the home.

5.37 A number of agencies tried to find work or volunteering opportunities for Adult A.

5.38 A member of staff from the Neighbourhood Office attended a conference on adult safeguarding in November 2007 with the key objective of learning about best practice in safeguarding vulnerable people, demonstrating their great commitment to try to find solutions to the problems surrounding the family.

5.39 Concerns about what was happening to the family were shared at numerous PACT meetings, notably in 2007 and again in 2010 when recorded incidents seemed to be increasing again. There were a number of case review meetings following the 2007 safeguarding alert. There was some lack of clarity about the focus of some meetings; some issues of consistent attendance; and a view that individual family issues should not have been discussed in a PACT meeting.

5.40 The main conclusion in this area is that there was a great deal of commitment to protect the family. Some agencies engaged in a high level of activity and staff worked ‘beyond their job description’; but there was some confusion of focus (see discussion under Question 1), lack of robust monitoring of plans; some ineffective CCTV and fencing; and lack of clarity over the lead agency (see Question 8).

Question 4: Was this harassment and these offences of theft and assault against Adult A 'Hate Crime' and what difference would identifying the incidents as hate incidents or Hate Crime have made to the outcomes for Adult A?

5.41 A Hate Incident is defined as:

- Any incident, which may or may not constitute a criminal offence, which is perceived by the victim or any other person, as being motivated by prejudice or hate.

5.42 Hate Crime is defined as:

- Any hate incident, which constitutes a criminal offence, perceived by the victim or any other person, as being motivated by prejudice or hate[14].

5.43 Whilst "hate" was introduced as an additional aggravating feature of certain crimes that targeted people based on their race or religion, following the Stephen Lawrence Enquiry in the late 1990s, the inclusion of Disability Hate Crime did not take place until 2003. Section 146 of the Criminal Justice Act 2003 introduced the possibility of increased sentences for offenders who targeted people because of their disability.

5.44 This could be applied where, "at the time of committing the offence, or immediately before or after doing so, the offender demonstrated towards the victim of the offence hostility based on: -

a disability (or presumed disability) of the victim, or that the offence is; motivated (wholly or partly) by hostility towards persons who have a disability or a particular disability".

5.45 Research[15], supported by the recorded experience of some professionals in Tameside, indicates that there is general confusion about how to reach the conclusion that a crime constitutes a Hate Crime. There is also a debate about the benefit for the disabled victim of defining the crime as a Hate Crime, given that many people would be reluctant to use such an emotive word, though they would recognise that people are targeted because they seem weaker and less able to defend themselves.

5.46 Adult A is unlikely to have had the cognitive ability to identify what was happening to him was as a result of hate; he no doubt just wanted the pain to go away and for people to be his friends.

5.47 Young people targeted Adult A because they saw him as 'different' and powerless. There was certainly hostility expressed towards him, his mother reported one youth as saying he was "going to kill" him. The taunting reported

[14] ACPO (Association of Chief Police Officers) 2005

[15] Chih Hoong Sin et alia (2009) Disabled people's experiences of targeted violence and hostility. Office for Public Management on behalf of the Equality and Human Rights Commission

by a neighbour, when youths called out, "Windows", before throwing their brick was cruel and emphasised his powerlessness. Youths called him a paedophile on more than one occasion and he was very upset after a simulated sex attack by a group of young men.[16]

5.48 There were only 3 occasions prior to the month before Adult A's death when any professional mentioned the possibility of Hate Crime. On one of those occasions, in 2007, the Housing Association did complete a Hate Crime form as a result of an incident at the house. This form was posted to the police and copied to a local authority worker with some responsibilities for hate incidents. Neither agency has any record or memory of receiving this form. Nothing was ever heard of what happened to it but no one followed it up, in spite of a growing number of similar incidents. This illustrates some of the difficulties experienced at that time in understanding the concept of disability Hate Crime. As can be seen in the next paragraph discussions re-emerged in 2010 about Hate Crime but Adult A died before any decisions about specific action were taken.

5.49 On 26th January 2010, a member of Neighbourhood Office staff contacted the police to suggest that recent incidents should be discussed as Hate Crimes at a forthcoming neighbourhood meeting. At a Community Safety meeting on the 3rd of February a local resident suggested that, "*the victimization of the family should be treated as Hate Crime because the 2 brothers had learning difficulties*". This seemed to be the beginning of pressure to view what was happening through a Hate Crime lens, though there was no referral to the THIP (Tameside Hate Incident Panel). Other meetings, where this might have been explored further, were planned for the following few weeks.

5.50 Offenders were identified for some of the incidents, but without the clear evidence for the prosecution of an identified offender, it is arguable that it was irrelevant to identify the incidents as being motivated by hate. The neighbourhood police told the IMR author that they, "*had plans to visit Adult A's mum in the week beginning 16th March to obtain a full statement regarding all the events with a view to building a criminal harassment case*".

5.51 Sadly Adult A died before the plans were put in place.

5.52 The statistics set out in Appendix 4 illustrate the low level of reported disability hate incidents across Greater Manchester, though it is the fastest growing category. There were, however, only 4 incidents for Tameside in 2007/8 and 3 in 2008/9. It is significant that none of those appear to have triggered safeguarding alerts. Given that the research[17] tells us that people with learning disability and those with mental health problems are frequently the target of abuse that could be described as Hate Crime it is evident that the

[16]CPS (March 2010) Disability Hate Crime – Guidance on the distinction between vulnerability and hostility in the context of crimes committed against disabled people

[17] Chih Hoong Sin et alia (2009) Disabled people's experiences of targeted violence and hostility. Office for Public Management on behalf of the Equality and Human Rights Commission

statistics suggest this concept is not well embedded in Tameside or any of the North West authorities.

5.53 The final harassment of Adult A did not lead to a prosecution that included an allegation of Hate Crime. GMP informed the SCR Panel, that, "*both the prosecution barrister and magistrate in summing up referred to the fact that Adult A was targeted by the offender because he was an easy and vulnerable victim. There was no direct reference to the crime being a disability Hate Crime*"

5.54 On its website GMP, describe, "Hate Crime is the most impactive manifestation of unlawful prejudice and discrimination in our society. Hate Crime can have a devastating impact on its victims and the fear of Hate Crime is real and pervasive. Failure to recognise disability Hate Crime when it occurs is the biggest barrier to being able to tackle it. While the criminal justice system and disabled people themselves cannot recognise disability Hate Crimes they cannot be investigated, flagged or prosecuted".

5.55 As stated earlier there are differing views amongst learning disabled adults and organisations that advocate on their behalf, about the value of calling something a Hate Crime. There is recognition that such strong language can have an impact and, if used carefully, may redress some of the imbalance in the Justice system that is seen, on occasion, to be unable and/or unwilling to find ways of ensuring disabled people can exercise their right to justice.[18][19] If this had been done in relation to Adult A it would have "raised the profile of the problem regarding the family, at least to Neighbourhood supervision, if not to the Senior Leadership Team"[20]. Whilst the IMR author is referring to the police service, the same could be said of all the agencies involved with Adult A.

5.56 Some agencies did report that training on Hate Incident/Crime reporting had been available to staff, but all recognised that the low level of consideration in relation to Adult A indicated more and better needed to be provided *and* staff needed to attend.

[18] Disability Now Hate Crime Dossier (November 2010) –www.disabilitynow.org.uk
[19] Scope (2008) Getting Away With Murder -Disabled people's experiences of Hate Crime in the UK –
[20] GMP IMR July 2010

Question 5: Did Adult A suffer disability discrimination in relation to his health? Why didn't he have routine health checks and/or a Health Action Plan? Why were health professionals not involved in professional meetings about Adult A, including the safeguarding meetings in 2007?

5.57 Adult A's mum said Adult A was rarely ill and certainly his GP's records show very little contact with health professionals. He did, however, suffer an early death from diseases that had not been detected and might have been prevented/ameliorated with some life style changes, like stopping smoking and being given appropriate medication.

5.58 He also exhibited some behaviours that probably indicate high levels of anxiety, like biting his hands when he was upset.

5.59 He was recognised by his GP practice as having a learning disability (though only his brother's name was recorded on the Practice's Learning Disability Register). However, there is no evidence that in spite of knowledge of his learning disability and the fact that he was over 60 years of age, he was ever screened for any health risks (high cholesterol/diabetes etc.). On one occasion in 2007 he attended his GP surgery with abdominal pain; it is noted that 'bloods' were taken. There is no recorded follow up, even though his blood showed 'slightly raised levels'. There is no explanation about what this meant but it is recorded that it "should be followed up" after a couple of months.

5.60 His emotional distress was recognised by professionals, and in May 2007, as part of the safeguarding plan, a referral was made by the Adult Services' social worker to the learning disability Psychology Service provided by the Mental Health Foundation Trust. The objective was to give Adult A "an opportunity to talk about his feelings related to the harassment he had been experiencing"[21]. Due to staffing difficulties in the service Adult A was not assessed by a psychologist until November 2008. This delay was described as unusual for the service but it was not dealt with by action to seek an alternative psychology service.

5.61 His eventual contact with the psychologist revealed information that he was also experiencing tensions within his family as well as in the community, which if picked up earlier may have led to more urgency about providing him with appropriate support services, if not specific attention from health professionals to assess and treat his anxiety.

5.62 There have been numerous investigations and reports produced in the last 10 years describing the "evidence of avoidable illness and premature death amongst people with learning disabilities" (DH Valuing People 2001). A report by the Disability Rights Commission (2006), stated, "It is overwhelmingly acknowledged and clear from the evidence that people with learning disabilities and/or mental health problems experienced considerable

[21] IMR MHFT October 2010

inequalities in health, and that it was not acceptable that they died younger than other people and are four times as likely to die of preventable causes as people in the general population". This was again highlighted in the report produced following Sir Jonathan Michael's Inquiry (2008), "There is evidence of a significant level of avoidable suffering and a high likelihood that there are deaths occurring which could be avoided." The Michael Inquiry concluded that there was evidence of some institutional disability discrimination in some health provision.

5.63 The introduction to the 2009 DH document, 'Health Action Planning and Health Facilitation for people with learning disabilities: good practice guidance', sums up the position as follows:

"A succession of reports, including most recently that of Sir Jonathan Michael's independent inquiry, have highlighted some basic shortcomings in the way that services are provided for people with a learning disability, contributing to poorer health outcomes, avoidable suffering and, at worst, avoidable deaths. All NHS organisations, whether as providers or commissioners, have a basic duty to promote equality for disabled people and make reasonable adjustments to the way in which services are delivered to meet their individual needs. This should apply as much to promoting health as it does to treating illness".

5.64 The original Valuing People Plan (2001) set out, amongst other actions, that, **"**All people with a learning disability to have a Health Action Plan by June 2005". This didn't happen though the next stage of the national learning disability strategy in 2008, 'Valuing People Now' reported the numbers of people receiving an annual health check were increasing, with the checks improving understanding of learning disability in primary care.

5.65 The Valuing People Now: The Delivery Plan 2010-2011, 'Making it happen for everyone', identified that in spite of progress few people with learning disabilities access health screening and make particular mention that "research has highlighted inadequate diagnosis and treatment of specific medical conditions, including heart disease, hypothyroidism and osteoporosis".

5.66 A Local Enhanced Scheme (LES) to assist GPs to demonstrate that they were making 'reasonable adjustments'[22] and adopting a more proactive and preventive approach to meeting the needs of learning disabled adults was promoted in 2009. Tameside PCT adopted the LES but not all GPs are part of the Scheme; this was the case with Adult A's GP.

5.67 When an adult safeguarding strategy meeting was held in 2007, no health professional was invited to attend, presumably as the issues identified by agencies were seen as social and community based. The emotional/mental wellbeing consequences for Adult A of what he was experiencing were

[22] Disability Discrimination Act 2005 (now incorporated into 2010 Equalities Act) – "The DDA expects all service providers to take 'reasonable steps' to anticipate the needs of disabled people, not just to react as these arise".

recognised in that he was referred for psychology support. However, when there was a significant delay, there is no evidence that his GP was contacted to see if there were other routes of referral to provide that support. His GP did not make contact with Adult Services or Adult Safeguarding following his visit to Adult A on 12th July 2007 to treat the pain he was experiencing after he was kicked in the chest. When the GP referred the family to Adult Services in early April 2009, it was as a result of Adult A's mum telling him she "*finds it hard to cope with two mentally handicapped adult sons*". The IMR finds no recorded interaction/feedback from Adult Services on this referral.

5.68 Although Adult A might have been "treated the same as all registered patients in terms of access to services and receiving care and treatment from this agency",[23] research evidence and best practice in relation to disability discrimination suggests that he needed a proactive and preventive approach to meeting his health needs. This would have given him a better chance of achieving equal health outcomes in line with non-disabled patients.

Question 6: What did agencies do/what can they do to prevent the 'inheritance' of harassment behaviors by the next generation of young people?

5.69 The number of occasions when reference is made to youths and even very young children harassing Adult A, and the appearance of new names on the list of known tormenters is very concerning. 26 named young people were known to have been involved in, carrying out anti-social acts, tormenting, harassing, and committing crimes against Adult A and his family from 2007-2010. Many of these young people lived in the same neighbourhood as him and his mum believed some of their parents were the young people who had harassed him when they were youths.

5.70 The SCR Panel agreed that it was not within its remit to explore the details of the young people involved with Adult A. It was agreed that the SCR author should seek some general information from relevant agencies about their involvement with young people and whether they had any learning to share with the Panel about how young people could be deterred from the abuse of vulnerable people in the future.

5.71 In his response to the IMR report writer, a member of staff from the Neighbourhood Office, who knew the family and the area well wrote, "The incidents of harassment, crime and disorder suffered by the family were so numerous, and so long-standing that the practice of "taxing" ("tapping"?) Adult A for money or cigarettes was taken up by successive generations of perpetrators. If one cohort of perpetrators was successfully tackled, within weeks another would spring up in its place".

5.72 The two local secondary schools who were contacted for this Review appeared to have an impressive array of educational preventive programmes to inform young people about the importance of respect and equality for

[23] IMR GP/Primary Care June 2010

vulnerable people. School staff, with specific safeguarding responsibilities, described generally good working relationships with partner agencies, particularly the police whose visibility at the school was felt to have a positive impact on young people. It is, however, likely that a number of the young people involved with Adult A would not have been in school to benefit from these positive influences.

5.73 There was a plan at one stage for Adult A's mum to be part of a video project to be shown in schools to explain disability and the issues disabled people faced but it was not pursued for fears that it would make her more visible and lead to more harassment.

5.74 Over the years, a number of youth projects were run by a variety of agencies, including one by the local police officer who knew Adult A's family well. One project had young people provide hands on support at Adult A's home when it needed some sorting out to have some renovation work done. There is no evidence of evaluation of the effectiveness of any of these projects.

5.75 As well as the attention to preventive work, the young people who were identified as perpetrators, received interventions ranging from talking to them, taking them home and talking to their parents, referral to the Early Intervention Group (part of the Youth Offending service), being issued with Acceptable Behaviour Contracts, made subject to ASBOs and in a few instances being convicted of criminal offences for which they received a range of community orders supervised either by the YOT or the Probation Service.

5.76 The Youth Offending Service and the Probation Service described some of the issues of the short term and task focused service they were able to provide for some of the young people who committed offences. The Probation manager, in particular, identified that many of those subject to various community orders supervised by the Probation service were vulnerable people in their own right; many having been 'looked after' (in care) children who still had emotional needs that were not being met. The manager wrote; "The criminal justice system is not equipped to provide support at this level of risk; and the Probation Service is not very well placed to provide support to a partnership in tackling anti-social behaviour. The assessment thresholds (for allocation/intervention) are based on levels of risk of (criminal) harm".

5.77 He believed, "The challenge is to explore how the courts can support communities in tackling prevalent problems though 'Problem-solving in Courts', and how offender managers and community services can better align themselves to ensure that justice is delivered as well as providing support and guidance to vulnerable people".

5.78 Research and experience confirms that people who look different or display certain behaviours will be identified as vulnerable and are more likely to be targeted for abuse or subject to criminal behaviour by others. Many of those who commit crimes against the obviously vulnerable are themselves often

vulnerable for other less visible reasons[24]. This seemed to be the case with the young man who was convicted of harassing Adult A.

5.79 Tameside are involved in redesigning its Early Intervention Services for families and has developed a number of COMPASS teams[25]. The belief is that, "The key to giving children the best chance not to inherit the dysfunctional behaviours of their parents is to engage 'at risk' families and young people in nurturing and empowering activities at the same time as assisting them to improve their financial security. Their objective is to assist families to recognise and build on their own resilience and resources to improve their lives and keep their children safe and happier". Compass teams are made up of a range of professionals, including Youth Workers, YOT prevention officers, Community Safety officers, Family Support workers, Education Welfare, Future Jobs Fund, Early Years workers, Health Visitors, and CAF administrators.

5.80 Some of the agencies working with Adult A and his family and others with similar difficulties felt there needed to be better joint working across the agencies working with young person and those working with adults. The police, in particular, believed that there needed to be more proactive sharing of information. These new Compass team arrangements need to develop arrangements for workers involved with vulnerable adults if the 'Think Family'[26] agenda is to be inclusive of all those who live in the locality.

Question 7: What agency had/should have had lead responsibility for bringing all information together (evidential file) and monitoring and planning? Were there too many agencies involved? Was 'working beyond the job description' an effective strategy?

5.81 There were certainly a lot of agencies involved with Adult A and his family either directly or indirectly because of their involvement with young people.[27] Adult A's mum said she wasn't always sure which agencies people came from, though she was very positive about most of them and some she saw as friends.

5.82 A member of the Neighbourhood office left the service 12 months before Adult A died. The report by the member of staff contained in the IMR shows their continuing frustration and regret that they were not able to solve problems for the family. This member of staff appears to have adopted a lead role in initiating a series of meetings to discuss the family and began to keep an incident file but it is unclear how this was viewed by others, particularly the police. The police IMR author is describing a different sort of file when he is critical that an 'evidential file' was not created to build a harassment case.

[24] Time for a fresh start -The report of the Independent Commission on Youth Crime and Antisocial Behaviour (2010)
[25] See www.tamedside.gov.uk and the report from Sinead Brophy Consultants for more information
[26] SEU (Social Exclusion Unit) Taskforce (2008b) *Reaching out: think family*, London, Cabinet Office.
[27] See appendix 3

5.83 The author of this SCR believes that the separation of the incidents, involving Adult A and his family, into two classes would have helped to identify the need for two people to lead the information gathering, assessment, and analysis of what was happening and to develop an effective action plan. One would likely need to be from Adult Services, with a concentration on Adult A's human rights and his needs for protection including ensuring all safeguarding issues were referred regularly to the Safeguarding Team so that the whole picture was being collated. The other, possibly from a Neighbourhood or Community Safety Service would concentrate on the targeting of the family home and neighbourhood issues. The overall leadership and monitoring of the action plans would need to be a senior person with safeguarding responsibilities, preferably from the police, as this was fundamentally a criminal justice issue rather than a social care issue. Oversight, organisation of meetings, and monitoring of action plans should have been firmly located within the multi-agency safeguarding service.

5.84 These arrangements could have provided greater clarity of contact for Adult A's mum and for the neighbours and a personal focus on Adult A's needs. This focus would also have likely prompted escalation to more senior decision makers.

5.85 Safeguarding is everyone's business but without clear leadership and clarity of task and a focus on protecting the individual, it will not receive the time and skill needed from busy agencies to resolve the problems.

5.86 It seems unfair to criticise people for working beyond their job description but it does suggest an environment where people became increasingly frustrated by their lack of power to make real changes, and developed a propensity to mirror Adult A and the family's feeling of helplessness. This can lead to an inability to see the whole picture and think strategically. In the need to feel that they are 'doing something to help' people can easily become drawn into the everyday hands on tasks.

Question 8: Did Adult A ever have a holistic risk assessment that included looking at the protective factors in his life and was his risk to others ever assessed?

5.87 The evidence from the psychologist of the potentially risky dynamics in the family was presented towards the end of the SCR Panel meetings. This was not surprising information but it is concerning that it was either unknown or unrevealed by other agencies.

5.88 There was evidence and suggestions that Adult A's behaviour was sometimes seen as risky to others. In the latter part of 2007 there seemed to be an increasing focus on his behaviour and how it made a 'contribution' to his harassment problems. References are made to him 'egging lads on', taking retaliatory actions, and shouting without provocation, urinating in the garden, following lads, and looking through a window into a school classroom. He is also banned in April 2007 from one of his favourite places, the local betting shop, and in September 2007, after a meeting with the

Housing Association he receives a letter, which to all intents and purposes is an Acceptable Behaviour Contract. This includes an agreement to not go out after dark.

5.89 There are no assessments of Adult A's risk to others or any suggestion that he had the capacity to understand an acceptable behaviour type of contract.

5.90 There are no overt references in assessments to Adult A's sexuality but this is an issue for many adults with learning disabilities. He suffered the, often reported in research reports, 'paedo' taunts.

5.91 There does not appear to be any assessment of Adult A's risk to others. The reason why a neighbour barged into the family home thinking Adult A was hiding his son is never explained but could be concerning. The Adult Services IMR author was unable to locate a fully completed risk assessment on Adult A's file. If there is no risk assessment then it is difficult to develop a shared risk management plan.

5.92 As well as identifying risks, a good assessment also looks at protective factors in the person's life and a good risk management plan would build on those protective factors. Wider family supports are seen as a strong protective factor, but other than one relative, the family appeared to have no involved wider family. It seems clear that mum had been a capable 'coper' but her physical abilities were declining; this did not appear to trigger a formal assessment of her needs as a carer for her two learning disabled sons. Some of the neighbours were supportive of the family but others were hostile on occasion and the family could be seen as becoming more isolated and barricaded in with fencing and CCTV. It is unsurprising in those circumstances that there were growing tensions within the family.

5.93 If all the risks for Adult A and for the family had been identified and a balance sheet created by looking at their very few protective factors, the starkness of their multiple vulnerability would have been exposed. It could have easily been mum who died and it is possible that Adult A could have accidentally harmed another person but these possibilities were not assessed.

Question 9: Was there an acceptance by all including the family that 'this is how it is for disabled people' particularly living in a poor community?

5.94 A member of the Neighbourhood Office writes, "The harassment and criminal behaviour was acceptable for some local residents, and so commonplace that a few others ignored or excused it; a terrible stain on the reputation of the majority of decent residents. To the family also, this was normal, they were subjected to so much abuse that they learned to tolerate all but the worst. To the extent mum only called the police when things escalated beyond a certain point, e.g. If once again, she was showered in broken glass".

5.95 The psychologist also notes that, “Many vulnerable people are housed in areas where other residents have issues. This can often lead to harassment from the community due to prejudice and misunderstandings regarding people with learning disabilities”.

5.96 In spite of all the incidents Adult A’s mum was prepared to continue to live in the same house and it was significant that it was her increasing inability to climb her stairs that prompted her application to move in early 2010.

5.97 The Research for the Equality and Human Rights Commission drew attention to significant under-reporting of crimes and abuse of disabled people. They identified that there were several reasons for this, including: “Disabled people may blame themselves for what had happened to them, or may simply come to accept that these incidents are part of everyday life”.

6. Conclusions

6.1 In reaching my conclusions and in formulating recommendations in discussion with the SCR Panel, I have considered all the available information that is specific to the family. I have trawled for relevant policy and research information; drawn on my professional experience; consulted professional colleagues with expertise in the area of learning disability, safeguarding, young offenders, and anti-social behaviour. I have also examined the very limited information available on similar Serious Case Reviews.

6.2 There are a number of Summary Reports of SCRs, that describe cases where there has been harassment, torture, and murder/manslaughter of adults with learning disabilities. In Adult A's case, the police and medical findings were that he was not killed by any other person. He was tormented, harassed, and assaulted on numerous occasions but his history does not bear the same hallmarks of the lives and deaths of Steven Hoskins or Brent Martin[28], who were brutally murdered. Unlike those two men, Adult A was living with his mother and brother, and was 'looked out for' by numerous local people and professionals working in his locality.

6.3 One SCR that involved the deaths of a mother and her disabled daughter, (Fiona Pilkington and Francesca, her daughter[29]) has also been linked with Adult A's death. The similarity here is the anti-social behaviour that occurred at/near the family home, which was judged by some to be targeted at the family because of their disability/vulnerability. There appear to be some features in common: the persistence and impact of anti-social behaviour and how it is dealt with by multi-agency staff in communities; consistency of identification of vulnerability; holistic risk identification and management; and the importance of making safeguarding alerts. There are also some significant differences[30]: the circumstances of the deaths (murder and suicide in the Pilkington deaths); Adult A's age and the fact that he was an independently mobile and active person, who had been in paid employment for a number of years; neighbourhood/community, police and adult services as well as other agencies were actively involved with the family; substantial physical barriers and detection equipment had been installed to protect the family home and deter the perpetrators; Adult A's mum spoke positively about some of the help she was given; and the family were offered the opportunity to move. I will, however, make some link with the recommendations of Pilkington SCR in the recommendations section of this report.

6.4 The key questions are whether Adult A's death was predictable and was it preventable.

[28] See www.cornwall.gov.uk- For Steven Hoskins SCR –there is a published SCR report but the author was unable to find one for Brent Martin but see www.disabilitynow.org.uk
[29] www.leics.gov.uk –Summary of SCR relating to A and B.
[30] It is not possible to be definite about this as the full SCR is not published and the Summary is brief.

Predictable?

6.5 Adult A possessed a number of characteristics that statistically would have predicted that he would have an early death. He had learning disabilities and research indicates that the average age of death for a man with learning disabilities is significantly lower than for the non disabled population.

6.6 Adult A was a smoker, which is a high risk factor for lung cancer and heart disease, which are associated with reduced life expectancy. His possession of cigarettes was critical to his visibility to children and teenagers i.e. it was a significant factor in his targeting but it was also his means of attempting to make friends. People give relief of stress as one of the reasons they smoke so if this applied to Adult A it set up a vicious circle: smoking brought on the causes of some of his stress for which it also gave some relief.

6.7 Adult A also lived in an area of high statistical risk; in social housing on an estate in a deprived area that is in the bottom 5% in England for deprivation. Typically, males in Tameside die nearly 2 years younger than the average for the rest of England. Death from heart disease is particularly high[31].

6.8 He suffered physical and extensive emotional harm over many years. In spite of the best efforts of his mum, public agencies and active concerns from a range of individuals, the targeted abuse of him in his neighbourhood and at his home was persistent and intermittently intense from at least 2006 to his death in 2010. Whilst, according to agency records, the frequency of incidents appears to have waxed and waned, the incidents never went away. On an occasion when his mum told the psychologist that the incidents had decreased he disagreed with her i.e. the reduction may have been illusory, at least as he experienced life.

6.9 The events on the day of Adult A's death were a 'normal' experience for him and better than many days when he had been robbed and/or assaulted. Adult A's mum said he had been with his brother watching his favourite football team on TV shortly before he went out into the garden where he died.

6.10 There is no validated research that proves a direct relationship between stress and the development of early heart disease. The Pathology report[32] on Adult A refers to a combination of a heart attack (50% furring of one of his arteries to his heart) and a small cancerous tumour at the junction of his oesophagus and stomach. The pathologist stated that the stress of the harassment could have exacerbated the (medical) issues but he could not confirm this was the case.

6.11 As agency concern began to build up again about the harassment at Adult A's home at the beginning of 2010 a multi-agency Community Safety Theme Group was convened. In that meeting a local resident representative said she "*was concerned that if something wasn't done there would be a death in the family".* Some care should be exercised in interpreting this statement with the

[31] Health & Deprivation in Tameside –PCT Annual Report and Public Health Report 2008/9
[32] This information was provided by GMP

gift of hindsight. It encompassed his mum as well as himself, and it seems most likely that the concern hinged on physical harassment or violence and not what actually happened. In short it was not a significant prediction on which action could be based.

6.12 Agencies were concerned well before 2010 that something serious would happen and were taking action. The family home had begun to resemble a fortress with high fencing and CCTV. Adult A was being kept in more frequently to try to protect him and no doubt to minimise allegations that were made by some local people who witnessed his behaviour, that he was 'egging lads on'.

6.13 In mid 2009 Adult A began to receive a more personalised support service to get him out of the house in the day time. After some initial difficulties this developed well and he was described as very happy with the support he was receiving to play pool and go bowling.

6.14 Agency chronologies record concerns about Adult A's mum, given her age and health problems and on at least two recorded occasions she was out of breath when reporting incidents at the house and on one occasion an ambulance was called.

6.15 What is surprising is that Adult A rarely seemed to be ill enough to seek medical support. There is no evidence that he received any routine medical checkups, primary health care screening or had a Health Action Plan. These might have identified his underlying health problems and possibly given him access to smoking cessation support.

6.16 I conclude that:

- Adult A's early death was predictable on general statistical grounds. His deprived environment, his learning disability, his smoking (the health implications and the negative transactional value of the cigarettes) and his undetected and, therefore, untreated health problems all put him at risk of early death. Whilst there are lessons to be learnt about how these health problems might have been prevented and/or detected by agencies adopting a preventive health approach with Adult A, deficiencies in his health status or oversight were not the impetus for conducting this Serious Case Review;

- There were no atypical events (for Adult A) on the day of his death that may have led to it being predicted; and

- There is no evidence that harassment *causes* death and it is likely that when it was said three weeks before his death, "*there will be death in the family*" it expressed a general concern for all its members.

Preventable?

6.17 Could agencies have done more to prevent Adult A's early death?

6.18 There is no dispute that the family were regularly offered the opportunity to apply for a house move. When a move was rejected agencies responded to the vulnerability of the family home and local environment by providing better lighting, installing CCTV equipment in the locality and the house, and building more and higher fences at the house. Whilst there is some criticism of the quality, effectiveness and sometimes delay in installing/maintaining these technical solutions, the evidence supports the conclusion that agencies were active in their attempts to protect the family.

6.19 Certainly from 2007 onwards police and patrollers attended the area regularly in both a preventive role and in response to incidents. Meetings with neighbours took place and they were given information and supported to report incidents, though sometimes this was inconsistent.

6.20 A house move may have decreased harassment at the family home. However, if the family was to move to a similarly deprived locality and Adult A continued to behave and interact with young people as he did, it is not obvious that a move would have materially lessened or prevented the problems. Arguably it would have had negative consequences for the complex family dynamics as collectively, they did not want to move.

6.21 Adult A spent 13 years in continuous paid employment. Research indicates that work in itself is a protective factor. Additionally Adult A was employed in a setting where he was valued, *protected* and regarded as "a gentleman" - albeit by women colleagues who were known to "mother" him. The loss of this employment towards the end of the 1990s was significant in Adult A's life and circumstances. He had less structured days and became accustomed to spending more time in the family home and in his neighbourhood. We can speculate that attentive and benign colleagues no longer satisfied his yearning for friendship, and tragically, Adult A sought the company of those with whom he identified – young people. Part time voluntary work was made available to him but as his mum said, "*there never seemed another job that suited him*". Adult Services did arrange some support for Adult A to access 'drop in' services when he stopped attending his voluntary work. It is important to remember that Adult A was reaching pensionable age and would not have been regarded as a priority for paid work.

6.22 Adult A's at risk situation was recognised on many occasions, although only 1 alert was made to the Safeguarding Adult's Team in 2007 and the protection process was not consistently followed through and did not include assessment and intervention from health professionals, other than from a psychologist in the later part of 2008.

6.23 In the later part of 2009 Adult A had a specialist learning disability social work assessment and began to receive a more bespoke service enabling him to get out with a support worker and enjoy his preferred activities. It is noticeable that there were no direct attacks recorded on Adult A in 2009[33], though the harassment at the house continued.

[33] GMP police officers also believed his barring from the local betting office meant he spent less time in the shopping precinct.

6.24 I conclude that:

- There were some delays but no significant failures by agencies within their areas of responsibility and from their single and multi-agency perspective of the problem based on the information available to them.

- It is questionable that a house move would have had a material impact on outcomes over the long run.

- It seems likely that the biggest contributor to Adult A's early death was his general health, and undetected heart problems, and that his smoking habit was a significant component of these health problems. This was not, however, only a health issue. The evidence suggests that cigarettes were the currency used in the transactions between him and the youths who harassed him (Adult A at times offering and the youths at times demanding cigarettes). For these reasons probably the most effective risk reduction measure would have been to assist him to stop smoking.

6.25 One of the added sorrows of what happened to Adult A is that many of those who assaulted and targeted him, and tormented and harassed his family, share many of features that put him at risk[34]: they lived in a deprived area and a few were already identified as vulnerable as a result of family circumstances, exclusion from school, homelessness, and lifestyles that included smoking.

6.26 Agencies did work singly and together to try to divert these young people from their anti-social behaviour. They increasingly took more proportionate and focused action against the young people, though as new cohorts of tormenters appeared this must have been experienced as a hopeless task.

6.27 There are many lessons to be learned from this SCR and the recommendations that follow will hopefully provide the impetus for that learning to be embedded in practice. It is to be hoped that the significant commitment shown by agencies in carrying out this Review will achieve positive change. The collection of substantial amounts of data, the effort to shape it into information, and the drive for this to be transmitted as knowledge, which leads to greater wisdom[35] should be the key objective of carrying out an exercise like this.

6.28 Most of the organisations that contributed to this Review appropriately identified some of ways they were planning or had already begun to bring about improvements. They were using the learning from their internal Management Reviews to improve their responses to similar situations.

[34] "The deprivation that created the perpetrators is characterised by damaged childhoods, poor parenting, alcohol abuse, violence, and despair. In many ways the harassment of the family is ultimately a story of deprivation and it was no co-incidence that it occurred in one of the most deprived places in England". Staff member of the neighbourhood office in their evidence to the IMR author.

[35] Neil Fleming (2008) Knowledge Management-Emerging Perspectives www.systems-thinking.org

6.29 It is to be hoped that the learning from this Review will go some way to ensure that vulnerable people have greater opportunities to have their human rights respected and live 'a life like any other'[36] person.

[36] A Life Like Any Other? Human Rights of Adults with Learning Disabilities Seventh Report of Session 2007–08 www.bild.org.uk/humanrights/docs

7. Recommendations

These recommendations pick up the key learning points from this Serious Case Review identified in IMR reports and in the Findings and Analysis Section of this Overview Report[37].

Local Policy and Practice

7.1 Training and Learning

In common with many recommendations from SCRs, the need for training in a number of areas was raised by most IMR authors. Training is only effective in improving services if the right staff undertake the training, it is appropriate for the audience, and it promotes solution focused learning that leads to improved practice.

Recommendation 1

TASP should review, within 3 months of the publication of this SCR, its training programme to ensure all staff from public and independent sector agencies coming into contact with adults who may be vulnerable are offered:

a. Information and training with and about adults with learning difficulties/ disabilities, including discussion of the evidence of discrimination against disabled people, and the range of responses to incidents and relationships that may increase vulnerability in certain situations.

b. Information, simple 'tools', and practice opportunities to assess risks faced by adults who may be vulnerable, and enable staff to identify and build on protective factors, and make person centred interventions that reduce and/or manage the risks to the individual.

c. Information and guidance on use of the Equality Act 2010 with particular emphasis on protection from harassment related to disability.

d. Information and practice opportunities to identify Hate Crime in an environment that enables staff and disabled people to learn together and to explore the complexity but also the potential of using the term Hate Crime to achieve just outcomes for disabled victims of crime.

e. Further awareness raising on making safeguarding alerts, using experience from this SCR to demonstrate that repeat incidents of abuse should be reported to the Safeguarding Team.

[37] Through the IMR process each agency has identified individual recommendations for its own service and will develop individual action plans.

f. Regular updates on relevant research and how to use the learning in practice.

g. Training in all areas that is case and practice based and includes attention to the safeguarding issues arising from persistent anti-social behaviour[38] and enables multi-agency staff to consider how they can work together to risk manage their collective decision making including when to escalate concerns to more senior decision makers.

7.2 Information collection and communication

A number of agencies collected extensive data about incidents involving Adult A and his family. There was, however, no common system for electronic collection, collation, and analysis of data, and most agencies were unaware of the number and variety of the incidents involving Adult A. Meetings were held to share information and make plans, but analysis of the issues and consistency and urgency of action were sometimes lacking. There does not seem to have been a general unwillingness to share information, but there was some inconsistency in who attended meetings, particularly from agencies involved with young people.

Recommendation 2

In light of the finding that many staff were surprised at the number and type of incidents involving Adult A and his family, TASP should require all Partnership agencies to review their data collection processes and the sharing of information about neighbourhood anti-social behaviour and harassment incidents. They should report their improvement plans back to the Board within 3 months of the publication of this SCR Report. Specific additional recommendations are that:

a. Whilst there was some understandable, evidence based, scepticism from the Panel that an electronic multi-agency data system could be operated across the relevant agencies, the plan initiated by GMP to achieve a web based system should to be supported and evaluated by all agencies involved with anti-social behaviour in Tameside.

b. GMP, Community Safety, agencies working with young people and housing providers involved in neighbourhood meetings should be clear about their agenda and purpose, and assess their effectiveness in taking solution focused action. Attendance should be consistent from all agencies including those working with actual or potential offenders.

c. Meetings to discuss the protection and support needs of individuals and families should be confidential and information only shared on a 'need to know' basis.

[38] A similar recommendation is made in the Pilkington SCR

d. GMP should provide leadership in building an 'evidential file' where individual incidents are rated low risk but persistence is identified, taking into account the requirements of the 2010 Equality Act in relation to disability harassment.

7.3 **Technical and physical solutions to protect individuals and communities at risk.**

Some agencies gave a great deal of attention and financial resource to provide equipment (CCTV and fencing) to protect the family. It is evident that this was not always 'fit for purpose', and arguably had negative unintended consequences for the family.

Recommendation 3

Before installing any equipment all agencies with community safety responsibility should agree a plan, that identifies the outcomes required from the technical equipment/barriers, responsibility for the financial and ongoing maintenance costs and responsibility, a review timescale and prompt action if the plan is not working, and consideration of unintended negative consequences.

7.4 **Prevention and health services involvement in safeguarding**

Adult A was found to have ischaemic heart disease and adenocarcinoma of the oesophagus on examination after his death. He was rarely ill but he was a smoker. Some of his behaviour also demonstrated a high level of anxiety. There is, however, no evidence that he received proactive health screening and his identified emotional needs were not given urgent attention. Adult A's GP was not invited to any safeguarding discussions and did not make a safeguarding alert even though he was aware of pain caused by an assault on Adult A. He did make a referral to Adult Services following concerns raised by his mum about her continuing ability to cope, but there is no evidence that he was kept in the picture.

There was a very significant and unacceptable delay in Adult A being seen by the specialist learning disability psychology service; although it was clear that, he was anxious and disturbed by what was happening to him.

Recommendation 4

The PCT, within 3 months of the publication of this SCR, should use the findings of this Review to issue guidance to General Practitioners and other health providers of their responsibilities under the Equality Act 2010 (formerly DDA 2005). They should encourage full participation by Primary Care providers in the Direct Enhanced Scheme[39] for people with learning disabilities. The PCT should also ensure the provision of psychology services is sufficient to meet the needs of vulnerable adults. In particular, health professionals should:

a. Be mindful of the findings from research about the health inequalities experienced by learning disabled adults and ensure all services make reasonable adjustments to ensure equal access to health services, including preventive health measures.

b. Encourage learning disabled adults to have health checks.

c. Develop Health Action Plans with individuals and family/supporters as appropriate.

d. Encourage and assist disabled adults to adopt a healthy life style including stopping smoking.

e. Assess learning disabled adults emotional/mental health needs and ensure timely and effective interventions.

7.5 **Eligibility for adult care services – and the relationship of social care support services with safeguarding.**

Adult A was known to Adult Services, received assessments, was referred for employment/day activity support, and had intermittent involvement from a social worker in the AACCT team; but he did not have a consistent specialist learning disability social worker allocated to him until the middle of 2009. In spite of all the incidents of harassment and assault, only 1 alert was made by any agency to the Safeguarding Team in April 2007. The understanding of Fair Access to Care criteria (FACs) is generally poor outside adult social care agencies and not always fully understood within them, particularly for adults who have low personal care needs but high needs for protection.

[39] Successor to the Local Enhanced Scheme –see Section 8.5, paragraph 12 of this Report.

Recommendation 5

TASP should require that within 3 months, Adult Services review, and if necessary, amend its guidance on FACs and how this relates to adult safeguarding. Guidance to staff in all agencies and to the public should be clear:

a. That adults who may be vulnerable and in need of safeguarding and, therefore, eligible for assessment for community care services, can access support to have their protection as well as their personal care needs met[40].

b. That social work/care coordination support is a service and may be needed on a long term basis where risks cannot be managed consistently.

c. Where abuse continues to take place alerts should be made by any agency to the Safeguarding Unit even when a member of Adult Services' staff is actively involved with a service user.

d. Cases should not be closed to social workers/care coordinators where protection issues continue even when service providers are involved.

e. Adult Care and partner agencies should adopt 'a case finding' approach to identify other individuals who may be in/at risk of similar circumstances to Adult A, particularly where there are older carers who may have diminishing capacity to protect their disabled son or daughter.

7.6 **Safeguarding and Leadership**

Adult A was at risk when he was alone in the community. He and his family were at risk when they were in their own home. There were 90+ recorded incidents in a 3 year period that could have been reported as safeguarding alerts for either Adult A and/or other family members but only 1 alert was made.

The agency with lead responsibility for safeguarding the members of this family was unclear, though it appears to have been assumed to be local Neighbourhood Partnership. Recommendation 7.5c above picks up some of the issues about making safeguarding alerts.

Recommendation 6

[40] A similar recommendation is made in the Pilkington SCR

When abuse is persistent and responsibility for safeguarding is shared by a number of agencies, a lead professional should be identified as having the overall safeguarding responsibility to ensure protection plans are being actioned; regular monitoring is taking place; and where protection is not being achieved concerns are escalated to senior managers in all relevant agencies.

7.7 Assessing and managing risks

The purpose of risk assessment is not to limit individual freedoms but to identify where individuals and communities may need extra support and how that can be provided in a way that reduces and/or manages the risk. Whilst some agencies used formal risk assessment processes, there is no evidence that these processes came together in a consistently effective way to manage the risks to Adult A of threats, robbery, and assaults, and the risks to the whole family as a result of targeted anti-social behaviour. There is some evidence that risk assessment documentation was not always complete and risks were not always effectively communicated to partner agencies.

Recommendation 7

TASP should establish a Task and Finish group to review the assessment processes of key agencies, identify gaps and significant differences and develop a common process and tool to assess and manage risk-using learning from MAPPA and MARAC developments. This work should be completed within 6 months of this SCR Report being published[41].

7.8 Adult and children's' services interface

There has been some contribution to this Review from agencies working with children and young people. Many young offenders are living in vulnerable circumstances. It is vital that all agencies focus on the prevention of future offending and ensure equal outcomes from the criminal justice system for disabled people.

Recommendation 8

TASP should hold an event, within 3 months of the publication of this SCR, to bring local residents and professionals together to share the learning from this SCR, with a particular focus on how all can work together to stop the inheritance of the behaviour that created so much torment for Adult A and his family. In addition, all agencies should consider restorative justice approaches for offenders.

[41] There has been a start on this in the new ASBRAC process

7.9 **Advocacy and communication support to abused people to seek justice**

There is evidence that Adult A received some advocacy support; the exact purpose was unclear but seemed focused on supporting him to access community activities. It is also unclear why Adult A did not want to identify his assailants or appear as a witness in court proceedings.

Recommendation 9

Agencies who commission services should be clear about the purpose of service provision. Advocacy and communication support services should be commissioned to work with individuals to enable them to act as witnesses and provide good evidence that can be used to gain justice for them.

7.10 **Learning from the Process of conducting this first Serious Case Review**

The SCR Panel has worked well together and with the Chair and author of this report. There is some learning to be done about double-checking the involvement of all agencies at the beginning of a Review as this led to some delay in this instance. There is also learning about the scoping of such a large review involving many agencies over a long period of time that has proved a challenge to the report author and has led to some delay.

Recommendation 10

TASP should review, within the next 6 months, the SCR Policy and Procedure to ensure learning about the process of this Review is captured in Policy and Procedure updates.

7.11 **National Policy**

Review of Hate Crime; application and definition

The Equality and Human Rights Commission is currently calling for evidence on the low reporting of Hate Crime and the use of current legislation.

Recommendation 11

The findings of this SCR should be reported to the Equality and Human Rights Commission review, noting the difficulties that experienced and committed staff have in using the concept of Hate Crime in their everyday work and when prosecuting an offence of harassment against a learning disabled person.

Appendix 1

Terms of Reference for SCR
Tameside Adult Safeguarding Partnership (TASP)

1. The purpose[42] of the Serious Case Review (SCR) concerning Adult A is to establish whether there are lessons to be learned from the general and specific circumstances that surrounded his death in March 2010. TASP is keen to learn whether organisations, both statutory and independent, which had involvement with him, could work better together to safeguard and protect the welfare of vulnerable people who display needs and difficulties similar to those presented by Adult A.

2. The SCR will focus on how lessons learned from this case will be acted upon within individual organisations and by Tameside Adult Safeguarding Partnership, and how identified actions can lead to better interagency work on safeguarding.

3. In addition to learning about this case, TASP also wishes to use this SCR to learn about how to conduct effective SCRs in the future.

Terms of Reference

4. The scope of the SCR will cover the period from January 2004 to Adult A's death on 10th March 2010. Only significant events relevant to Adult A's status as a vulnerable adult will be considered up to January 2007. There will be a more detailed examination of his circumstances from 1st January 2007 to his death.

5. This SCR will specifically examine:

    a. Whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Adult A.

    b. If there were ways, agencies could have worked more effectively to safeguard Adult A.

    c. If agencies could have communicated and shared information about Adult A's circumstances more effectively.

    d. If this case raises any general concerns about difficulties in information sharing and communication in safeguarding.

    e. If there were legal routes that could have been taken by any of the agencies that would have had an impact in relation to safeguarding

[42] Purpose of an SCR "All those involved in an SCR should focus on the depth of the learning the review provides and the quality of recommendations that will protect vulnerable adults in the future" (Based on 2010 Ofsted guidance)

Adult A.

f. If there were any policy gaps that impacted on the safeguarding of Adult A or on the action taken by the agencies.

g. If there are any specific learning points about housing policies and practice for vulnerable adults.

h. If there are any specific learning points about community safety and policing policy and practice in relation to vulnerable adults.

i. If there are any equality and diversity issues that have impacted on the safeguarding of Adult A.

j. If there were any culture, status or reputation issues that impacted on the safeguarding of Adult A.

This SCR will also:

k. Make recommendations to improve inter-agency working and to better safeguard vulnerable adults.

l. Identify any preventative strategies TASP could adopt or encourage agencies to adopt to reduce or eliminate similar safeguarding incidents.

m. As this is the first SCR conducted by TASP under these procedures this review will test out whether TASP's new SCR process and procedures are 'fit for purpose' and make recommendations for improvement.

6. Information will be collated from the Individual Management Reports (IMRs) from the agencies listed in point 12 below and analysed by the Panel and Overview Report Author.

7. The SCR Panel will review and amend these Terms of Reference as required during the course of the SCR and agree any amendments with the TASP Board.

The Panel

8. TASP Board has commissioned an independent author of the Overview Report and independent Chair of the SCR Panel.

9. The Panel will be made up of:

Independent Chair
Safeguarding Adult Co-ordinator
Community Services - Adults
Greater Manchester Police
Victim Support and Witness Services
Primary Care Trust
Mental Health Foundation Trust
Housing strategy
Community Safety Unit
Housing Association

10. The Panel reserves the right to invite an expert to a Panel meeting/seek expert advice if required as identified during the process.

Individual Management Reports

11. The following agencies have been invited to contribute to the SCR by submitting Individual Management Reports (IMRs):

Greater Manchester Police
Victim Support and Witness Services
Housing Association
Community Safety Unit
Neighbourhood Partnership
Acute Foundation Trust
Primary Care Trust
Hate Incident Panel
Community Services – Adults

13. The IMRs should ideally be carried out by someone who was not directly concerned with Adult A or his family, or the immediate line manager of the practitioner/s involved. Where this creates difficulties, particularly for smaller organisations, they should make this clear in their IMR and document their efforts to provide some independence/challenge into their review process.

14. All IMRs should be completed in the format (template) provided.

15. All IMRs must include a full chronology of significant events in the format provided.

16. The SCR Panel Independent Chair will inform in writing and in person Adult A's family that this Review is taking place. A person agreed by the Panel and whom the family to make this contact trusts will accompany her. Adult A's family will be invited to share their views with the Panel Chair and have those views represented in the Overview report.

Timetable

17. All identified agencies will be invited to produce an Individual Management Report to reflect their involvement with Adult A in brief from January 2004 and in more detail from January 2007 until his death.[43]

18. All IMRs must be submitted to the Safeguarding Adults Co-ordinator electronically by 30/06/10.

19. All agencies submitting an IMR will have the opportunity to present their findings to The Panel on 8th July 2010.

20. The Panel will, having considered the IMR's and taken account of the agencies presentations agree the main themes for the SCR report and advise the report writer.

21. The final Draft Overview Report will be available for all agencies to comment on inaccuracies week commencing 27/09/10 All agencies will have 7 days to notify or any inaccuracies or concerns.

22. The Final Overview Report will be circulated to all Safeguarding Adults Board Members week Commencing 04/10/10. Adult A's family will also be notified of the key findings.

23. An extraordinary Safeguarding Adults Board meeting will be convened on 19/10/10 for the Overview Report to be presented by the independent chair and author, for the Board to discuss and for commitment to implementing the report's recommendations to be agreed.

24. Once the report has been presented to the Safeguarding Adults Board:

- All agencies involved with the SCR will debrief their staff
- The Communication plan will be initiated
- An executive summary will be produced
- The report will be presented to the key agencies
- The action plan will be monitored by the Safeguarding Adults Board until it is completed.

Communications plan

[43] It is recognised that not all agencies will have long or detailed involvement with Adult A.

25. All public or media enquiries will be managed by the Local Authority and Greater Manchester Police. All agencies, statutory, voluntary, and independent, should re-direct any enquiries to the Council Communications Team. An Executive Summary of this SCR will be published on the Council website.

26. The action plan will identify how all agencies should report the SCR through their respective governance routes.

Other issues

27. **Parallel Investigations**

The SCR Panel is aware of potentially 3 parallel investigations/processes that could impact on this SCR; a criminal investigation, a complaint referred to the Independent Police Complaint's Authority (IPCA), and a Coroner's Inquest. Initial contacts have been made with the relevant people and agreement about open communication sort. There is currently (April 2010) no objection from any agency to this SCR being started.

28. **Legal Advice**
The Safeguarding Adults Board and The Panel will take legal advice where it is required.

29. **General Advice**
General advice on TASP's Serious Case Review procedure will be available from the Safeguarding Adults Co-ordinator.

30. **Other Local Authorities**
At the time of agreeing these Terms of Reference there are no other Safeguarding Adults Boards with an interest in the person who is the subject of this SCR; therefore, no formal notification to other Boards is required.

However The Panel will keep this decision under review and will notify other Safeguarding Adults Boards of this SCR if it becomes evident they have an interest in this review.

These terms of reference have been agreed by TASP Serious Case Review Panel and the Chair of TASP Board on 20/04/10

Appendix 2

How this Review was carried out

1. This was the first Serious Case Review (SCR) of an adult carried out by Tameside Adult Safeguarding Partnership (TASP) under its Adult Safeguarding Procedures.

2. The full terms of reference for this SCR can be found in appendix 1 to this Report.

3. A SCR Panel was set up with representation at a senior level from all the statutory agencies on the TASP and from the Victim Support and Witness Service and the relevant Housing Association.

4. It had been decided by TASP to appoint an independent person, experienced in adult safeguarding, and contracted as the independent chairperson of an adult safeguarding board in a North West authority, to chair the Panel, and write the Overview Report.

5. The Panel agreed that relevant organisations would be asked to carry out an Individual Management Review (IMR) and submit a report and a chronology of their involvement with Adult A from January 2004 to his death on 10th March 2010. Only significant events relevant to Adult A's status as a vulnerable adult were to be considered and detailed in a chronology up to January 2007. A more detailed examination and recording of Adult A's circumstances was requested from 1st January 2007.

6. Once Independent Management reports had been completed, it was evident that some agencies had known Adult A for many years but there was nothing to suggest a longer period of detailed investigation would have added anything to the learning from this Review.

7. The following agencies were invited to contribute to the SCR by submitting reports of their IMRs.

    - Greater Manchester Police
    - Victim Support and Witness Service
    - Housing Association
    - Community Safety Unit
    - Neighbourhood Partnership
    - Acute NHS Foundation Trust
    - Primary Care Trust (including GP & NHS Community Provider Service)
    - Hate Incident Panel -
    - Community Services – Adults

8. After submission of the original group of IMRs, the Mental Health NHS Foundation Trust was asked to complete an IMR as it became evident that the Foundation Trust learning disability psychology service had some contact with Adult A during the relevant period.

9. There was also discussion about how the Panel could capture some of the lessons that could be learned from organisations that were involved with

some of the young people who had been involved in tormenting Adult A. The Chair agreed to communicate with the two local secondary schools, the Youth Offending Service, Probation Service, and the Youth Service to discuss how they might contribute to the learning from the SCR.

10. There was discussion about getting in touch with neighbours and members of the local community but the Panel agreed that this should take place after the Review and would form a recommendation in the Review report for future action.

11. The SCR Panel agreed early in the Review that Adult A's family would be approached to see if they were willing to contribute to the Review. Adult A's mum was very willing to be involved and his brother also participated. The Chair of the SCR Panel visited the family in the early stage of the Review and the information and views they provided are reflected in Section 3 of this Report.

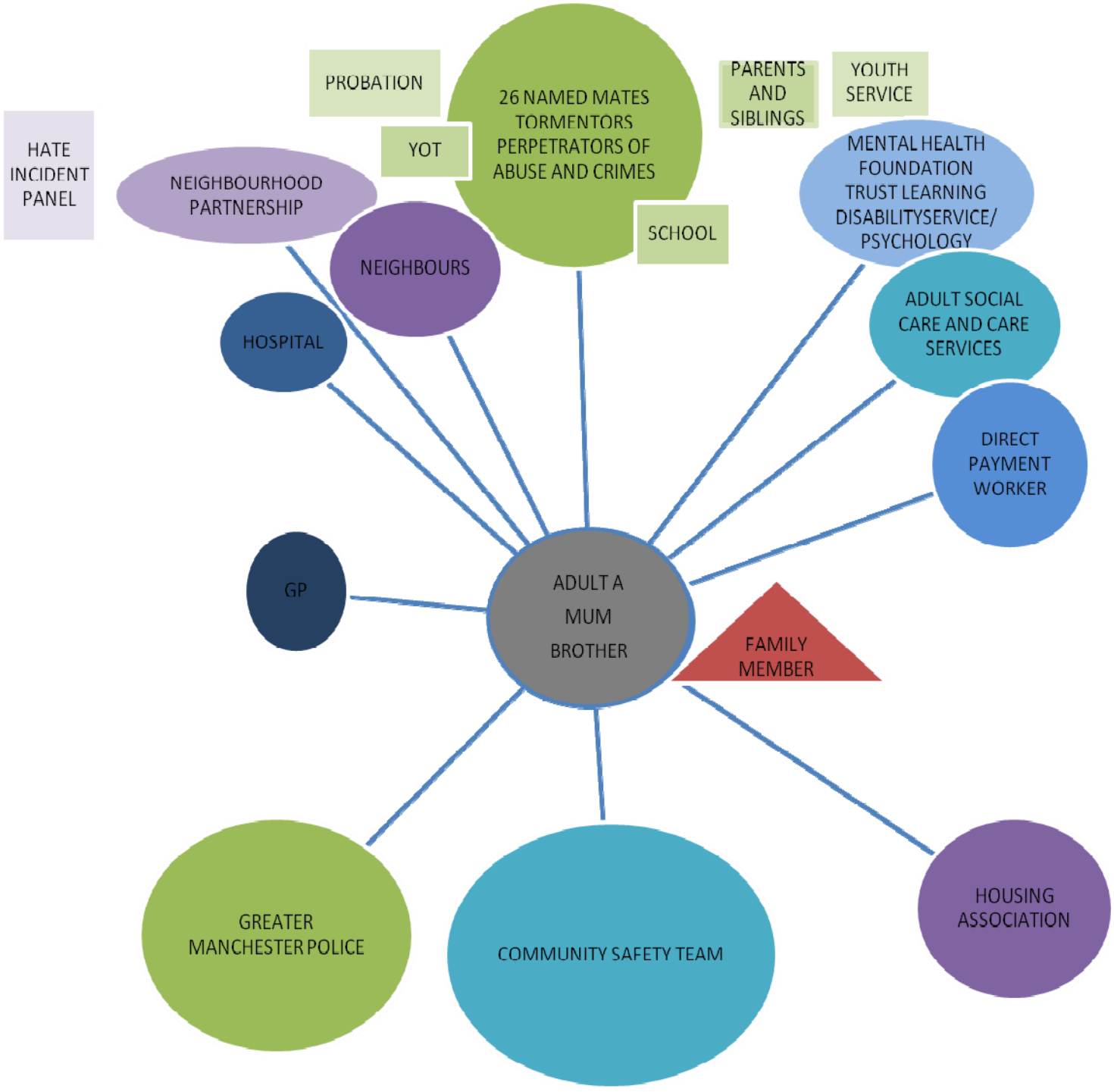
12. All agencies[44] submitting an IMR report were given the opportunity to present their findings to the Panel on 8th July 2010, to answer questions for clarity, and to engage in discussion about lessons they had learnt and/or wanted others to learn from their review of their involvement with Adult A and/or the broader issues about agencies working together.

13. The Mental Health NHS Foundation Trust presented their findings to a Panel meeting on 14th October 2010.

[44] This was with the exception of NHS Community Health Provider Service that had no contact with Adult A and the Hate Incident Panel (HIP) but the Chair did have a subsequent telephone discussion with the HIP IMR author.

Appendix 3

Key people/organisations involved with Adult A



Appendix 4

References and Research

1. Policing Plan 2010-11
www.gmpa.gov.uk/documents/Policing_Plan_FINAL

Hate Crime

Anyone can be the victim of a Hate Crime. We all have a racial identity; all have a sexual orientation, and all have some sort of beliefs. Any one of us could be targeted because of some aspect of our identity. Tackling Hate Crime supports each and every one of us.

GMP launched the Disability True Vision pack in September 2009. This is a national self-reporting initiative for Hate Crime which complements the existing packs for homophobic, transphobic, racist and religious Hate Crime. The pack is also available in large print. Following on from this GMPA has been working with partners through the Learning Disability Partnership Boards to develop reporting processes for victims with learning disabilities.

In December 2009, an enhanced risk assessment for victims of hate incidents and crimes was launched. The assessment, undertaken by officers, now establishes the level of risk and complements the Force's risk assessment for vulnerable people.

GMP will be reviewing its Hate Crime policy later this year following revised ACPO guidance and the outcomes of the Equality and Human Rights Commission investigation into Disability Harassment.

2. Reported Hate Crimes in Tameside GMP Annual Reports

	Tameside 2007/ 8	Tameside 2008/9
Race	285	311
Religion	5	11
Sexual Orientation	28	28
Gender	0	0
Disability	4	3
Combination	8	8
Motivation u/k	20	17
	350	**378**

Greater Manchester Hate Crime Figures (Put together by Andy Searle – Chair TASP)

Hate motivation	2004/5	2005/6	2006/7	2007/8	2008/9
RACE	3,464	3962	4331	4559	4542
RELIGION	71	97	194	203	187
SEXUAL ORIENTATION	150	273	380	533	451
GENDER	39	61	51	32	36
DISABILITY *(Fastest growing)*	9	20	38	61	79
COMBINATION OF FACTORS	110	119	263	235	256
MOTIVATION UNKNOWN	422	556	410	330	270
TOTAL	4,265	5,088	5,667	5953	5821

3. Health and deprivation in Tameside –PCT Annual Report and Public Health report 2008/9.

4. Chih Hoong Sin et alia (2009) Disabled people's experiences of targeted violence and hostility. Office for Public Management on behalf of the Equality and Human Rights Commission.

5. Association of Directors of Social Services (2005) Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work.

6. Audit Commission (2006) Neighbourhood crime and anti-social behaviour: making places safer through improved local working. Community Safety National Report.

7. Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century.

8. DH Valuing People Now: The Delivery Plan 2010-2011.

9. DH (2000) in “No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse”.

10. Disability Rights Commission (2005) Equal Treatment: Closing the Gap: A formal investigation into physical health inequalities experienced by people with learning disabilities and/ or mental health problems.

11. NPIA (National Policing Improvement Agency) 2010 Guidance on responding to people with mental ill health or learning disabilities.

12. Caroline Hunter,* Nick Hodge, Judy Nixon, Sadie Parr. (2009) Anti-social behaviour and disability – the response of social landlords.

13. Sir Jonathan Michael (July 2008) Independent Inquiry into access to healthcare for people with learning disabilities.

14. Welsh Centre for Learning Disabilities (2002) ‘Primary care, Evaluation Audit and Research in Learning disabilities’ (PEARL study).

15. CPS (March 2010). Disability Hate Crime – Guidance on the distinction between vulnerability and hostility in the context of crimes committed against disabled people.

16. House of Lords & House of Commons Joint Committee on Human Rights. Seventh Report of Session 2007–08. A Life Like Any Other? Human Rights of Adults with Learning Disabilities -‘Making it happen for everyone’.

17. NHS February 2009 Primary Care Contracting

18. DH 2010 Guidance on Eligibility Criteria for Adult Social Care (FACs)

19. Scope 2008 Getting Away With Murder -Disabled people’s experiences of Hate Crime in the UK

20. YJB 2010 A Review of YOTs and Children’s Services’ Interaction with Young Offenders and Young People at Risk of Offending.

21. Caroline Hunter, Judy Nixon & Sadie Parr (July 2004) What works for victims and witnesses of anti-social behaviour. Sheffield Hallam University.

Appendix 5

Glossary

AACCT	Adult Assessment Community Care Team

ABC	Acceptable Behaviour Contracts
ACPO	Association of Chief of Police Officers
ASB	Anti-Social Behaviour
ASBO	Anti-Social Behaviour Order
ASBRAC	Anti-social behavior risk assessment conference
CAF	Common Assessment Framework
CSU	Community Safety Unit
DH	Department Of Health
EIG	Early Intervention Group
FACS	Fair Access to Care Services criteria
GMP	Greater Manchester Police
NPIA	National Policy Improvement Agency
IMR	Individual Management Report
LES	Local Enhanced Scheme
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
PACT	Partners and Community together
PCT	Primary Care Trust
PCSO	Police Community Support Officer
RIPA	Regulation of Investigatory Powers Act
SCR	Serious Case Review
SNAT	South Neighbourhood Action Team
SGAT	Safeguarding Adult Team
TASP	Tameside Adult Safeguarding Partnership
THIP	Tameside Hate Incident Panel
TRHAMP	Tameside race hate multi-agency panel
YOT	Youth Offending Team