MEETINGS: Constabulary Management Board	**DATE:**	**AGENDA NO: 5b**	
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NAME OF PAPER: Adults at Risk Assurance Report	**PURPOSE OF THE PAPER:** Assurance	**OPEN SESSION**	

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V1	*12.01.2021*	*Draft*
V2	*14.01.2021*	*Final version for CMB*

1. PURPOSE OF REPORT

To provide the Constabulary and the OPCC assurance of the Constabulary approach to Adults at Risk (AAR) against the areas jointly scoped and agreed. The report makes a number of recommendations for CMB to consider.

2. UNDERSTANDING OUR CURRENT AND FUTURE DEMAND IN RELATION TO ADULTS AT RISK

2.1 Definition and flagging of Adults at Risk – the current challenges

Prior to the introduction of the Care Act in 2014, the 'No Secrets' statutory Guidance which covered adult safeguarding used a broad definition of a 'vulnerable adult' as a person: "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

The Care Act 2014 has since superseded this, and s42 now identifies 'an adult at risk.'

An adult at risk of abuse or neglect is defined as someone who:

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect him themselves against the abuse or neglect or the risk of it.

There are challenges with this definition particularly around what constitutes care and support needs. The national eligibility criteria sets out a minimum threshold for adult care and support where two conditions must be met as follows:

1) The adults needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors. This includes if the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

2) As a result of the adults needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section 'Eligibility outcomes for adults with care and support needs'

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the adult's home safely
- Maintaining a habitable home environment

- Developing and maintaining family or other personal relationship
- Accessing and engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
- Carrying out any caring responsibilities the adult has for a child

There are obvious challenges for frontline staff being able to assess whether any involved party would meet the Care Act definition of an 'Adult at Risk' (AAR)'. In Niche there is a Vulnerable Adult (VA) qualifier and a Safeguarding Adult (SA) qualifier that anyone can apply to an incident. Since 2012 the SA qualifier has been used as the basis for any reports generating performance data, including the quarterly submissions to the five Local Safeguarding Adult Boards (LSAB's). These reports have recently shown significant increases in both crimes and incidents (see Figure 1). This significant increase will in part be attributed to the rapid and improving nature of our teams focusing and understanding 'vulnerability' and labelling anything with an element of any vulnerability with an SA qualifier.

Figure 1. Safeguarding Adult data to the end of quarter 3

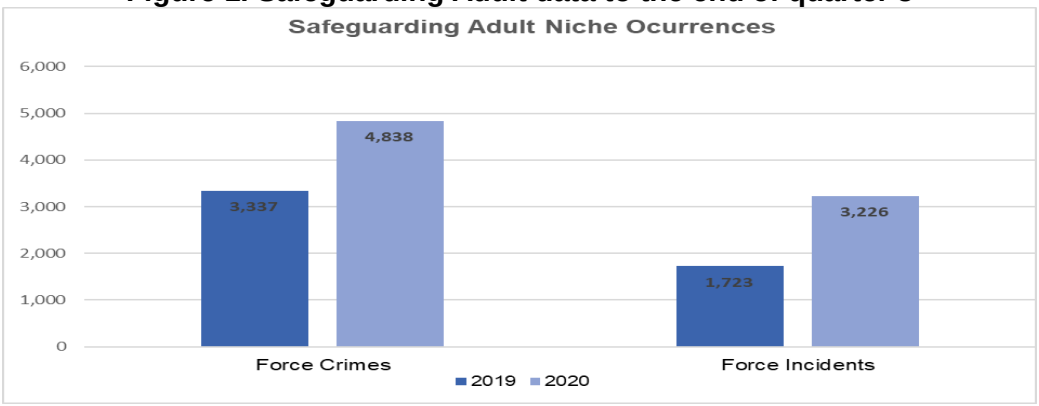
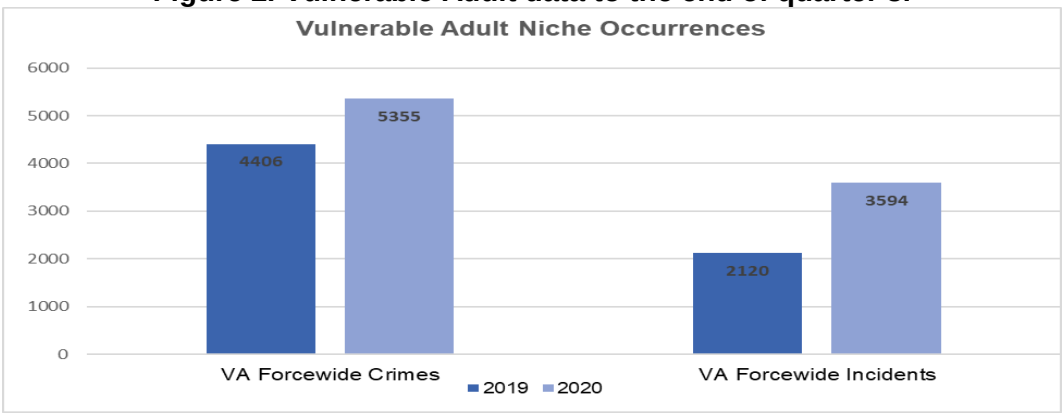


Figure 1 illustrates a 45% increase in the number of safeguarding adult crimes and an 87% increase in incidents across the Force. This increase is also reflected, although to a lesser extent, in Figure 2 which illustrates a 21.5% increase in crimes and 70% increase in incidents that have a Vulnerable Adult Qualifier.

Figure 2. Vulnerable Adult data to the end of quarter 3.



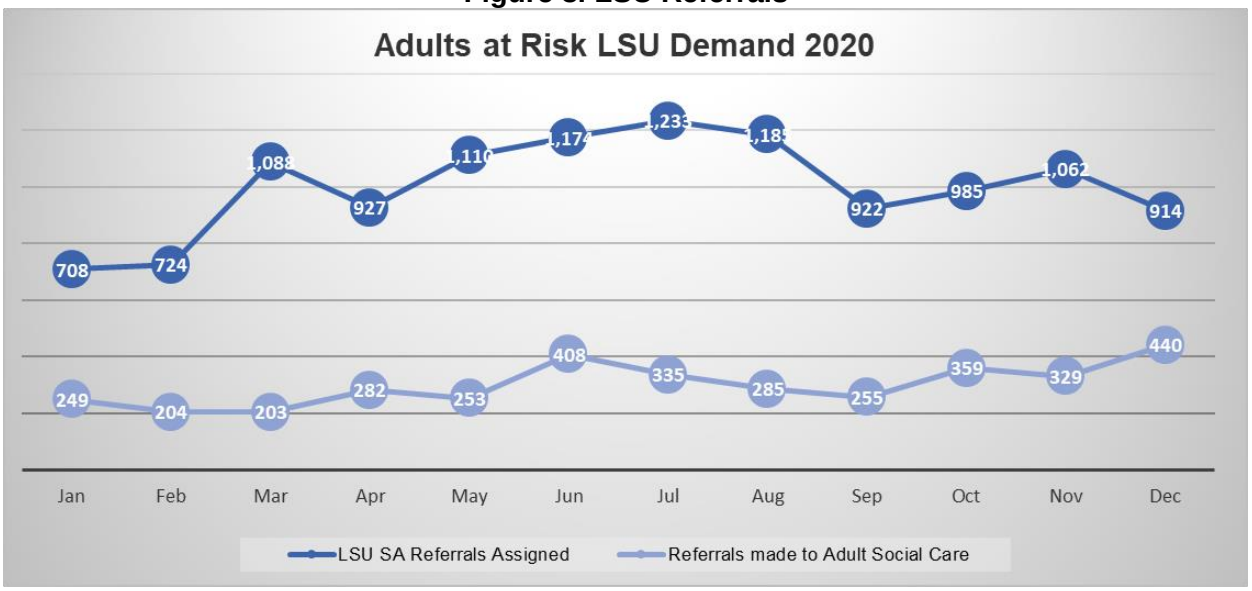
The increases prompted a dip sample of 50 incidents with the VA NICL qualifier. The findings showed that the two qualifiers are used interchangeably, and are often combined with Domestic Abuse (DA) and/or Mental Health (MH) qualifiers.

The data also showed that nearly half of all occurrences with a VA qualifier also had a SA qualifier, and around a fifth of all SA occurrences had a VA qualifier on them. An occurrence type of Adult Safeguarding exists in Niche and of the 8946 adult safeguarding occurrences in 2020, 5503 (61.5%) had a VA qualifier, 3273 (37%) had a SA qualifier on them, and some had neither.

This demonstrates a confusing and complex landscape.

In 2020, 12,032 Safeguarding Adult referrals were made into the Lighthouse Safeguarding Unit (LSU). However only 3602 (30%) were referred on to Adult Social Care meaning that 70% of referrals are being triaged out by LSU staff as either not meeting AAR criteria or not having an appropriate referral pathway (see figure 3).

Figure 3. LSU Referrals



Although the increases in the SA & AAR figures indicate that officers and staff are getting better at recognising and responding to vulnerability, there is no way to identify the specific Adult's at Risk group within the wider vulnerable demographic. As a result we are therefore unable to provide any meaningful performance information to assess current demand, inform assurance activity, or to share with our partners.

LSU staff as subject matter experts remove the SA qualifier on occurrences that do not meet AAR definition, and therefore contribute to an improvement in performance data. The LSU do not have capacity to take on any additional administrative tasks so currently the only meaningful AAR performance data is the workflow of AAR tasks in and out of the LSU. There could be immediate performance improvement in understanding the AAR data and delivering better outcomes for these victims if a triage or gatekeeping type function is undertaken.

In addition to the above, Minerva will be introducing a new set of national qualifiers in 2022 which will include 'PP- Vulnerable Adult', 'PP Domestic Abuse' and a separate Mental Health qualifier. An extensive range of local qualifiers will also be available which will include 'Adult Abuse Sec 42 Care Act'. The existing Safeguarding Adult qualifier currently used will disappear.

Recommendation 1: Agree a new internal definition and identification of an Adult at Risk.

Recommendation 2: Before the Niche update takes place in 2022 review how qualifiers are managed and their permissions.

When the new definition of Adults at Risk is agreed this will be cascaded through internal communications and training.

There will also be work undertaken with regional forces including lobbying the College of Policing and National Police Chiefs Council to provide greater direction and deliver the national guidance.

2.2 The demographics of Adults at Risk – and how many meet the CPS definition of 'older people' (over 65 years old)

The Office of National Statistics (ONS) estimates that nationally there are 12.4 million people aged 65 years and over, equating to 18.5% of the total population. This is based on figures recorded in mid-2019. The proportion is lower in city areas. The demographic for Avon and Somerset mirrors that found

nationally with North Somerset & Somerset having almost a quarter of their population aged 65+, in contrast to Bristol with just 13% of its population in this age range and making up 19% of the total population across Avon and Somerset (see figure 4).

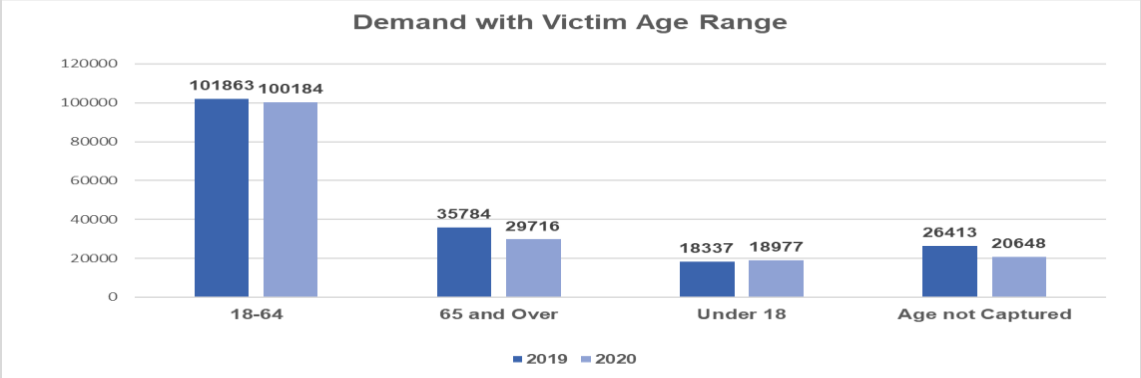
Figure 4. Age demographics in Avon and Somerset

Age Group	B&NES	Bristol	N.Som	S.Glos	Somerset	Total	Percentage
0-17	36247	94136	43711	59243	111190	344527	20.04%
18-64	120353	308896	119700	172153	311122	1032224	60.05%
65+	36682	60345	51641	53697	139913	342278	19.91%
Total	193282	463377	215052	285093	562225	1719029	
65+ %	**18.98 %**	**13.02%**	**24.01%**	**18.83%**	**24.89%**	**19.91%**	

In both 2019 and 2020 the over 65's equated for around a fifth of total demand where there was an identified victim and age recorded (see figure 5).

Figure 5. Number of occurrences by victim age

** 1036 Duplicates were removed from the data as more than one victim was linked to the occurrence*



The following two tables are taken from the NHS Safeguarding Adults, England 2018-19 Experimental Statistics. This Safeguarding Adults Collection (SAC) records safeguarding activity relating to adults aged 18 and over with care and support needs in England. Safeguarding adults is a statutory duty for Councils with Adult Social Services responsibilities in England under the Care Act 2014, in order to safeguard adults from abuse or neglect. Data is recorded by safeguarding teams based in councils, and submitted to NHS Digital through a secure data collection system

Table 1. Regional Safeguarding Activity 2018/19

	Safeguarding Concerns	Section 42 Safeguarding Enquiries	Other Safeguarding Enquiries	Total Enquiries	Conversion (Enquiries / Concerns)
Somerset	3200	1150	30	1175	37%
B&NES	1150	315	10	325	28%
Bristol	5190	1190	25	1210	23%
N Somerset	3285	1210	35	1245	38%
South Glos	1145	530	5	535	47%
Total	13970	4395	105	4490	32%

Key:
Safeguarding Concern – A sign of suspected abuse or neglect that is reported to the council or identified by the local council.
Section 42 Safeguarding Enquiry – Where a concern is raised about a risk of abuse and this instigates an investigation under safeguarding procedures in accordance with Section 42 of The Care Act 2014.
Other Safeguarding Enquiry – Where a concern is raised about a risk of abuse but does not meet the three criteria under Section 42 of The Care Act 2014.
Total Enquiries – The sum of Section 42 Safeguarding Enquiries and Other Safeguarding Enquiries.
Conversion (Enquiries / Concerns) – (Total Enquiries / Safeguarding Concerns) x 100

Although the safeguarding activity statistics do not illustrate police involvement, it provides an insight into potential demand across the different force areas. North Somerset for example has been identified as having the second highest population of over 65's which correlates to having the highest number of enquiries and second highest conversion rate in the table above.

Table 2. Individuals involved in Section 42 safeguarding enquiries per 100,000 adults by age group

	18-64	65-74	75-84	85+
Somerset	104	165	517	1,660
Bath and North East Somerset	85	120	466	2,069
Bristol, City of	160	440	917	2,186
North Somerset	223	314	1,277	4,418
South Gloucestershire	106	193	576	1,917
Total	678	1,232	3,753	12,250

Table 2 shows that the majority of people involved in a Section 42 enquiry are aged 65 and over.

Recommendation 3: To commission the Open University with a specific piece of work around understanding our demographic and future demand from AAR and older people.

3. HOW ADULTS AT RISK ARE IDENTIFIED AND SUPPORTED AT A LOCAL LEVEL

3.1 The use of BRAG for Adults at Risk

The AAR BRAG review concluded that the overall performance of Avon and Somerset Police regarding the use of, quality and compliance of the BRAG safeguarding tool is 'fair'. The compliance level and number of BRAG questions reviewed for quality were decisive factors in determining the judgement rating. In addition, case study evidence from reviewing officers has been documented.

336 Niche occurrences were reviewed; a BRAG was indicated in 245 instances and completed in 204 cases. BRAGs were completed **correctly 75% of the time** and considered to **add value** to the safeguarding process or response in **84% of cases.**

Of the 245 BRAGs completed 129 were considered to have had all six questions completed with sufficient detail, however it was noted that there were varying templates which may have had an adverse effect on the quality of responses. There appears to be a lack of understanding regarding the differentiation between each question.

96.7% had a BRAG rating applied and the reviewing officer agreed with the rating in 81.5% of the cases. Overall the correct people are mentioned with clear demarcation of concern and vulnerabilities identified.

184 of the BRAGs completed added value but the quality could be improved as only 34% were considered to be 'Excellent' or 'Good' content.

Other themes that emerged were:

- **LSU pathways:** Officers are unclear of what pathways and referrals the LSU can make to other agencies. This can be demonstrated with reference to both mental health and substance abuse. Once officers have completed the BRAG and referral, in the main they do not return to filed occurrences. When the LSU do not have a referral pathway, due to demand and capacity, they do not routinely task back to officers.

- **Confusion over process and duplication**: It can be evidenced that the role of PPNs and BRAG continue to be confused despite the LSU guidance being clear in this regard.

- **Lack of consistency using tags**: Tags and qualifiers can be added at many stages in an investigation. Whilst there is some automation within WebStorm around Domestic Abuse, this is not the case around vulnerability and may reflect the difficulties in clearly defining AAR. As a result, where DA tags may be automated, those that suggest vulnerability and potentially serve to identify AAR are added manually by any number of people including officers, supervisors and call handlers.

- **Adults at risk PPN's**: A number of occurrences had AAR PPN's attached.

In addition to the audit, focus groups were carried out with 27 frontline officers which, although not a statistically significant sample, provides context and reasoning to some of the quantitative findings.

The focus groups found that officers wanted feedback over the quality of their BRAG and felt ill equipped over what to do if the BRAG did not require an LSU referral being unaware of what LSU could and could not offer. Officers reported feeling deflated when they refer to the LSU (especially around mental health and substance misuse) and an OEL entry is made regarding there being no onward referral pathway. Officers feel opportunities are missed as they are not tasked back and frequently their occurrence is filed prior to this and they feel they are letting vulnerable people down (and they may never know).

Officers felt uneasy recording a BRAG but not then referring onwards either internally or externally. 33% either stated they had no training, or they could not recall any; and those who have had some training find it hard to recall when this was and the content of the training.

Most officers had a good understanding of the process but were uncertain if they should complete BRAG if they've completed a DASH. The process around completion of both BRAG and DASH was unclear to officers.

Just under half (48%) of the officers thought they understand what support mechanisms are in place for a person identified as vulnerable.

- The use of Qlik in performance management of the BRAG process was commonly seen as compliance focussed rather than supportive.
- Officers felt ill equipped to complete BRAG when they have only spent a very short period with the person.

Officers were asked 'do you know what an adult at risk is' and 'what is your understanding of this'? A variety of answers was provided in response to this question. Although the majority did understand the term, the responses they gave regarding their explanation highlights the definition is not clear enough.

Recommendation 4: To agree the recommendations made in the BRAG AAR Assurance report, which are:

- Additional training should be given to staff in relation to the BRAG which should include:
  - Why, when and how to use the BRAG tool, including consequences of not.
  - How to access guidance to support use of the BRAG tool.
  - Pathways for onward referrals for vulnerable individuals and understanding who is responsible for what (including when officers should make referrals directly).
- The force should define the term 'Adults at Risk' and use consistent terminology and thresholds when referring to Adults at Risk.
- The force should agree governance procedures for tagging/qualifiers, including who adds them, when and under what definition, with specific reference to use of safeguarding flags.
- Address lack of mental health and substance abuse pathway for support for vulnerable people.
- Implement a review process to ensure that cases referred to LSU with no onward referral are not just closed with no action from anyone.
- Consider a mechanism for officer feedback on the quality of BRAG completion to help improve quality and instil confidence in using the BRAG.

3.2 Local identification of Adults at Risk

As already outlined there is considerable confusion over the difference between a 'vulnerable adult' and an 'adult at risk', both of which are used interchangeably. Anecdotally an 'adult at risk' tends to be considered in the context of a vulnerability strand i.e. mental health or domestic abuse.

Adults at risk are identified through: officer attendance at local addresses; local partnership meetings and agency referrals; local community engagements; STORM logs; emails into the Force; and direct calls/mailboxes to the local neighbourhood teams, for example a member of public may contact police to highlight an adult they believe is at risk (e.g. dementia sufferer wandering the streets at night).

Risks are also identified through indirect contact, for example when we come into contact with young people who we identify are at risk due to vulnerabilities of parents or with contacts with associates.

Adults at risk of exploitation are highlighted to us by third party reports; partner agencies; safeguarding referrals; or through interaction with local officers. Missing Persons Coordinators are based within each geographic area and are able to support with the highest risk/demand cases.

Qlik is also used as a way of identifying adults at risk, specifically through use of the persistent caller/missing person's apps. These are discussed through the Local Tasking Meeting (LTM) process and a problem solving plan created where appropriate. However the Vulnerability App on Qlik does not necessarily allow the LTM to pick out the right people because of volume, and an AAR may only be raised by a Sergeant on a team where the demand for service is high or because they are attached to County Lines which generates wider problem solving.

The CPS definition of an older person is 65+. Availability of support and pathways would be through the LSU via the BRAG process. Some proactive officers would make their own referrals. However the older people element would not be particularly considered unless there were other vulnerabilities identified associated with age (e.g. dementia).

On initial attendance dynamic risk assessments are carried out to establish if immediate interventions are needed and contact with other agencies are made where required. A referral into the LSU will be made with a BRAG completion to provide details of any concerns. Matters that cannot be resolved satisfactorily through a referral route approach can be discussed at local multi-agency forums whereby joint partnership problem solving approaches are considered.

If a longer-term, multi-agency problem solving approach is required then a problem solving plan (PSP) will be created. There are some weaknesses in our current processes in that we currently have no formal facility to refer into healthcare providers, GPs etc. or directly to Mental Health provision.

This 'ad hoc' approach to identifying and safeguarding adults at risk needs a clearer framework to ensure rigor across the organisation.

3.3 The use of problem solving to manage AAR

The type of problem solving approach used will depend on the issue identified and the support/intervention needed.

An adult who is identified as at risk would be referred into the LSU and a needs assessment completed. Appropriate onward referrals are made and discussions through the MASH can take place for immediate tasking.

A PSP may be created if it is thought that a longer term, multi-agency approach is required to address the needs of the adult. This allows all strategy discussions, actions and outcomes to be recorded in one place and avoids the loss of information pertinent to the case.

Each policing area has different multi-agency forums and meetings to discuss people of concern with different referral pathways available. Local neighbourhood staff attend these meetings and are encouraged to refer in as early as possible to involve partners in the problem solving.

Where a problem is more serious or persistent and involves several agencies, it is added to the bi-weekly Priorities Agenda. As well as the statutory members of Together and One Teams, representatives from the commissioned Hate Crime support services also attend Priorities. Police provide the agenda and minutes for these and the local NPT Inspector chairs the proceedings. Individual cases are discussed and actions decided upon. An audit process ensures that the process is accountable. This process and the Together / One Team approach in West Somerset is not consistent across the organisation but should be considered best practice for multi-agency discussions for AAR who are not more obviously flagged i.e. those at lower or medium immediate risk.

Our approach to high risk adults with mental health concerns is to have a response plan put in place. There are currently 20 across the force and a limited number of people who can create them. The response plan sits on a Mental Health management occurrence on Niche and can be initiated both internally and externally e.g. at the request of clinicians, by Comms or a Neighbourhood Officer who identifies that someone is high risk and causing high demand. Plans are written in partnership with clinicians who provide relevant information and opinion to help inform the options. Although written in partnership they remain a Police document as they provide policing options. They are not to be confused with a clinical Care Plan which is an NHS document.

There is currently no automated data or way to identify who has a response plan and who might benefit from one. Plans are based on the National Decision Making model and an OIC/attending officer can use the information contained within to make risk-based decisions. Work to date has essentially been a proof of concept and it is recognised that there needs to be improvements with regards to governance, procedures etc. which is currently being undertaken.

Example of AAR problem solving approach:

PSP 5220277150 refers

The subject lives in an Alliance Homes property, is known to MH Services and known to NPT due to minor MH associated incidents that occurred within Portishead.

In less than a 24 hr period, NPT became aware of concerns in relation to his MH deteriorating and the threat of harm he may pose to others within his community including his neighbour. Concerns were being

raised from multiple sources including Alliance Homes, MH Services, family, Force Mental Health Officer and a nearby neighbour he threatened to kill.

Due to potential risk he posed to himself and the public a Professionals Meeting was arranged the following day involving all services with an interest in him and all agencies identified taskings to take forward.

The police identified the need to take positive action, a PSP was set up with the aim of the plan to link all agencies involved with the subject, to identify what support is in place for him, to identify if he does pose a risk to himself or others and to consider what safeguards should be in place. This PSP will be to ensure necessary support is in place for all concerned, to ensure action from other agencies is documented and look to reduce the THR concerns around the subject which he is within the community.

The Police used information within Niche, Assist and Webstorm to compile an overview for the PSP and Storm information Markers were placed on both the neighbours and the subject's address so all who may have to engage with him were fully aware of the concerns and risk to harm markers.

Following contact from family in relation to a MH episode and threats that he was going into the community to harm people, everything was in place so police were aware of the concerns and history.

On police attendance, positive action was taken, he was arrested, taken into custody, were he received a MH assessment and is currently held under Section 2 at Callington Road.

A follow up Professionals meeting is to be held imminently and consideration of Steering/ MAPPA and Potential Dangerous Person cases were considered but decision was taken to remain as PSP and Steering with case under constant assessment.

3.4 Adults at Risk and our County Lines response

The vulnerability data is centred around Child Criminal Exploitation (CCE) as this has been considered the priority. In terms of vulnerable adults and addresses of interest these are identified by the Development Hub through daily scanning of intelligence. They are then flagged to neighbourhood teams who are tasked with attending and conducting a safeguarding visit. The neighbourhood teams have their own vulnerability meetings (but these vary from area to area) and the Violence Reduction Units (VRU) have their own APP and tasking meeting, where joint information is shared by partners. Some areas such as Bath and Somerset have a good relationship with partners and conduct joint visits.

In summary whilst there is some scanning and some great partnership work in areas, it is not consistent. We often 'trip' across vulnerability, usually after the individual has been cuckooed for a considerable time.

Recommendation 5: Develop a more proactive approach to AAR and CL, such as looking at hot spots for CL activity and cross-referencing with partnership data to understand who may be at risk from cuckooing.

3.5 Knowledge and understanding of Adults at Risk and vulnerable adults

As part of the BRAG AAR audit and as mentioned in section 2.1, a small sample of Response officers/staff were asked for their opinions on Adults at Risk and BRAG.

In the main, all of the officers spoken to understood what an 'Adult at risk' was. The term 'broad spectrum' was quoted which encapsulates this area of vulnerability.

Ultimately the findings reiterate the message throughout this report; that there is a lack of clear understanding of what constitutes an adult at risk, and addressing this issue is fundamental to driving improvements in this thematic.

3.6 Progress against HMICFRS report 'Poor Relations' and Serious Case Reviews

This report looked at the police and CPS response to crimes against older people. There were various recommendations or areas for improvement with many being at the national level. There were five to be responded to locally: two have been completed and the remaining three are below.

1) Within three months, chief constables should conduct analysis of the current and future demand for adult safeguarding, including the gap in knowledge that may exist from those cases where referrals aren't made because of errors or omissions. This analysis should be incorporated into force management statements (FMSs)

Force systems are unable to extract data for the number of Adult Social Care (ASC) referrals received that resulted in police intervention. Local Authorities hold this information and have been asked to provide it along with data errors and omissions to enable analysis of 'hidden' demand (i.e. referrals that we should have received but did not). Once all the data has been gathered it will be included within our FMS. This recommendation will then be complete.

2) Within six months, chief constables should find good ways to assess the current demands on the police made by older people. These assessments should include a prediction of future changes in demand, account for the work of other organisations, and be incorporated into FMSs

The force assesses current demand made by older people through the use of the Vulnerability App in Qlik. Predicting future demand is based on working closely with our partners and understanding their constraints alongside assessing previous and current performance/qualitative data, coupled with horizon scanning. The forces Adult at Risk delivery plan now has a specific action to address this recommendation, and this is the area we will be looking to approach the Open University to carry out further research. It has been incorporated into the FMS.

3) Within six months, chief constables should work with police and crime commissioners and their mayoral equivalents, and other relevant organisations, to review whether victim support services can be provided in a better way.

HMICFRS are happy that we have introduced various measures to improve services to victims. However they still require assurance that the Constabulary has worked with the Police and Crime Commissioners and other relevant organisations to review whether victim support services can be provided in a better way since the contracts were issued in April 2019.

The other national recommendations made within the report have been reviewed for the purpose of driving improvements in our response to older people. This relies partly on updates and centralised support from the NPCC and CoP which is an issue being raised by the regional AAR Lead based in Devon and Cornwall at the next national meeting. There will also be a regional review of the responses to the inspection.

4. INVESTIGATING CRIMES IN RELATION TO ADULTS AT RISK

4.1 The investigative approach

There exists a broad spectrum of offences committed under the AAR umbrella. For example:

'18 year old care leaver in a controlling relationship having finances misused by partner / excessive use of force against a care home resident with dementia / targeting of an adult with mild learning difficulties within a community / cuckooing of addresses'

Each incident requires a bespoke investigative response.

The majority of calls for service are received by Comms and some go direct to the LSU from partners (such as Adult Social Care). Risks and vulnerability are generally well recognised and an appropriate resource is dispatched. Due to the complex nature of vulnerability and the importance of correctly identifying this at first point of contact, there is scope to make improvements to call scripts.

Following initial attendance the standard of investigation is variable. Whilst the AAR assurance panel only reviews a small number of cases quarterly, a theme that has emerged is gaps in investigative decision making that support the victim. There is some evidence of myths and stereotypes at play too.

The best investigations show documented discussions with partner agencies; listening to the views of victim, professionals and family members; use of intermediaries to obtain evidence via visually recorded interviews; and appropriate safeguarding plans.

Adults at risk are often unable, unwilling (frightened or not able to quickly understand or evaluate what is required) or more complex to obtain evidence from. Sometimes investigations are closed before fully exploring how this can be achieved or whether there are alternative lines of enquiry. There are a number of reasons for this:

(1) Some AAR victims will make decisions which an objective onlooker may consider to be unwise (for example to allow a drug user to stay in your property as it provides company). Opportunities are being missed to take a more offender centric approach.

(2) Where it is apparent obtaining evidence will be difficult (e.g. needing an intermediary) efforts to obtain this are not as thorough as they could be.

(3) There can be improper or early conclusion that another agency is best placed to take an investigation forward which means that evidence is not gathered. AAR cases do not seem to be approached with the same vigour as, for example, crimes against children.

(4) Investigations which are obviously very serious or with particularly at risk victims tend to be appropriately referred to CID. In other cases, where it would have been appropriate, patrol teams do not always hand over investigations to CID or seek advice despite the fact it would have been appropriate.

(5) Where victims are less able to engage in investigations there is a tendency to update other appropriate persons on their behalf (e.g. support workers). This assessment may be inaccurate or poorly founded and reduces the opportunity for the victim to have their voice heard in the investigative process. This is one of the areas that will be supported through the forces revised approach to vulnerability and was highlighted in the recent vulnerability self-assessment exercise.

Recommendation 6: Conduct a larger dip sample of investigations to bolster the findings from the few cases looked at in the AAR scrutiny panel.

Recommendation 7: From the dip sample findings build a clear AAR pathway within the allocation policy and link clear, prioritised training subjects.

5. VICTIM SUPPORT AND SAFEGUARDING FOR ADULTS AT RISK

5.1 LSU support for Adults at Risk – providing a fair level of service

Adult referrals into the LSU by officers are made in accordance with the Victims Code of Practice (VCoP) entitlement to an enhanced service or due to safeguarding concerns. It is reasonable to assume that AAR may come to the attention of the LSU by either route, with the response to each outlined below. If an occurrence is purely for safeguarding i.e. no offence committed, the victim will not be contacted.

- AAR is referred to LSU because they are an enhanced victim. The task will be allocated to a VWCO to make contact. A common needs assessment (CNA) is completed to further understand needs, current support, safety etc. This, alongside a review of historical information on Niche, enables the VWCO to decide on which support services to discuss with the victim and whether there is a need to refer to Adult Social Care in accordance with thresholds. In some cases it will not be appropriate for the VWCO to contact the AAR directly such as where the victim has a support worker or social worker so, it may be more suitable to make contact with that person instead and the accompanying

rationale added to Niche. Safeguarding referrals should still be completed if the incident meets the threshold.

- AAR is referred to LSU as an adult safeguarding concern. This will be reviewed by a Safeguarding Officer (SGO) who will consider, based on the information available in that incident and historical information, whether the threshold for information sharing with Adult Socail Care is required. If they also identify that the AAR is an enhanced victim of crime it will be internally referred to a VWCO for victim contact as per above.

Any referral made will include a copy of the BRAG / DASH completed by the attending officer and a CNA if we have had victim contact. This will highlight any support service or safeguarding referrals made so that all receiving parties are aware of the actions we taken. The LSU process was introduced with the input of Social Care when LSU merged and a triage function for their service was adopted to reduce police demand on social care services.

Due to the nature of attempting to contact adults with additional and/or complex needs, phone call attempts are often unsuccessful and make it difficult to complete a meaningful CNA. If three contact attempts are made without success, a standard Lighthouse letter is sent. If someone was assessed as having extremely complex needs then a VWCO would speak to the OIC before making contact to try and understand those needs to best respond.

Recommendation 8: Review LSU correspondence to assess how accessible letters might be to AAR victims, and look at whether adapted/simplified versions of correspondence could be implemented.

5.2 Identifying repeat victims and safeguarding referrals

Background checks and history review process within the LSU enable staff to identify previous incidents that the AAR may have been involved with, either as a victim or as a suspect. Relevant information to support the need for intervention is added to the onward referral document. This enables partners to see patterns of behaviour, escalation in concerns, and highlights the need for the referral if the incident itself does not necessarily meet threshold in isolation.

A ‘Repeat Victim’ flag exists within Niche but is not consistently used, and there is debate about the definition of a ‘repeat victim’ and when it would be appropriate to apply the flag. It is good/expected practice that a VWCO will link themselves to the victim on Niche when they first open the incident. This means that the same VWCO should receive any repeat victims for continuity of contact and background knowledge. However this is not necessarily achieved consistently in all areas. Improvements to officer understanding and the ability to identify repeat victims would drive an improvement in this area. Officers may be able to make a more informed decision about whether to make a safeguarding referral to the LSU if they had more information on the individual.

Recommendation 9: Conduct a focus group with officers to explore if victim history is viewed or if the approach is one of isolated incident review.

6. WORKING WITH PARTNERS

6.1 The local escalation process

All staff within the LSU are aware of the escalation processes for resolving professional differences and instigate these as required. Staff are confident to do so and at the appropriate level in the partner service. Escalation of issues from partners is not always at the correct level and can often skip opportunities for tactical and operational resolution, starting at strategic manager level instead.

Recommendations have been raised this year in regard to wider understanding of the escalation process and an awareness campaign coupled with a refresh of the guidance will be undertaken in the coming months.

Escalation is also dependent on LSU staff feeling able and supported to challenge professional differences in opinion, and different Local Authorities have different practices in regards to their willingness to engage in discussions around escalation. Below is an example of one local authority who in the opinion of a member of LSU staff 'was consistently difficult to get a response from':

On one occasion, I sent a referral to Adult Social Care for a partially deaf, autistic, learning disabled female who had been sexually assaulted by her boyfriend (who was a registered sex offender). She and her family were not aware of his RSO status, he had been living in her family home (where children were present), and had attempted suicide in front of her 10 year old brother. Through speaking with her, it transpired that every member of her family had either a physical/learning disability, two of them used wheelchairs, and they received no support and were not open to ASC or CSC services. It took multiple emails chasing a response to my referral and considerable escalation before the manager eventually made contact and stated it didn't meet their threshold. I replied stressing my concerns and points evidencing the risk of serious harm/exploitation, to which he continued to refuse to open the referral. I resolved it by requesting our LSU Safeguarding Sergeant referred the case into MASH (therefore bypassing the rejected referral by the LA ASC). I attended the MASH, and the meeting resulted in the family being opened to both ASC and CSC for assessments. The LA manager in question also attended the MASH and was confrontational throughout. I fed back to my line manager how difficult/unprofessional the escalation process had been, but there was no further action or response in regards to it being resolved.

6.2 Update on the Wood Review and Local Safeguarding Boards

The Wood Review focuses on Child Safeguarding Boards and as such does not link directly to changes to process or set up of adult structures that would oversee AAR. That said, two LA areas (Bristol and BANES) have chosen to merge their Adult, Child and Community Safety Partnership structures into one strand e.g. Keeping Bristol Safe. This is efficient in streamlining activity and enables a whole family approach rather than disparate activity. All LA areas are reviewing the success and areas of improvement following the transition year and it may be that the remaining three LA areas decide to merge in a similar way.

6.3 Local referral pathways and MASH arrangements

The availability of pathways for AAR is dependent on need. Thresholds are the same in regard to legislation, however the benchmark for hitting threshold for acceptance varies between LA areas and is dependent on resource availability. The LSU do not differentiate their response in regard to information sharing with partners across the force area. The vast majority of referrals into the LSU for Adult Safeguarding are related to mental health concerns at all levels. Some of these request action to set up contact with a GP which is not possible for the LSU, or request access to mental health provision or assessment. There is no direct route into primary mental health for the police. The Head of Victim Care and business lead for Mental Health are working on ways in which pathways can be developed, but this is a significant piece of work as it requires buy in and investment from partners. A recent incident has prompted an Ethics Committee meeting attended by the Mental Health Co-ordinator. It is not the first time that it has been discussed in this forum. As a result, the Ethics Committee have offered to gather all examples where the issue of mental health referral has been brought up and write a paper to assist in future discussions with partners. The current pandemic however is hampering the NHS' ability to discuss change at present, and this may continue for some time.

Aside from safeguarding and mental health, if an AAR is an enhanced victim of crime then pathways for access to support to cope and recover will be explored with that individual. This will depend on crime type, the outcome of the CNA and the victim's wishes.

Adult Mash arrangements exist within three of the five LA areas and all are being reviewed for their efficiency and effectiveness. This is being led by the LA. The LSU will be involved in any redesign and development processes once the review is completed.