Resident to Resident Abuse Briefing

Durham Safeguarding Adults Partnership

What is resident to resident abuse?

The Care and Support Statutory Guidance tells us who can abuse.

"Who abuses and neglects adults?
14.33 Anyone can perpetrate abuse or neglect, including:

- **spouses/partners**
- **other family members**
- **neighbours**
- **friends**
- **acquaintances**
- **local residents**
- **people who deliberately exploit adults they perceive as vulnerable to abuse**
- **paid staff or professionals and volunteers**
- **strangers."**

"14.34 While a lot of attention is paid, for example, to targeted fraud or internet scams perpetrated by complete strangers, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power."

What makes resident to resident abuse different is that people are within the system of organised services, in many cases residents are unable to leave, and while a peer such as a fellow resident is known to the adult, they are unlikely to be in a position of trust and power.

Resident-to-resident harm in care homes and other residential settings: a scoping review

In this scoping review by the Social Care Institute for Excellence (SCIE), published in August 2021, the opening paragraph makes a distinction between harm and abuse, defining abuse narrowly as "abuse occurs within relationships where there is the expectation of trust."

The Care and Support Statutory Guidance is clear, as above, that "Anyone can perpetrate abuse or neglect" including strangers and known people where there is no expectation of trust.

Where it takes place

While usually assumed to be in a residential or nursing home, resident to resident abuse can take place in any organised accommodation, usually where people do not choose who else is living there: shared flat for adults with a learning disability, hospital wards, supported living, hostels and other temporary accommodation, Assessment and Treatment Units, secure accommodation for people sectioned under the Mental Health Act 1983, prisons, and approved premises.

Types of abuse

The SCIE report identified "types of resident-to-resident abuse:
verbal (yelling, screaming), physical (hitting, kicking, pushing, throwing things), sexual (inappropriate touch, exposing themselves), violation of privacy and taking/damaging another's belongings. Linked to this was bullying, mainly highlighted in 'senior living facilities'."

The report went on to say "Abusive behaviour was rarely documented or reported in some settings, with evidence that some care managers consider it an inevitable or predictable part of living in a residential setting. Some services allow harmful behaviours to be accepted and unchallenged."

In some cases resident to resident abuse may also be domestic abuse, for instance a couple or siblings who move together to live in a care home or people who have begun a relationship while living in a hostel, where one partner or family member is abusive. In these examples as the Care and Support Statutory Guidance states, "it is wrong to violate the trust of those closest to you."

What are the risk factors in residential settings?

The SCIE report identified risk indicators and protective factors for resident-to-resident harm or abuse in care homes and other residential settings.

Likely indicators and risk

- In the majority of incidents, the person causing harm was a man with a cognitive impairment, yet with high levels of what was described as cognitive awareness and physical functionality, and a history of aggressive behaviours.
- The victims were most likely to be cognitively impaired women, who had a history of wandering, were verbally abusive, and behaved in socially inappropriate ways.
- Most incidents took place in the evening or at night, presumably when staffing levels were lower and there were fewer organised activities.
- Environmental risk characteristics include a crowded environment, inadequate staffing levels, lack of staff training, high numbers of residents with dementia, a lack of meaningful activities, crowded common areas, and excessive noise.

Protective factors

- High levels of dependency and the need for high levels of support were identified in the research as protective factors.

Risk which seems to be low level

Beware of normalisation of poor care and risk:

- Do families have low expectations where, for example, a push or a slap is seen as just a part of living in that type of setting? Do they know how to raise concerns?
- If there are many incidents, have professionals become desensitised?
- Do staff no longer see the harm? Do not infantilise adults and view it as like children squabbling.
- Resident to resident abuse should not be seen only as a single agency issue to be dealt with internally – the residents are within the care system and there may need to be a multi-agency response.

Unintentional harm or deliberate act?

Abuse may be unintended and in the context of social care, health care, or supported living, may be the result of a person's behaviour due to their medical condition.

→ Unintended harm and avoidable accidents still need to be resolved and safeguarding adults concerns reported as appropriate.

It may be the case that the environment, living situation, combination of clients, or a poorly managed situation by untrained staff are exacerbating the likelihood of an incident.

→ If there are numerous police callouts to the same premises, could the placements be inappropriate? Does the admissions criteria require review?

It may be a deliberate act as a part of the individual's aggressive or offending behaviour. Domestic abuse and coercion and control are deliberate abuse. Disabled people are more than twice as likely to endure domestic abuse as non-disabled people.

→ If it was a deliberate – does it amount to a criminal matter? If a crime may have occurred, it should be reported to the police.

→ Do not view an assault on person with learning disability, an autistic person, or a person living with dementia as different to assault on any other person. People have human rights, a right to be free from abuse, and a right of access to justice regardless of disability or capacity.

Learning from Safeguarding Adult Reviews and other reviews

Safeguarding Adult Review (SAR) into the death of Eileen Dean, published by Lewisham SAB, November 2022

Key findings:

- No reports to police – assumptions that the poor mental health of The [abusive] Adult precluded police involvement and criminal justice.
- No knowledge of The Adult's previous contact with the criminal justice system.
- Risk assessments were not done or were not shared between organisations.
- No clinical pathway for community clinical oversight of Wernicke-Korsakoff's Syndrome.
- Severity of risk downplayed, in seeking dementia-friendly accommodation.
- Care home assured there was no risk to patients and no longer threatening behaviour.
- Moved to care home with no specialist support.

Findings:

- The impact of The Adult's Wernicke-Korsakoff's Syndrome and the risk of threatening and aggressive behaviour was not well understood by services (The Adult's condition was viewed as being a dementia).
- Risk assessment and risk formulation was insufficient, and information on risk was not well documented or communicated.

SAR in respect of Leanne Patterson, published by North Tyneside and Northumberland SAB, 2019

Leanne was living in a hostel, where she endured domestic abuse from another resident who was evicted as a result, and she was then assaulted by two other residents. There were referrals into MARAC due to the domestic abuse and to safeguarding adults, but some opportunities were missed as previous referrals had been made and so a full picture of what was happening was not gained.

MARAC processes took precedence over safeguarding adults, which masked the risks to Leanne from other residents outside the domestic abuse, and from self-neglect.

The SAR featured the difficulties in assessing and managing risk when residents with complex needs cannot access other services "due to their entrenched problems" and are housed with other residents facing similar issues.

Multi-agency procedures at the time in considering Leanne's situation would not have assessed the interpersonal risk that the residents posed to each other.

Mental Health Homicide Review (MHHR) Care and Management of MR, published by NHS England 2016

- MR was not eligible for Older People's Mental Health Services.
- The care home's concerns were not understood by NHS services – it was seen by the social worker and the Community Psychiatric Nurse as a minor management problem (wandering) rather than the level of difficulty or risk experienced by the care home.
- Safeguarding reports were made by the care home to the local authority after some incidents but the local authority did not appreciate the level of risk nor escalate internally.
- Despite a clear assault with injuries the police were not contacted.
- No consistent recording of risks by care home nor follow up of the safeguarding concerns they had reported.
- Risk Threshold Tool did not allow distinct and separate assessment of the risk posed by the person causing harm when it was resident to resident abuse.
- Everyone took reasonable corrective action to manage the risk but there was no multi-agency care plan.
- Everybody thought everyone knew all that they should when they did not.

Deprivation of liberty and the criminal justice system

There is a distinction between managing risk to the adult and protecting other people, and between detaining somebody under the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005, or under the Mental Health Act 1983, and in using the criminal justice system.

The Mental Capacity Act (MCA) and care planning with DoLS is only concerned with the Best Interests of the person. The Mental Health Act can be used to detain somebody with a diagnosed mental disorder to protect them and / or to protect others. The criminal justice system functions to protect others.

In a Court of Protection hearing published in December 2022, it was argued that the care plan and DoLS authorisation was to protect the public from harm, not the person. The Court found that the focus of the care plan was to protect the adult who would self-harm and would have self-loathing if he committed an offence. It also found that it is a myth ("a false dichotomy") that protecting the person cannot also include protecting him from harming the public, in his Best Interests, under the MCA.

Risky adults and when a crime has been committed

The police should be involved when there is a crime (See also DSAP criminal offences briefing).

Criminal offences in resident to resident abuse can include assault, theft, fraud, sexual offences, and hate crime. The police can bring their oversight and access to criminal records, to gain a fuller picture of relevant history that would then inform ongoing risk assessment and risk management.

> "Ignorance of the criminal law is no defence." But if the person causing harm has dementia or another condition affecting their capacity, the police may well decide it is not in the public interest to charge the person with an offence.

Many adults with needs for care and support have capacity for their actions including their offending behaviour.

The Court of Protection judgement as above went on to find that the adult did have capacity about his care and support despite making impulsive decisions. It clarified that DoLS in the MCA is not to be used to manage risk instead of the criminal justice system.

> "…any further offending is a matter for the Criminal Justice System. The current SHPO [Sexual Harm Prevention Order] is an example of such risk management. The truth is that most sexual offenders and risky adults have capacity, and, like DY are not to be managed by a Deprivation of Liberty within the provisions of the Mental Capacity Act 2005."

Fitness to plead

Fitness to plead means that the person understands the criminal proceedings and what they are charged with.

- The UK age of criminal responsibility is 10.
- The age a person is assumed to have mental capacity under the MCA is 16.
- A child under 16 may have mental capacity to consent to or refuse medical treatment – known as Gillick competency; applies to social care and other decisions.
- Diminished responsibility is a partial defence for murder or manslaughter, caused by mental disorder / unsound mind… during sentencing their retained responsibility is assessed as high, medium, or lower.

Rightly or wrongly, people who lack capacity for some decisions under the MCA can be found fit to plead and can be prosecuted in the criminal justice system.

Compared to the general population there are a disproportionate number of offenders in prison who have a learning disability, mental health condition, or impairment due to substance misuse. There are people in prisons who lack capacity in some areas such as to consent to medical treatment.

When P is an Offender

A webinar about how the law approaches offenders or those at risk of offending when they do not have the mental capacity to make decisions for themselves.

When P is an Offender Webinar Recording - YouTube

A lack of capacity may mean sentencing is different

In an article on navigating the criminal justice system for those who lack capacity, Stone King solicitors said:

> "Defendants who have committed a criminal offence but who lack mental capacity are likely to be sentenced differently. For those with more involved needs, a Hospital Order or Guardianship Order might be appropriate. There are other Mental Health Treatment Requirements that can form part of a community order. Those technically guilty of a criminal offence but who lack capacity in some respects might be absolutely or conditionally discharged."

What to do

The SCIE report said that

> "interventions to prevent resident-to-resident harm include:
> - professional training,
> - development of person-centred care practices, and
> - the use of a multidisciplinary approach.
> - environmental considerations (such as reducing crowding, noise, and clutter, and prompting meaningful activities) and
> - care practices (including care plans, staff training, identifying risk factors, consistent staffing to build relationships)."

Assessing risk and the incident - some questions to ask

- Consider was it a one-off? Is it safeguarding adults? Or is it really about managing the situation, addressing possible poor care?
- Have things happened in the past? Do you have full information and history? Is there a pattern? Perhaps there have been previous reports?
- What would happen if nothing was done? Will it be repeated? Could other adults also be at risk?
- If there was little harm this time, could the same incident have potential to cause great harm?
- Can it be managed by changing the environment or a care review? Is the placement appropriate to the risk and the needs of the person causing harm?
- Was it intentional or deliberate? Is it at a criminal level?
- Beware of judgemental language about the victim.
- "They are both as bad as each other." Mutual abuse is a myth including in domestic abuse and coercion and control. There may be a dominant person causing harm and a victim-survivor resisting. The situation needs disentangling.

Social Care Direct may have information about other agencies who have been involved, or other low-level incidents that you are not aware of.

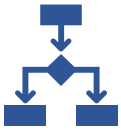
Make use of both the Risk Threshold Tool and Risk Factors Recording Sheet to inform your judgement.

Risk management of person causing harm when they are a service user

A safeguarding adults report and Section 42 enquiry are about the risk to the person harmed, and so may not focus on potential risk to others posed by the person causing harm.

- Does your safeguarding incident log allow risk by the person causing the harm or interpersonal risk to be indicated?
- Is there a structured risk assessment process, risk management process, and documentation of how risk is to be reduced?
- Make comprehensive records including what are viewed as small incidents.
- Review the incident log – is there a pattern of repeated incidents and does it flag the increased risk?

When to call a multi-agency meeting



If a situation is changing or deteriorating does the care plan need to be reviewed?

If incidents could repeat – consider calling a multi-agency meeting.

Resident to resident abuse should not be seen only as a single agency issue to be dealt with internally – the residents are within the care system of commissioners, providers, assessment and review, and safeguarding adults.

In situations of intimate partner / ex-partner domestic abuse, MARAC is the Multi-Agency Risk Assessment Conference held for high risk, focused on the person enduring domestic abuse. Use the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Identification and Assessment Checklist at the end of the County Durham and Darlington MARAC referral form to assess the level of risk.

In situations not at the MARAC level of high risk, after six domestic abuse incidents involving the same perpetrator or the same address, Durham Constabulary will convene a MATAC – Multi-Agency Tasking and Coordination meeting.

Is there a difference of opinion about the situation?
Sometimes Safeguarding Adult Reviews (SARs) have found an apparent reluctance to challenge interagency decision-making in safeguarding adults where there are differences of opinion. Proactive challenge may have altered the professional response and the outcome for the adult.

Managing Professional Differences is a new DSAP document that gives examples of situations when difference of opinion may arise, and the agreed four-step procedure for constructive professional challenge to resolve them in County Durham.

Resources

- Care and Support Statutory Guidance updated June 2023
- Risk Threshold Tool
- Risk Factor Recording Sheet
- Provider checklist dealing with a safeguarding concern
- Managing Professional Differences
- NICE guidance Safeguarding adults in care homes Overview | Safeguarding adults in care homes | Guidance | NICE

Available from DSAP Business Unit:
- DSAP criminal offences briefing
- Preserving forensic evidence document

To request a copy email Safeguarding_training@durham.gov.uk

MARAC
The MARAC form was updated in 2021 and has been sent to MARAC partners. To use the DASH Risk Identification and Assessment Checklist and to make a MARAC referral please source the form from your organisation's MARAC partner or domestic abuse lead.
- For MARAC correspondence and to make referrals contact marac@durham.police.uk

References

SCIE report
- Resident to resident harm in care homes

Lewisham SAR re Eileen
- LSAB 7 Minute Briefing - Eileen Dean (safeguardinglewisham.org.uk)
- https://www.safeguardinglewisham.org.uk/assets/2/lsab_eileen_dean_sar_report.pdf
- https://www.safeguardinglewisham.org.uk/assets/2/sar_eileen_dean_-_family_statement.pdf

SAR in relation to Leanne Patterson
- Adult-U-Executive-Summary-report-PUBLISH.pdf (northumberland.gov.uk)]

References (continued)

Mental Health Homicide Review (MHHR) Care and Management of MR, published by NHS England 2016

- invest-rep-bm-28-11-2016.pdf (england.nhs.uk) or
- https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2016/11/invest-rep-bm-28-11-2016.pdf

Court of Protection decision, December 2022

- https://www.bailii.org/ew/cases/EWCOP/2022/51.html

Diminished responsibility

- https://www.legislation.gov.uk/partial-defence-to-murder-diminished-responsibility

Navigating the criminal justice system for those who lack capacity

- https://www.stoneking.co.uk/navigating-criminal-justice-system-those-who-lack-capacity

Appendix 1 Extracts from Reviews and the Court Judgement

MHHR: Response to safeguarding adults concerns:

4 March – MR found with his hands around the neck of a woman with learning disability; she said he hit her. There was no note of any further discussion of the woman's allegation of assault.

30 May - MR seen punching a woman in the face causing injury (p111) – the SW suggested she sees her GP as the only action; there was no police involvement. It was noted that the woman would have verbalised strongly. Does this mean she was seen as equally to blame?

24 June - MR pushed a women who fell – no harm recorded (physical harm that is)

26 June - MR pushed the same women who fell and hit her head causing the fatal injury

invest-rep-bm-28-11-2016.pdf (england.nhs.uk)
or
https://www.england.nhs.uk/north/wp-content/uploads/sites/5/2016/11/invest-rep-bm-28-11-2016.pdf

Court of Protection decision, December 2022
https://www.bailii.org/ew/cases/EWCOP/2022/51.html

"the social worker responsible for DY's care stated that he was not able to think through the consequences if he was to go into the community unaccompanied. She described him as being 'able to talk the talk, but not walk the walk'."

"DY had tried to restrain a resident in the care home and had scratched him. He had put himself into a situation of risk without understanding that it [the risk] was there." Social worker

"by reference to Finklehor's model he [the psychiatrist] concluded that the fact that DY can make impulsive decisions regarding further offending does not lead him to make what he describes as an intuitive leap that these are due to an absence of capacity." Dr I the psychiatrist

"I have come to the conclusion on the balance of probability that DY has capacity to make decisions as to his care and support. I accept Dr Ince's evidence. In arguing otherwise, it seems to me that the respondents are setting the bar of capacity at too high a level. In the final analysis, their arguments relied heavily on the fact that DY makes contradictory statements about his need for care and supervision, that he was inclined not to think things through and that fact that he can overestimate his abilities. In doing these things, DY is no different from many people who do have capacity. People with capacity can make unwise decisions and act on impulse."

"…any further offending is a matter for the Criminal Justice System. The current SHPO is an example of such risk management. The truth is that most sexual offenders and risky adults have capacity, and, like DY are not to be managed by a Deprivation of Liberty within the provisions of the Mental Capacity Act 2005."