BRIEFING

Hidden in Plain Sight – What the Commission's Inquiry into Disability Related Harassment means for Safeguarding

Equality and Human Rights Commission

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Introduction

On 12 September, the Equality and Human Rights Commission published the findings of its formal inquiry into disabled related harassment. Our extensive evidence indicates that for many disabled people, harassment – including verbal and physical abuse, theft and fraud, sexual harassment and bullying – is a commonplace experience. Many disabled people have come to accept it as inevitable because public authorities have not put adequate structures in place to prevent and address it.

Disabled people often do not report harassment for a number of reasons: it may be unclear who to report it to; they may fear the consequences of reporting; or they may fear that the police or other authorities will not believe them. A culture of disbelief exists around this issue. For this reason, we describe it as a problem which is 'hidden in plain sight'.

There is a systemic failure by public authorities to recognise the extent and impact of harassment and abuse of disabled people, take action to prevent it happening in the first place and intervene effectively when it does. These organisational failings need to be addressed as a matter of urgency and the main report makes a number of recommendations aimed at helping agencies to do so. This briefing sets out the key issues for adult safeguarding.

Key areas for improvement for Safeguarding

- **Increase reporting of harassment**
- **All agencies should refer safeguarding concerns to adult safeguarding services for further investigation**
- **Adult safeguarding services should refer all cases where harassment amounts to criminal behaviour to the police**
- **Intervene effectively to prevent escalation**
- **Replace concepts of individual vulnerability with a focus on risk of harm**
- **Implement rights based approaches to safeguarding**
- **Provide better support for disabled victims**
- **Promote safeguarding as everybody's business**
- **Improve joint working and communication between agencies**
- **Improve serious case review process and sharing of lessons**

Reporting, recognition and action

Our research suggests that disability related harassment is widespread but under-reported by disabled people. Whilst most harassment is unlikely to trigger the need for a safeguarding intervention, some cases of harassment, particularly where it is ongoing, may require public authorities to investigate and take action to safeguard the victim.

As part of this inquiry we examined a number of very serious cases of harassment in which disabled people have died or been seriously injured. Ten of these cases are considered in the full report of the inquiry. We found that the appalling abuse of disabled people has been greeted with disbelief, ignored or mishandled by authorities, with tragic consequences. The cases give us some clues as to how and why such behaviour happens, and how, even when it is of a very extreme nature, it can go unchallenged. They show that a failure to tackle harassment can have dreadful results, both for the victims and also for society as a whole.

The cases contain lessons for health services, councils, police and other agencies about how to encourage disabled people, their families or neighbours to report incidents of harassment and how to respond when they do. We learnt most from authorities who had taken the opportunity to reflect on what went wrong, either because they had undertaken a thorough serious case review themselves or an in-depth review had been conducted by an independent agency such as an inspectorate.

We found some encouraging examples of these agencies learning from their mistakes, particularly where they had shown senior level commitment to implementing changes as a result of the review. However, the learning was often only applied in the area where the case had happened and had not been shared effectively across the country.

Our key findings are:

- Public authorities were often aware of earlier, less serious incidents but had taken little action to bring harassment to an end. In some cases, no effective action was taken to protect the disabled person even when public authorities were aware of allegations of very serious assaults. This left the disabled person at risk of further harm. Social isolation is a factor in many of the cases we reviewed. The harassment often took place in the context of exploitative relationships;
- Left unmanaged, non-criminal behaviour and 'petty' crime has the potential to escalate into more extreme behaviour. Several of the deaths were preceded by relentless non-criminal and minor criminal behaviour, which gradually increased in frequency and intensity;
- Public authorities sometimes focused on the victim's behaviour and suggested uncalled for restrictions to their lives to avoid harassment rather than dealing with the perpetrators;
- The failure of public agencies to share intelligence, co-ordinate their responses and treat harassment as a priority meant that opportunities to bring harassment to an end were missed. In a number of cases, the violence subsequently escalated resulting in serious harm or death;

- Disability was rarely considered as a possible motivating factor in crime and antisocial behaviour. As a result, the incidents are given low priority and appropriate hate incident policy and legislative frameworks are not applied;
- Extreme violence was a frequent feature in the murders of disabled people, often accompanied by degrading treatment and torture. Most of the murders that we investigated were not prosecuted as disability hate crimes even though this type of dehumanising treatment appears to be more common in the murders of disabled people than in other murders;
- Reports of violence may be treated by public authorities with disbelief and disregard, resulting in inaction and leaving the disabled person at risk of further harm.

The full report sets out lessons for agencies across the country in the areas of practice, training and guidance, changing attitudes, investigation, partnership working, outcomes, recognising risk.[1]

'Vulnerability'

The Commission has previously set out its concerns[2] that the framing of 'No Secrets'[3] and 'In Safe Hands'[4] (the policy frameworks for safeguarding in England and Wales respectively) suggest that disabled people are inherently vulnerable rather than recognising that they may experience vulnerable situations. Both frameworks are based around the concept of the 'vulnerable adult' which tends to encourage a protectionist response from social care agencies rather than a multi-agency response which aims to secure both safety and freedom. The frameworks have each been recently reviewed and changes are anticipated to introduce more human rights based approaches to protecting adults at risk of harm. Scotland already has a rights based framework for adult safeguarding under the Adult Support and Protection (Scotland) Act although the language of vulnerability is still used by some agencies.

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[1] Equality and Human Rights Commission, 2011, *Hidden in Plain Sight,* p52-55. Available from: http://www.equalityhumanrights.com/

[2] See, for example, Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People.* Available from: http://www.equalityhumanrights.com/uploaded_files/research/promoting_safety_and_security_of_disabled_people.pdf and Equality and Human Rights Commission, 2009, *Response to consultation on review of 'No Secrets' guidance.*

[3] Department of Health, 2000, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

[4] Welsh Government, 2000, *In Safe Hands: Implementing Adult Protection Procedures In Wales*. Available from: http://wales.gov.uk/topics/health/publications/socialcare/reports/insafehands?lang=en

Many disabled people resist being labelled vulnerable and may be concerned about reporting harassment if they feel it will remove their choices. The Commission's previous report[5] suggested that the term situational vulnerability was more appropriate, recognising that the risk of experiencing harassment is influenced by the circumstances in which someone lives their life including wider social, economic and community conditions.

The 'vulnerable' label has presented difficulties for agencies. The terms of reference for the serious case review into the death of Michael Gilbert, who was murdered by a family who had tortured him for years and kept him as a domestic slave, included: 'All agencies to scrutinise their own and other organisations' definition of "vulnerable adult" and analyse the impact in this case. Additionally an analysis should be undertaken of eligibility criteria relating to services and access to support.' At the hearing examining this case, agencies suggested that the definition was too narrow and had impeded their ability to intervene to protect Michael Gilbert from escalating violence.

The serious case review into the deaths of Fiona Pilkington and Francecca Hardwick recommended that agencies in Leicestershire should review the definition of 'vulnerability' 'to ensure it was inclusive enough'.[6] This resulted in the development of a local definition of vulnerability, namely 'a person is vulnerable/at risk if as a result of their situation or circumstances they are unable to protect themselves from harm'.[7]

Agencies in Leicestershire have developed a vulnerability factor checklist and an antisocial behaviour vulnerability risk assessment tool to help frontline staff to identify wider vulnerability. Factors which may be considered in the Leicestershire context include health and disability; equalities/discrimination factors (e.g. age, gender); personal circumstances (including being affected by antisocial behaviour); and economic circumstances (such as deprivation/financial concerns).

Environment can play an important role in relation to risk of harassment but this is often overlooked by agencies.[8] Deprived areas, where disabled people are more likely to live than non-disabled people, are linked to a greater risk of harassment.

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[5] Equality and Human Rights Commission, 2009, *Promoting the Safety and Security of Disabled People.* Available from: http://www.equalityhumanrights.com/uploaded_files/research/promoting_safety_and_security_of_disabled_people.pdf

[6] Leicester, Leicestershire and Rutland Safeguarding Adults Board, 2008, *Executive Summary of Serious Case Review* in relation to A and B, p14. Available from: http://www.leics.gov.uk/index/social_services/protect_children_adults/adult_protection_procedures/safeguarding_adults_partnership/seriouscasereview.htm

[7] Leicester, Leicestershire and Rutland Community Safety Partnership ASB/vulnerability task and finish working group document, 15 June 2010.

[8] Sin et al. for Equality and Human Rights Commission, 2009, *Disabled people's experiences of targeted violence and hostility*, p82. Available from: http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf

Although agencies may have an awareness of the impact of environment this does not tend to be included in formal risk assessment. The recognition of environmental factors such as economic circumstances within Leicestershire's approach is a welcome step although we continue to have concerns about the value of the term 'vulnerable' as a label to be applied to individual disabled people.

The Inquiry supports the proposals in the reviews of 'No Secrets'[9] and 'In Safe Hands'[10] to replace the terminology of 'vulnerable adult' with a definition of 'adults at risk' and 'adults at risk from abuse who cannot protect their own interests' respectively and to introduce more rights based approaches to safeguarding.

Safeguarding and justice

The Commission has found that the focus on help and protection within the adult safeguarding system can be at the expense of ensuring justice and redress.[11] Agencies may encourage disabled people to change their behaviour or may move them away from the perceived risk rather than taking action against the perpetrator. Although no national data is available, it appears that only a small proportion of safeguarding referrals in England and Wales result in a criminal prosecution of the alleged perpetrator of the abuse which had triggered the safeguarding referral. Several sources of evidence indicated that police sometimes referred incidents to social services to deal with, even though the underlying issue was actually criminal behaviour.

Calling a crime a crime is an important part of getting it right. For example, we have come across agencies using the term 'abuse' rather than 'physical assault' or 'rape', and 'financial exploitation' in place of 'theft' when referring to disabled people's experiences. The impact of this, whether or not intentional, is at its best unhelpful and misleading and at its worse prevents appropriate legal redress.

Changing language is often part of the solution to changing attitudes, and as we highlight in the full report, attitudinal barriers are some of the most pervasive barriers that need to be tackled if we are to address this issue effectively.

Serious case reviews

Unlike child deaths in Britain and domestic violence homicides in England and Wales, there is no statutory requirement to conduct a serious case review into the

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[9] The Law Commission, 2011, *Adult Social Care* (LAW COM No 326). Available from: http://www.justice.gov.uk/lawcommission/adult-social-care.htm

[10] Welsh Institute for Health and Social Care, University of Glamorgan, 2010, *Review of In Safe Hands: A Review of the Welsh Government's Guidance on the Protection of Vulnerable Adults in Wales*. Available from: http://www.nmc-uk.org/Documents/Safeguarding/Wales/Review%20of%20In%20Safe%20Hands.pdf

[11] Sin et al. for Equality and Human Rights Commission, 2009, *Disabled people's experiences of targeted violence and hostility*, p82. Available from: http://www.equalityhumanrights.com/uploaded_files/research/disabled_people_s_experiences_of_targeted_violence_and_hostility.pdf

murder of a disabled person. In situations where a disabled person dies or is seriously injured as a result of disability-related harassment, the local safeguarding board or Adult Protection Committee makes the decision on whether or not to conduct a serious case review.

Serious case reviews were conducted in only four out of the 10 murders of disabled people investigated by this inquiry. No serious case review was conducted in another case investigated by this inquiry, the gang rape and chemical burning of a 16-year-old woman with learning disabilities, even though her age and the severity and consequences of the assault would suggest it should have been considered under the statutory framework for serious case reviews relating to children.

The purpose of serious case reviews is to identify any lessons to be learned and improve practice as a result. Serious case reviews are particularly important where victims and/or perpetrators were in contact with public authorities or where authorities should have been aware that individuals were being abused or at risk of serious harm. Without the rigour of a detailed review, agencies are less likely to identify and learn from mistakes.

A serious case review might not necessarily have been appropriate in all of the cases we have considered. However, in the context of a widespread lack of recognition of the extent of the hostility towards disabled people, and the low rates of prosecution of crimes as disability hate crimes, serious case reviews are particularly important. The failure to undertake them has contributed to the widespread ignorance of the extent and impact of disability-related harassment and the inadequate responses to it.

The quality of the serious case reviews that had been conducted was patchy and they often focus only on the victim and don't consider what contact there had been between the authorities and the perpetrators. The better ones, such as that into the murder of Steven Hoskin, have a real value in improving agencies' awareness and understanding of disability-related harassment. Much of this learning applies across areas and is not specific to the localities in which it was developed. The response of the Scottish Government to the case of the 'vulnerable adult' and the introduction of the Adult Support and Protection (Scotland) Act has helped share some of the learning from Borders with other authorities in Scotland. There is currently no mechanism, however, for sharing lessons from Scotland with agencies in England and Wales and vice versa.

The evidence suggests a change of approach to serious case reviews, with learning from the approach taken in sectors such as aviation and healthcare. The Munro Review's 15 recommendations in respect of transforming child protection represents the opportunity to deliver holistic reform of the child protection system. These recommendations could be used as a basis for a review of the adult safeguarding systems and its perceived shortcomings. There should be a stronger focus on understanding the underlying issues that made professionals behave the way they did and what prevented them from being able to properly help and protect the victim. The current system is too focused on what happened, not why.

Recommendations

Our full report sets out measures which our evidence suggests could help prevent disability related harassment and improve responses to it. Over the next six months we will consult widely with stakeholders on whether these are the right steps, how they might work and whether there are any other measures which might be more effective. We are keen to engage with all parties to find out how the improvement can be achieved for the most reasonable cost. Most importantly, we recognise that we will only succeed in effecting change when others take responsibility and ownership for these recommendations.

Seven core recommendations

At this stage, it is clear that there are seven areas where improvements will show to us that society is achieving real progress in tackling harassment:

1. There is **real ownership** of the issue in organisations critical to dealing with harassment. Leaders show strong personal commitment and determination to deliver change.
2. **Definitive data** is available which spells out the scale, severity and nature of disability harassment and enables better monitoring of the performance of those responsible for dealing with it.
3. The Criminal Justice System is more **accessible and responsive to victims** and disabled people and provides effective support to them.
4. We have a **better understanding** of the motivations and circumstances of perpetrators and are able to more effectively design interventions.
5. The wider community has a more **positive attitude towards disabled people** and better understands the nature of the problem.
6. **Promising approaches** to preventing and responding to harassment and support systems for those who require them have been **evaluated** and disseminated.
7. All **frontline staff** who may be required to recognise and respond to issues of disability-related harassment have received effective **guidance and training**.

A number of more detailed recommendations lie beneath these seven core areas including:

a) Removing all barriers to reporting for disabled people and putting in place processes to **encourage reporting**;
b) Routinely asking all victims of anti-social behaviour or crime whether they are disabled and considering whether this may be a factor in why the anti-social behaviour or crime occurred. Reconsidering **disability motivation** throughout the investigation;
c) **Improving data collection** and recording;
d) Reviewing the effectiveness of current **awareness raising activities** concerning disability-related harassment where they exist and assessing where gaps in campaigns could usefully be filled;
e) **Training for frontline staff** where disability-related harassment, antisocial behaviour or other similar forms of activity are likely to be an issue, in how to recognise and ensure appropriate safeguarding;
f) **Evaluating response and prevention projects and sharing knowledge** of the most effective routes to take to deal with harassment and reduce its occurrence;

g) Using the **public sector equality duty** as a framework for helping promote positive images of disabled people and redressing disproportionate representation of disabled people across all areas of public life;
h) Encouraging all individuals and organisations to **recognise, report and respond** to any incidences of disability related harassment they may encounter.

Specific recommendations

In addition to the core recommendations, there are recommendations targeted at local agencies and partnerships and health and social care bodies:

1. Health and social care providers should put robust and accessible systems in place so that **residents living in institutions can be confident of reporting** harassment by staff or other residents;
2. Health and social care providers should review **eligibility criteria** to increase social interaction and reduce social isolation for disabled people;
3. Adult Protection Committees and Community Safety Partnerships should ensure that **accessible information and advocacy services** are available to enable disabled people to understand and exercise their rights;
4. Health services (especially GPs, accident and emergency and ambulance services) should ensure that their **safeguarding alerts process** is sufficiently robust and staff are adequately trained;
5. Local agencies and partnerships should **review the priority they give to dealing with harassment** and work together to eliminate it. If appropriate, this should be formalised in a joint action plan;
6. All agencies and partnerships dealing with crime and disorder should appoint a **local harassment co-ordinator** (unless they can evidence properly there is no requirement) and such co-ordinators should meet on a regular basis to identify issues of joint concern;
7. **Statistics on the performance of local agencies** and partnerships in addressing harassment, and any service guarantees, should be published annually in a uniform format using accessible media. These should include surveys which measure community satisfaction with their work;
8. Local **partnership boards should be fully accessible for disabled people** to join, which may include providing additional support to them to participate on an equal basis;
9. Local agencies and partnerships should ensure **support and advocacy services** in their area are adequate, accessible and that the victims of disability-related harassment, and potential victims, know their rights and the options available to them with regard to all forms of harassment. Those experiencing high-impact disability-related harassment should be referred to specialist services while the families of murder victims should also be offered counselling services;
10. Whenever **repeat perpetrators or repeat victims** are identified, the **priority** given to solving the case should always be increased to urgent. Local partnerships and agencies should ensure that the police are immediately notified of this information and act on the basis of this;
11. All local agencies should ensure that their **needs assessment and service provision arrangements minimise the risk of harassment;**

12. **Standards,** and any associated terminology, **for identifying 'at risk' individuals should be consistent** and agreed across agencies and relevant information should be shared at officer level on a regular basis as 'case conferencing'. However, all agencies and partnerships must avoid an overly intrusive approach to identifying at risk individuals so as to ensure the privacy and independence of those whom they seek to protect and to encourage full reporting.

The Commission will seek to progress and finalise the recommendations in partnership with the various groups and agencies in the coming months. But everyone should be aware that disability-related harassment is predominantly a social problem and one that, in the final analysis, also requires an individual response and commitment to change.