



Safer  
**Bristol**  
Crime, Drugs and Alcohol  
Partnership

Safer Bristol Partnership and Bristol  
Safeguarding Adults Board  
Thematic Mate Crime Review

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## 1. Introduction

### 1.1 Rationale for carrying out a Thematic Review

1.1.1 A referral was received on the 3rd April 2017 from the police requesting that the Bristol Safeguarding Adults Board consider whether the criteria was met for undertaking a Safeguarding Adults Review following the death of a man called Derrick Carr<sup>1</sup>.

1.1.2 Derrick was a 51 year old Black Caribbean man living in supported accommodation. The care provider specialises in services for adults aged 18 to 55 with moderate to severe mental health and learning disabilities. This accommodation was commissioned and funded by Bristol City Council. Derrick had qualified for support under the Care Act 2014 criteria. When Derrick died concerns were raised that he had been the victim of Maltreatment while living in supported accommodation. His death was sudden and unexpected, and due to the circumstances surrounding it his family questioned whether Derrick's death was suspicious and could have been linked to the crime he was experiencing.

1.1.3 Following two post-mortems, including one forensic post mortem, both pathologists concluded that Derrick died of a heart attack that could not have been caused by another party. An Inquest was held in January 2018 which also concluded that Derrick died as a result of a heart attack.

1.1.4 The Bristol Safeguarding Adults Board has a statutory duty<sup>2</sup> to arrange a Safeguarding Adults Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or;
- an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and there is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.1.5 As Derrick's death did not result from abuse or neglect, the criteria for a Safeguarding Adults Review were not met.

1.1.6 However the Board agreed with the Safeguarding Adults Review Sub Group's recommendation that the case raised concerns about agencies' knowledge and

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<sup>1</sup> The Boards have used Derrick's full name in this report at the request of his family

<sup>2</sup> Sections 44(1)-(3), Care Act 2014

ability to respond effectively to Mate Crime and exploitation of adults with disabilities.

- 1.1.7 On the 10th May 2017 the Bristol Safeguarding Adults Board agreed that a joint Thematic Review with the Safer Bristol Community Safety Partnership, who have the strategic lead in the city for responding to Hate and Mate Crime, should be undertaken to ascertain whether there were practice issues in this instance and/or opportunities for development in the protection of adults in the city in this area.

## **2 Review Process**

### **2.1 Scope and focus of the Review**

2.1.1 The review sought to answer the following research questions:

- How effectively are professionals and organisations in Bristol safeguarding adults from Mate Crime particularly when in accommodation settings where they are being supported to make choices and be in control of their own lives?
- What further steps could be taken by the BSAB and Safer Bristol to improve protection in this area?

2.1.2 Derrick's family have raised their concerns about how agencies responded to Derrick's death including delays in the family being informed. These issues are outside the scope of this report as Derrick's death has not been found to be linked to the Mate Crime he experienced and so will not be commented on, however we would like to acknowledge the significant impact that the handling of Derrick's sudden death had upon his whole family.

### **2.2 Reviewers**

2.2.1 Tom Hore is the Director of Bristol Mind. He has extensive experience of delivering services and advocating for adults with support needs. He is a member of Safer Bristol's group responding to Disabilism and Hate Crime.

2.2.2 Becky Lewis is the Business Manager for the Bristol Safeguarding Adults Board. She is a qualified social worker and has a background in delivering and running services for victims of sexual exploitation.

2.2.3 Neither Tom nor Becky had direct experience in working with Derrick and are independent of the agencies involved in commissioning and delivering his support.

## 2.3 Methodology

- 2.3.1 The review approach sought to identify key themes from Derrick's case and national learning and ascertain whether these were replicated in current practice. This was done by:
- 2.3.2 A review of agencies files concerning their involvement with Derrick since he was placed in supported accommodation was undertaken by a representative who was not involved in the direct work with Derrick. This was used to provide a thematic report of their involvement and consideration of Mate Crime issues.
- 2.3.3 A meeting was held with members of Derrick's family to seek a family perspective of the organisational response to Mate Crime.
- 2.3.4 A national review of current research, guidance and policies relating to Mate crime was completed by the Bristol Safeguarding Adult Board's Policy and Projects Officer.
- 2.3.5 The reviewers used this information to identify key learning from Derrick's case and conducted a multi-agency learning event to test the hypotheses of the report authors and ascertain similarities and trends in current practice. Over thirty representatives from care providers, voluntary sector services, hate crime services, housing, mental health, adult social care, health and criminal justice agencies attended and contributed to this event.
- 2.3.6 Multi-agency consultation was undertaken to seek the views of providers concerning issues related to Mate Crime. 145 attendees from agencies across the city with particular representation from supported housing providers, were given the opportunity to submit views.
- 2.3.7 The following agencies were identified as having been involved in Derrick's care and support and submitted individual reports of their involvement with Derrick:
- Bristol City Council Adult Social Care
  - Bristol Clinical Commissioning Group
  - Avon and Somerset Constabulary
  - Independent Supported Accommodation Provider
  - Avon and Wiltshire Mental Health Partnership NHS Trust
- 2.3.8 With the exception of the report from the Independent Supported Accommodation Provider and the Police, the reports provided were brief due to the limited engagement of agencies with Derrick. This is a finding in and of itself

as it indicates that these issues were not identified as requiring a multi-agency response and is commented on within the report.

2.3.9 The report from the Independent Supported Accommodation Provider highlighted a significant number of areas where they have already sought to develop their practice as a result of Derrick's experience. Some of these are summarised in the findings.

2.3.10 There were delays in receiving information from some of the agencies involved. This was due to communication between commissioners and providers, and allocation of resources for a non-statutory review. As the Bristol Safeguarding Adults Board is a statutory Board and can undertake any activity required to safeguard adults in the city, these issues have been raised with relevant Board members and processes reinforced to minimise similar delays to future reviews.

### **3 Case Summary - Derrick**

#### **3.1 Background**

3.1.1 Derrick was 51 years old when he died in March 2017. He is described as a quiet, pleasant and caring man who took pride in his appearance and was close to his family. Derrick had a large, caring family who lived locally to him. Derrick lived with his mother until 2013, and saw her and other family members almost daily after he moved into supported accommodation.

3.1.2 Records show that Derrick was considered to have the mental capacity to make decisions and choices for himself.

3.1.3 Derrick had a diagnosis of bipolar affective disorder and borderline learning disability. Risk assessments undertaken by mental health services in 2010 and 2012 identified he had a susceptibility to exploitation, such as lending people money they did not repay, but there is no information relating to any specific safeguarding adult concern in their records.

3.1.4 Derrick's involvement with community mental health services ended in 2013, with his care being managed solely by his GP. This was due to a longstanding stability in his mental health. Derrick had a positive relationship with his GP, who he trusted, and sometimes attended the surgery with family members and sometimes on his own.

3.1.5 Derrick's mother had been his primary carer throughout his life. In 2013 he was assessed by a Social Worker within Bristol City Council's Adult Care and Support Services initially for a respite placement. An Independent Supported Accommodation Provider was commissioned to provide supported

accommodation in the community. The period of respite was extended and Derrick requested to move to this type of supported environment on a permanent basis in order to increase his independence. This was agreed and Bristol City Council commissioned an Independent Supported Accommodation Provider to provide this support on a permanent basis.

- 3.1.6 On the 28th January 2015 Derrick became resident in a low level supported accommodation unit where he received 10 hours per week of support based around practical independent living skills such as money management, shopping, cooking, healthy eating, medication management and personal hygiene. As a low support unit it did not provide evening/night support or enhanced weekend support but staff from a nearby high support unit visited during the evening and occupants of the project had access to an out of hours emergency contact number.
- 3.1.7 In the period Derrick was in supported accommodation no review was undertaken by social care. There is no statutory requirement for this type of care review but the council representative informed the reviewers that best practice would be for them to undertake them once a year. We would have also expected that a review would have been undertaken when Derrick's placement became permanent in order to assess whether his needs and circumstances had changed. At the time of his death Derrick had been in placement for over three years and no review was undertaken.
- 3.1.8 In 2016 the accommodation provider's records state that they made two Safeguarding Referrals to the Bristol City Council Safeguarding Adults Team, one in June and one in December. There are no records that these referrals were received by the local authority team. It is believed that there may have been issues because the provider was still using fax to share safeguarding referrals. There is no evidence that the lack of response from the Safeguarding Adults Team was followed up by the provider. Both referrals were about concerns that Derrick was experiencing exploitation by other residents in the home, including being pressured for money.
- 3.1.9 One incident was reported to the police. In early September 2016 Derrick said that his housemate at the time had invited an unknown male into the property for a drink. Derrick left his phone on the floor and when he returned both the male and his phone had gone. His housemate had left the male alone in the property to go outside. The case was closed with no action due to no response being received from Derrick after two calls were made and a letter sent to him. Derrick was not recognised by police as a vulnerable victim and the possibility that Derrick was being exploited was therefore missed. Derrick's phone was later returned to him in circumstances that remain unclear.

- 3.1.10 While there were no prior entries on the Constabulary's databases that would have identified Derrick as vulnerable, though checks using the ASSIST computer system (an information-mining tool that can search across all police databases and systems) would have identified previous intelligence about two males exploiting other residents at that same location. This should have supported a more in-depth investigation as while the links to Derrick's phone might not have been clear but that intelligence could have triggered a more in-depth analysis of the circumstances of this offence. Furthermore, another incident (not related to Mate Crime) at the Independent Supported Accommodation Provider in 2015 highlighted the same issue with police attending the property and responding to a resident without identifying their care and support needs. It is a significant concern that this issue was identified previously but had not been resolved.
- 3.1.11 The accommodation provider moved the housemate to another housing unit on the other side of the city to manage the concerns. Support workers worked with Derrick to raise his awareness and understanding of circumstances where he may be subjected to exploitation even if he didn't feel he was being exploited. Support workers role-played with Derrick where he practiced saying "No" to unreasonable requests, e.g. borrowing money. He was helped to set up a different bank account which had limited immediate access to prevent others from persuading him to withdraw large sums of cash.
- 3.1.12 In December 2016 Derrick had contact with the police as a witness on an unrelated matter. Derrick was not identified as a vulnerable adult in this contact with the police either.
- 3.1.13 In February 2017 the police received intelligence from one of Derrick's support workers that Derrick was being financially exploited by two men. One of them was a relative of Derrick's previous housemate. The men had stolen Derrick's phone and were demanding money for it. On one occasion they turned up to the property looking for Derrick but Derrick was not home. They gained entry into the property and demanded money from another resident. They left without any money but the support worker suspected that they would come back and cause physical harm to Derrick or damage his property.
- 3.1.14 When the crime was reported, it should have been created as a 'live' occurrence on the police's crime recording system Niche and a live log generated. This would have dispatched a resource so that any suspicions of exploitation were investigated further – not solely recorded as an intelligence report. Certain categories of people, such as support workers, can in some circumstances report crime on behalf of a victim and so a crime could have been recorded in this instance.

- 3.1.15 Further to this, the police staff-member who received the intelligence filed the report in error. This may have been because of a lack of familiarity with the Niche system which was a relatively new system at that time. The report should have been investigated as a disability Hate Crime but due to the error the incident was closed.
- 3.1.16 A month later, the night before Derrick died, the same two males visited Derrick. Another resident in the block told police and staff that they got Derrick drunk to take money from him or otherwise take advantage of him. He said that this has happened on previous occasions as well but due to the resident's own vulnerabilities the details were not clear. There was also a suggestion that one of the men had taken Derrick's bus pass.
- 3.1.17 Sadly Derrick died the next morning. On the evening after Derrick's death, one of the men returned to collect his phone charger. When he was told Derrick was dead he did not believe this and he went into Derrick's room to collect his charger as he knew the code. Staff said that residents did give out the codes to their rooms even though this went against their advice.
- 3.1.18 Derrick's death has been found to be as a result of a cardiac arrest. There is no evidence that his death is related to the exploitation it is believed Derrick had been experiencing. However, the circumstances around Derrick's death led his family to explore the care he had been receiving prior to his death and raise concerns about the management of the risk posed to him in the accommodation. They had not previously been informed of the safeguarding referrals the provider states they made to the Safeguarding Adults Team, nor of the concerns from the previous nine months in relation to exploitation and Mate Crime.
- 3.1.19 Following Derrick's death, Avon and Somerset Constabulary investigated the allegations of Mate Crime against Derrick. There was not sufficient evidence to be able to take forward a prosecution.
- 3.1.20 The accommodation provider has challenged the assumption that could be made that Derrick was exposed to a constant level of high level mate crime, bullying and intimidation during his time living in this flat. They highlight that this was only identified on the occasions highlighted in this report despite frequent contact with Derrick. They do recognise however that Derrick was unlikely to recognise Mate Crime and so self-reported Mate Crime is likely to be low.
- 3.1.21 The review has not been provided with evidence that contradicts the provider's view, and the review has not identified additional incidents of Mate Crime, however given the previous assessment by Avon and Wiltshire Mental Health Partnership of Derrick's susceptibility to Mate Crime, it is likely that Derrick

experienced these incidents when living at home as well as in commissioned accommodation.

## 3.2 Family Views

- 3.2.1 As part of this review the report, the authors met with seven members of Derrick's family and his pastor. We would like to thank them for their time and for sharing their views at a time which was difficult for them following Derrick's death.
- 3.2.2 The family raised important points about how family members are included in care plans for adults with care and support needs. They highlighted that they had a lack of information about the type and nature of the accommodation Derrick was placed in. They say that they were not provided information about what to do should they have concerns for Derrick, nor did anyone speak to them about the potential signs of abuse or exploitation, or particularly risks that might arise from Derrick living independently.
- 3.2.3 Derrick's family spoke to the report authors about their concerns that without any formal review of Derrick's care, with the family members included, there was no chance for Bristol City Council to assess the quality and effectiveness of the care he was receiving. They also questioned how Bristol City Council support and work with commissioned providers to ensure that their residents are receiving services which are appropriately informed of current practice issues.
- 3.2.4 The family felt that information sharing agreements should have been established when Derrick moved into supported accommodation so that a relationship and threshold for sharing information with the family was established with him right from the start.
- 3.2.5 In hindsight, knowing now about the vulnerabilities and needs of other residents in the accommodation, Derrick's family question whether this was the most appropriate place for him to live and feel he should have been somewhere with 24 hour staffing.

## 3.3 Key themes from Derrick's case

- 3.4 The key themes from Derrick's case that were identified to inform the thematic review were:

<ul style="list-style-type: none"> <li>• Awareness and Identification of Mate Crime</li> </ul>
<ul style="list-style-type: none"> <li>• Preparing Adults and Families for increased independence</li> </ul>
<ul style="list-style-type: none"> <li>• Reviewing care</li> </ul>
<ul style="list-style-type: none"> <li>• Protecting Vulnerable Adults from Mate Crime</li> </ul>

## 4 Literature Review<sup>3</sup>

### 4.1 Definition of Mate Crime

4.1.1 There is no statutory definition of mate crime in UK law. The Crown Prosecution Service uses the definition of hate crime to cover such offences but recommends considering charging or sentencing an aggravated form if vulnerability is established:

"Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender."<sup>4</sup>

4.1.2 The Crown Prosecution Service (CPS) advises its prosecutors to avoid referring to "mate crime" but highlights that the term is used by some disability organisations within the disabled community to raise awareness of the issue. They explain that it not CPS policy to use this phrase as it may introduce confusion regarding terminology and is potentially confusing to people with learning disabilities in the context of criminal prosecutions.<sup>5</sup>

4.1.3 Safety Net, a project launched in 2009 to prevent the exploitation of people with learning disabilities by those claiming to be their friends, define Mate Crime as;

‘Many people with learning disabilities have so called ‘friends’ who go on to abuse them. This has led to people losing their independence, financial, physical and sexual abuse...even murder.’<sup>6</sup>

<sup>3</sup> Completed by Natalie Chamberlain, BSAB Policy and Projects Officer

<sup>4</sup> [http://www.cps.gov.uk/legal/d\\_to\\_g/disability\\_hate\\_crime/index.html#a4](http://www.cps.gov.uk/legal/d_to_g/disability_hate_crime/index.html#a4)

<sup>5</sup> [http://www.cps.gov.uk/legal/d\\_to\\_g/disability\\_hate\\_crime/index.html#a4](http://www.cps.gov.uk/legal/d_to_g/disability_hate_crime/index.html#a4)

<sup>6</sup> <http://arcuk.org.uk/safetynet/>

The project reported that;

‘The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a repeat and worsening abuse.’<sup>7</sup>

4.1.4 Furthermore, Green (2013) a moderator of the Disability Hate Crime Network argues that mate crime is the only term to use if a disabled person is befriended then bullied, harassed, robbed, beaten, abused and /or killed by their "befriender". To support this, Vasey (2016) argues that ‘Mate Crime’ should be used to highlight a particularly horrible and insidious form of disability hate crime. It is when vulnerable people, such as those with autism or learning disabilities, are bullied or manipulated by people they consider to be friends. This abuse of friendship can take many forms: it can begin in the playground, with pushing, shoving and low-level bullying. Among adults, it can result in vulnerable people being befriended by abusers and then coerced into giving away money or possessions or to commit crimes. It has even led to death.

4.1.5 These differences are highlighted by Doherty (2013) who critically assessed the usefulness of the concept of ‘mate crime’, as a means of understanding offending behaviour against disabled people. Doherty suggests that while those who commit hate crime offences tend to be strangers to their victims; the phenomenon of ‘mate crime’ occurs when crimes are committed against disabled people by people they consider to be their friends. Doherty also considers and concludes that ‘mate crime’ and disability hate crime should be construed as a sub-set of hate crime in terms of both policy and theory. In addition, Perry (2013) argues that ‘befriending’ and ‘grooming’ are more appropriate terms to consider and are applicable to all categories of victims, these terms better reflect the active processes involved and place the focus on the offender. Perry (2013) goes on to link these practices to similar acts of violence, such as those used to groom women for prostitution.

## 4.2 Features of Mate Crime

4.2.1 Quarmby (2013) also refers to mate crime as a pernicious form of hate crime, which seems to affect people with learning difficulties in particular and is often long-term and disturbing in nature given the particular targeting of vulnerability. The National Autistic Society has noted that "Many people with autism desperately want to have friends, but may struggle to know the best ways of

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<sup>7</sup> <http://arcuk.org.uk/realchangechallenges/real-change-challenge-mate-crime/>

starting and maintaining friendships" and are therefore at risk of mate crime abuse.<sup>8</sup> Arc (2013) refer to the term of 'Tuesday Friends' where their research highlighted a typical story of a young person with Asperger's who had, what was called, his 'Tuesday Friends', the day when his benefits arrived and where a particular group of people would turn up at his flat, 'help' him to the cashpoint and then to the pub where they 'helped' spend his money.

- 4.2.2 Quarmby (2008) analysed the deaths of 18 disabled victims of hate crime for the charity Scope. It reported that 11 were killed by people they considered to be good friends. Only two out of the 18 were killed by strangers and the rest were killed by acquaintances. Two were even killed by self-styled carers. Furthermore, Parry (2013) studied nine housing-related serious case reviews in which the person who died was harassed and subjected to anti-social behavior and found that seven of these individuals had learning disabilities.
- 4.2.3 Thomas (2011) states that 'mate crime' refers to criminal acts perpetrated against a person with a known or perceived disability status, where the victim has an affinity – rather than dependent – relationship with the offender(s). Typically, the victim values the relationship with the offender, whilst the offender uses the asymmetrical relationship to exploit, humiliate and attack their 'friend' (Thomas 2011).
- 4.2.4 Some victims may want their victimisation to stop, but their affinity with the offender is too important to jeopardise the relationship (Thomas 2011). Some people with disability, notably those with learning disabilities, may also not understand that they are being victimised, or find such behavior so endemic to their lives that it becomes internalised and normalised (Sin 2013). Instances of 'mate crime' are less likely to be reported – to anyone, let alone the police – because the 'mateship' takes precedence, and the threat of friendship breakdown is too distressing to contemplate (Thomas 2011).
- 4.2.5 According to the Real Change Challenge – Mate Crime: A Challenge for the Police, Safeguarding and Criminal Justice Agencies (2013) states that Mate Crime can be "Invisible crime" with invisible acts being carried out by invisible perpetrators on invisible victims in invisible circumstances.<sup>9</sup> They highlight that:

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<sup>8</sup> National Autistic Society, [The Protection of Children and Young People with Autism from Violence and Abuse](#)

<sup>9</sup> <http://arcuk.org.uk/realchangechallenges/files/2013/10/RCC-Mate-crime-PCJA.pdf>

- Mate crimes might have been invited, or appear to have been invited, by the person with a learning disability, raising issues of mental capacity, consent and informed choice
- Mate crimes are sometimes not criminal
- Mate crimes are likely to occur in private
- Mate crimes are likely to occur (though not exclusively) within long-term relationships
- Mate Crimes are unlikely to be disclosed by someone with a learning disability.
- Until recently, mate crime has been unrecognised in hate crime materials, educational resources, safeguarding procedures, etc.

4.2.6 The Department of Health (2001) 'Valuing People' report found that only 30% of people with learning disabilities have any friends at all. Furthermore Emerson and Hatton (2008) suggest that even when people have friends, one third have no contact with them. This may mean that four out of five people with learning disabilities are, to all intents and purposes, friendless. Given so few opportunities for relationships that bring warmth, mutual support and validation, then any connection is often viewed to be better than none. People are desperate for friendships, and such desperation is easily exploited. This makes it more likely that any offer of 'friendship' will be accepted – "better to have horrible friends than no friends at all" (Wallis 2010). It also means that people will be far less likely to end a friendship, even when it has become dysfunctional.

### 4.3 Prevalence

4.3.1 The ARC Safety Net project was set up in 2009 to research the issue of mate crime, raise awareness, and deliver training. The project develops resources and local protocols, and began with a specific objective of establishing the size and nature of mate crime. The project swiftly became aware of the extent of mate crime, with many ARC members sharing anecdotally that from a large range of crimes had been targeted against people with disabilities as a form of Mate Crime. The project argues that this places an even greater responsibility on services. They argue that if people cannot, or will not, see the crimes to which they are subjected, it is up to the people around them to do so and to take decisive action.<sup>10</sup>

4.3.2 The British Crime Survey estimates that up to 98% of learning disability hate crime is unreported. Vasey (2016) reported that regional research in Liverpool found

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<sup>10</sup> <http://arcuk.org.uk/realchangechallenges/files/2013/10/RCC-Mate-crime-PCJA.pdf>

that 80% of respondents to a survey of people with autism or their families speaking on their behalf had been bullied or taken advantage of by someone they considered a friend. In addition, 71% had been subject to name calling and verbal abuse and 54% of 12-16-year-olds had had money or possessions stolen. The survey found the most vulnerable age group to be 16-25. One hundred per cent of the respondents in that age category reported having difficulty distinguishing genuine friends from those who may bully or abuse the friendship in some way. Eight out of ten said that fear of bullying had caused them to turn down social opportunities. Furthermore, in a national survey by the National Autistic Society (NAS) in 2014, 49% of adults with autism reported that they had been abused by someone they thought of as a friend.

#### 4.4 Learning from National Serious Case Reviews

##### Steven Hoskins (2006)

4.4.1 In 2006 Steven Hoskins was abused, tortured and killed by people who he thought were his friends. The Serious Case Review of Steven Hoskins (2007) argued that the term 'disability hate crime' failed to recognise the duration of Steven's contact with his persecutors and referred to it as a 'counterfeit friendship.' It went on to report that 'Steven wanted friends. He did not see that the friendship he had so prized was starkly exploitative, devoid of reciprocity and instrumental in obstructing his relationships with those who would have safeguarded him.' Steven Hoskins' principal killer lived with him for a year before murdering him and his Serious Case Review listed more than 40 missed opportunities for intervention.

4.4.2 Real Change Challenge (2014) commented on the review and explained that the case has "serious implications for service providers, who must address the everyday, 'petty' examples of mate crime that so impact on people's independence and confidence because of the compelling evidence that unaddressed, minor mate crimes are often repeated, and escalate."<sup>11</sup> Flynn (2007) stated that Stephen wanted the acceptance, validation, pleasure and support that friendships can bring. His mother said he was generous, he knew he had a learning disability, he tried to do as others wanted, and he wanted friendships. He would say, 'They're my mates, I've got my own mates now' (Williams 2010).

##### Gemma Hayter (2010)

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<sup>11</sup> <http://arcuk.org.uk/realchangechallenges/real-change-challenge-mate-crime/>

4.4.3 Gemma age 27 had learning difficulties and suffered what was referred to as mate crime on many occasions over a period of time. She had been forced to drink urine from a beer can, beaten with a mop and stripped before being left for dead on a disused railway by people she regarded as her 'friends'. Gemma was not known to specialist health and social care services and had shown reluctance to access services. There were questions about her capacity but it was felt that she was able to decide on what help she wanted.<sup>12</sup>

4.4.4 The Serious Case Review found no evidence that her death could have been predicted or prevented. However, opportunities were missed to get a clearer picture of her situation and to have provided support that might have made her less likely to fall into the company of those people. No single agency had the whole picture. None of the agencies involved knew the details of her relationship with the five killers. Walker (2011) stated that an overall lack of thoroughness and information-sharing led to a number of missed opportunities to find out what was happening more generally in her life and the company she was keeping.

## 4.5 Conclusion of Literature Review

4.5.1 Landman (2014) states that despite a lack of firm data there is sufficient argument in the literature, combined with increasing anecdotal evidence to suggest that people with learning disabilities are particularly susceptible to "mate crime", and are being targeted by perpetrators. Landman (2014) argues that mate crime differs significantly from other manifestations of hate crime and abuse, and needs to be conceptualised, analysed and handled differently. Sin et al. (2009) expresses that from what we know about mate crime it follows a similar pattern to hate crime and therefore, if unchecked, offences are likely to be repeated and to escalate in severity.

4.5.2 Concerns are highlighted by Dunn (2009) that for people with a disability, the presence of fear has a critical impact on the (non) reporting of disablist violence. Dunn (2009) and Quarmby (2008) state that the fear of reporting disablist violence can be generated from two sources: the criminal justice system, and the offender. This is recognised locally by the Brandon Trust which has developed workshops on how professionals can tackle disablist hate crime and mate crime. The Trust has also joined Bristol Hate Crime and Discrimination Services (BHC&DS) which is a new collaboration of expert community-based services that provide advocacy and casework support for victims of hate crime and local agencies

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<sup>12</sup> <https://apps.warwickshire.gov.uk/api/documents/WCCC-779-97>

needing advice, training and education together with conflict resolution and restorative approaches, and other support services.

- 4.5.3 Sin et al. (2009) states that given the multiple barriers that impede the reporting and accurate recording of disablist violence, it is clear that a range of responses are required from within, and beyond, the criminal justice system. According to Sin (2013), the safety and security of disabled people can only be achieved if the structures and prejudices reproducing such crimes are dismantled. They also reference that recording practices are inconsistent. The Wales and Mencap Cymru See it Hear it report (2014)<sup>13</sup> asks victims to report crimes to the police and states that Mate crimes require a greater multi-agency response. It and warns that victims find it difficult to come forward for fear of not being believed and for fear of repercussions, and therefore agencies need to be aware of this together with the signs and potential impacts.
- 4.5.4 The United Nations Committee on the Rights of Persons with Disabilities (CRPD) recently published a report (2017)<sup>14</sup> on the UK's compliance with the UN Convention on the Rights of Persons with Disabilities. Recommendations include: strengthening measures to prevent bullying, hate speech and hate crime against people with disabilities. The Committee reported concerns about abuse, ill-treatment, sexual violence and/or exploitation to women, children, intersex people and elderly persons with disabilities, and the insufficient measures to prevent all forms of exploitation, violence and abuse against persons with disabilities. It expressed further concern at the information available on cases of disability hate crime, the absence of consistent data collection and differences in legal provisions for sentencing different types of hate crime, particularly in England and Wales.
- 4.5.5 The Committee recommended that measures are taken to ensure equal access to justice and to safeguard persons with disabilities, particularly women, children, intersex people and elderly persons with disabilities from abuse, ill-treatment, sexual violence and/or exploitation. It wanted the offense of disability hate crime comprehensively defined, ensure appropriate prosecutions and convictions; and that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities, in line with the Convention.

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<sup>13</sup> <http://www.disabilitywales.org/wordpress/wp-content/uploads/141014-mate-crime-factsheet-en.pdf>

<sup>14</sup> [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GBR/CO/1&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GBR/CO/1&Lang=En)

## 5 Consultation on Practice in Bristol

- 5.1.1 The most important finding of this consultation was that professionals reported that Derrick's experiences of Mate Crime were not extraordinary. It was found that a majority of professionals spoken with are working with adults in the city who are exposed to and experiencing Mate Crime at this level on a regular basis. Adults are targeted due to their vulnerability and disabilities, sometimes by other adults with care and support needs or their associates which adds layers of complication to the safeguarding response.
- 5.1.2 We heard that Mate Crime is experienced on a spectrum in Bristol – many Adults with disabilities experience Mate Crime over their lives perpetrated by individuals who are unconnected. In this way single incidents of Mate Crime are seen as low level and not appreciated as the cumulative, pervasive experience that they form a part of. Others are experiencing organised, escalating Mate Crime, sometimes linked to issues of cuckoo-ing (where an adult's home is taken over often for the purpose of selling drugs), sexual exploitation, financial abuse and other criminality. The failure to respond to lower level crimes robustly can mean that opportunities are missed to prevent these crimes escalating in severity or miss the ongoing impact on adults' wellbeing and right to safety in the community.
- 5.1.3 The findings below incorporate findings from the case review of Derrick's case and the wider consultation with professionals in the city.

### 5.2 Finding 1 - Awareness and Identification of Mate Crime

- 5.2.1 There is not consistent understanding or awareness of Mate Crime in the city, even from professionals with expertise in supporting adults with disabilities or vulnerabilities which place them at higher risk of Mate Crime. There is not a consistent understanding of crimes that could be understood as Mate Crime being recognised as a form of disabledist Hate Crime. This significantly limits professionals' ability to recognise, prioritise and protect adults from these crimes. Avon and Somerset Constabulary were one of the only organisations to report that Mate Crime was named in their safeguarding policies related to Hate Crime. They recognised that understanding of Mate Crime was largely limited to Safeguarding Leads but that training and work with partners in Hate Crime services is driving forward greater awareness.
- 5.2.2 It would be helpful for the phrase Mate Crime to be used to raise awareness of the seriousness of these crimes as a form of Hate Crime. There is a risk that currently low level crimes are not recognised as Mate Crime and opportunities to

protect adults at the earliest opportunity are therefore missed. This risks escalation in the behaviour and increasing risk to the adult. By using a common term to describe incidents and actions of this nature, it may be easier for professionals to identify patterns that affect certain individuals, residential addresses or even areas.

- 5.2.3 The review's consultation reinforced the need for families, friends and adults themselves to also be provided with advice and information about Mate Crime. The review found, both in Derrick's case and in wider practice, that it is often the families and friends of individuals who are better placed to identify Mate Crime if they know what to look out for. Families would benefit from advice about how best to support their family member.
- 5.2.4 Individuals in Bristol have benefitted from the support and training offered through organisations such as the Brandon Trust, however there is a need to expand the rights based approach with adults who are at increased risk so that they are empowered to recognise exploitation and speak out about concerns.
- 5.2.5 The review highlighted a lack of training on this issue for professionals. Mate Crime and other forms of disabilist Hate Crime are not routinely offered or delivered to staff as part of their training offer. The majority of organisations do not offer this training and many professionals are unclear whether this has been part of their training offer suggesting that if it is covered it is not being covered effectively.
- 5.2.6 The consultation echoed Derrick's family's view that there should be clear guidance on the management of Mate Crime from commissioners to providers of services for adults at high risk. Professionals felt that they would benefit from support from commissioners to consider how they manage the risk of Mate Crime between adults placed in their settings when they emerge.

### **5.3 Finding 2 - Preparing Adults and Families for increased independence**

- 5.3.1 Establishing expectations of both the adult and their family at the earliest opportunity is crucial in the professional response to safeguarding adults from all forms of abuse and harm. The balance for professionals of recognising and promoting the adult's rights and principles of independence while recognising the family's expertise as carers and/or advocates is a challenging one, but one which is central to ensuring the adult's best interests are achieved.
- 5.3.2 When adults enter supported living or care environments from a home environment, concepts of what independence means may differ between family

members and the adult. Family's expectations of care and their involvement should be explicitly explored, as well as establishing a clear understanding of what their relationship with the care providers will be and the parameters that are agreed with information sharing.

- 5.3.3 Sometimes adults will move out with little time for preparation or initially short term placements will become permanent arrangements, such as in Derrick's case. These points are important times for professionals to engage again with families, and re-establish boundaries and expectations.
- 5.3.4 Families are often well placed to identify early indicators of concern, and reinforce messages and skills that adults need to learn to manage independence safely. Families' capacity to do this will vary and it is important that discussions and expectations are considered as part of the assessment and discussed when an adult is placed with a new provider. The assessment should also carefully consider the views and wishes of the adult, although care should be taken to ensure that an adult's capacity to understand the concept of independence and family contact is fully explored and tested before conclusions are reached at face value.
- 5.3.5 In preparing adults for independence we need to consider their sense of identity in the community. Much of the risk related to Mate Crime comes from adults' reasonable and natural desire to have friendships. Many adults will see community accommodation as an opportunity to make friendships and take opportunities to live a 'normal' life in the community. Furthermore, moving into lower levels of support can come with feelings of disappointment, fear and loneliness when perceptions of independence are not fully achieved. To mitigate this we need to be offering adults safe opportunities to make friends and explore aspects of their adult identity and independence. Professionals should consider what groups, community events or social activities an adult may wish to get involved in to fulfil their hopes and aspirations for independence.

## **5.4 Finding 3 – Reviewing Care**

- 5.4.1 In all forms of chronic, cumulative abuse or harm the importance of reviewing care and outcomes should be paramount. Reviews should be undertaken in collaboration with the adult and their family who are able to assess the effectiveness of the interventions they are offered. They also offer the opportunity to review patterns to identify escalation of concerns, and ensure that the service commissioned and delivered is appropriate to the adult's needs.

- 5.4.2 In Derrick's case the move to an accommodation setting with a lower level of on-site staff presence was a key point in his life and care. Prior to his moving out of his mother's home, Derrick had only been assessed in terms of temporary respite, and so therefore no discussions of a permanent move towards greater independence took place at this stage. It would have been good practice for Bristol City Council to have held a review meeting at the point where Derrick was being offered a permanent placement or early into the move so that Derrick's progress and support could be considered. This may not be a statutory requirement but it was a significant missed opportunity in Derrick's case that there were no opportunities for review with the commissioning authority.
- 5.4.3 A further issue highlighted throughout the consultation is a lack of professional follow-up or challenge if there is no feedback or response to a safeguarding referral. Professionals highlighted that in 2016 feedback from the Bristol City Council Safeguarding Adults Team was limited. This has been improved in the last 12 months and recent audits undertaken by the Bristol Safeguarding Adults Board have highlighted good levels of engagement with referrers. However Bristol partnerships should be equipping all organisations to challenge each other effectively to ensure adults receive the most effective services.
- 5.4.4 The provision of effective supervision and review of case notes for practitioners who work with adults receiving support are essential to enable managers to ensure that safeguarding issues are followed up effectively and to support staff if they do not receive the response they require from other agencies.

## **5.5 Finding 4 – Protection of vulnerable adults from Mate Crime**

- 5.5.1 In a low level supported unit, such as where Derrick was placed, adults are free to choose with whom they associate and invite into their home and are acknowledged as having the capacity to make such decisions. While they may have capacity, they might not have the ability to identify abusive behaviour and end relationships that are unsafe. This poses significant difficulties to professionals in the identification and management of Mate crime in such residences. These difficulties are replicated for those professionals working with adults living in other environments in the community, including with family members.
- 5.5.2 Professionals reported low expectations of receiving support from statutory organisations in protecting adults from Mate Crime. There is a need to reinforce the commitment to responding robustly to Mate Crime. One of the barriers identified is that police do not always know that an adult reporting the crime has additional vulnerabilities or lives in supported accommodation. This means that

the police do not always provide a tailored response to adults who report crimes, such as in Derrick's case when letters were sent.

- 5.5.3 There are a range of support options that could have been put in place to support Derrick as a vulnerable victim of crime. These included referrals to the Lighthouse Victim Service, Victim Support or Bristol Hate Crime Services. None of these options were offered to Derrick by any of the professionals working with him. Better awareness of the options available to him by commissioned providers and identification and signposting by the police would have provided Derrick with appropriate advocacy and support.
- 5.5.4 There are options which can reduce the environmental risk of Mate Crime. These include the use of security systems and CCTV to gather evidence of people entering and leaving the property, community police officers building relationships with adults and staff living in supported accommodation in their area to build trust, and enhanced unannounced welfare checks. However, it must be recognised that supported accommodation such as that lived in by Derrick is governed by housing law and that landlords are unable to impose restrictions on occupants which contravene their privacy rights. Compliance with house rules is therefore voluntary and most are not legally enforceable. Therefore empowerment, awareness and rights based support has to be at the centre of any approach taken.

## **6 Recommendations to Safer Bristol Partnership and the Bristol Safeguarding Adults Board**

1. Safer Bristol Partnership re-establish their Disablist Hate/Mate Crime Working Group to lead improvements in this area
2. A consultation of adults experiencing Mate Crime in Bristol is undertaken to ensure professionals learn from the lived experience of adults in the city
3. The BSAB to update the regional Joint Safeguarding Adults Policy to include Mate Crime
4. A conference is held to raise awareness of Mate Crime and associated exploitation
5. Training is offered/advertised to support professionals to identify Mate Crime and know how to respond
6. Police to develop their system in partnership with care commissioners to ensure that supported accommodation addresses are flagged on their system in the same way

care homes are so that they are aware of underlying vulnerability when adult makes a crime report or contacts the police

7. Resources are developed to support adults to recognise Mate Crime and know how to report it
8. An information sheet is developed for families to be provided when their relative moves into a care or supported accommodation setting about risk indicators and who to contact if they have a concern about abuse or neglect, including Mate Crime
9. Bristol Hate Crime Services are promoted with care and supported accommodation providers to raise awareness of their offer
10. Bristol City Council to provide assurance to the BSAB about how they are ensuring the timeliness of reviews undertaken in supported accommodation settings and how reviews of adults moving from respite into long-term provision are prioritised
11. Organisations commissioning accommodation and care services to expect commissioned services to have a specific Mate Crime policy in place, or have a specific Mate Crime section in their Safeguarding policy as part of the commissioning criteria
12. Guidance on making safeguarding referrals should be issued by the BSAB to ensure that all referrals to the BCC Safeguarding Adults Team are acknowledged in writing and advising that organisations should only consider a safeguarding referral to have been made when they receive such an acknowledgement.
13. Bristol Safeguarding Adults Board to develop best practice guidance on how care and accommodation providers should balance an adult's right to independence with effective family engagement

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