# Learning Lessons Practice Briefing Note

## Ms. C Case Review, Spring 2016

## From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults. This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within or informs safeguarding adults training.

## What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

## Ms. C Case Review

The key messages on this briefing sheet reflect the findings to emerge from a recent case review of a young woman with learning disabilities thought to have been the victim of domestic violence and sexual exploitation. The case was presented to the Board in February 2016.

## How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

# Key considerations for practice arising from the review

## Sexual exploitation

***'Failure to recognise key features of sexual exploitation, including coercion and control, disclosures and retractions'***

- Sexual relationships should always be consensual. If a person is unable to consent, or has not consented to sexual activity, then this is considered to be sexual assault.
- Some people with learning disabilities are unable to understand or make decisions about sexual activity. If this is the case, then anyone who engages in sexual activity with them commits a criminal offence.
- In relation to sexual activity, consent is not valid when someone:
  - does not understand they can refuse sexual activity
  - does not know how to refuse
  - is offered a reward for sex
  - is scared to refuse because of threats.
- In some cases there will be genuine doubt about capacity – for example, it may be felt that the person can understand some types of sexual activity but not the consequences, or that they can consent with one person while another relationship appears abusive. These situations are complicated and need to be carefully assessed by those involved in care and support. The person may need some independent advocacy.
- Doubts about understanding and communication should never be a reason not to report or acknowledge abuse.
- People with a learning disability have a right to engage in consensual sexual activity and a right to respect of their private life, but can be particularly vulnerable to sexual abuse and assault for a number of reasons. They may:
  - have low self-esteem and therefore lack power within relationships
  - depend on care staff / services over long periods
  - not possess the social awareness or education to detect or anticipate abusive situations, and may lack sexual knowledge and assertiveness
  - be afraid to challenge potentially abusive situations
  - lack the capacity to consent to sexual relations
  - experience guilt or shame that prevent them reporting abuse.
- Sexual abuse is a major violation of human rights and yet the risks of disclosure for people with learning disabilities are low and the risks of prosecution even lower.
- It is important to recognise the importance of on-going sex education, to help those with learning disabilities to recognise appropriate sexual behaviours and the difference between pleasurable, consensual experiences and sexual abuse.
- Check your own assumptions and preconceived ideas to ensure you are alert to the signs of sexual abuse and exploitation.
- Many people with learning disabilities become accustomed to not having any choice. Set up safe situations where the person has the chance to say "No" and to learn appropriate non-compliance skills.

## Recognising the early signals of domestic abuse

***'Failure to engage mainstream provisions to address domestic violence on behalf of Ms C'***

- The definition of domestic violence and abuse is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'.
- A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015. The offence will impose a maximum 5 years imprisonment, a fine or both. The offence closes a gap in the law around patterns of coercive and controlling behaviour during a relationship between intimate partners, former partners who still live together, or family members, sending a clear message that it is wrong to violate the trust of those closest to you, providing better protection to victims experiencing continuous abuse and allowing for earlier identification, intervention and prevention.
- A considerable amount of adult safeguarding work in people's homes relates to the domestic abuse of people with care and support needs. To promote more effective support for people experiencing domestic abuse it is important to:
  - Develop a good relationship with the adult at risk and put their views and wishes at the forefront of all discussions
  - Be alert to patterns of coercive and controlling behaviour and be aware that an adult at risk may refuse to report abuse or retract previous disclosures because of fear
  - Consider any likely impact of abuse on an adult with care and support needs
  - Understand how local safeguarding services and Multi-Agency Risk Assessment Conferences (MARACs) fit together.
- People who are being abused may seem afraid or anxious to please their partner; go along with everything their partner says or does; check in often with their partner to report where they are and what they are doing; have frequent injuries; frequently miss work or social occasions; dress in clothing designed to hide bruises or scars; be restricted from seeing family and friends; rarely go out without their partner; have limited access to money or the car. They may have very low self-esteem, show major personality changes (for example, an outgoing person becomes withdrawn); be depressed, anxious or suicidal. It is important to speak up if you suspect domestic violence or abuse.

**Further reading:**

**Somerset Survivors – information for professionals**: information to help professionals set how they can raise awareness of domestic abuse and access specialist support and training

'**Adult Safeguarding and domestic abuse'**: comprehensive guide to support practitioners in making decisions about how to respond in individual situations

## Capacity and the Mental Capacity Act

***"An ill-informed assumption of capacity and a failure to implement formal tests of mental capacity in relation to specific and serious decisions"***

- The Mental Capacity Act (MCA) requires professionals to assist vulnerable people in making decisions for themselves but to also recognise when there is a reason to question a person's ability to do this.
- In situations where a person's decisions are likely to place them at risk of harm, a simple reliance on the assumption of capacity is often inadequate.
- Robust capacity assessments are critical in determining the approach to be taken by professionals, either to support the decision-making of a capacitated adult or to intervene to protect the best interests of a person who lacks capacity.

**Further reading:**
www.somerset.gov.uk/adult-social-care/safeguarding/mental-capacity-act
http://www.scie.org.uk/mca-directory/about/index.asp

## Safeguarding

***'Failure to see that Ms C feel into the category of a "vulnerable adult" or an "adult with care and support needs" within the terms of the Care Act 2014 and was therefore entitled to additional protection and support'***

- Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's well-being is promoted.
- A vulnerable adult is described as a person aged 18 years and over who is in receipt of or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be able to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.
- Workers across a wide range of organisations, including those in children's services, need to be vigilant about adult safeguarding concerns in all walks of life. Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, the death or serious harm might have been prevented.
- Anyone can witness or become aware of information suggesting that abuse or neglect is occurring. The adult may say or do things that hint all is not well. Regardless of how the safeguarding concern is identified, everyone should understand what to do and where to go locally to get help and advice.

**Are you worried about the safety or welfare of a vulnerable adult in Somerset?**
Contact Adult Social Care on 0300 123 2224 or email adults@somerset.gov.uk
Contact the Police on 101 or in an emergency call 999

## Keeping a person's history in mind

***'Failure to take Mr H's previous history of sexual offending into account because it had not led to a conviction'***

- Social work assessment has always been concerned to consider past events and their relevance to a person or families' current situation. Past life events are found in most of the indicators of risk produced
- Chronologies are often thought of in the context of work with children and young people, but have equal relevance in work with adults. They should seek to provide a clear account of all significant events in a person's life to date, drawing upon the knowledge and information held by agencies involved in their care. The purpose of a chronology is early indications of emerging patterns of concern.
- Recent inquiries into the care of children, adults at risk and people who commit serious crimes have all concluded that a chronology could have helped towards earlier identification of risks to the person, or from them.
- A chronology should be a useful tool in assessment and practice. It should not be an assessment or an end to itself, but form part of assessment, as a working tool promoting engagement with people who use services. It should be accurate, and relies on good, up to date case recording. It should contain sufficient detail but not substitute recording in the case file or record. It should be flexible – detail collected may be increased as risk increases.

## Effective transition

***'Important information did not travel with these clients and salient parts of their histories were lost or distorted including key assessments and understanding about the exact nature of their abilities, cognitive impairments and high-risk behaviours'***

- Effective person-centred transition planning is essential to help young people and their families prepare for adulthood. Transition to adult care and support comes at a time when a lot of change can take place in a young person's life. It can also mean changes to the care and support they receive from education, health or care services, or involvement with new agencies such as those providing support for housing, employment or further education.
- The wellbeing of each young person or carer must be taken into account so that assessment and planning is based around the individual needs, wishes and outcomes that matter to that person.
- Historically there has often been a lack of effective planning for people using children's services who are approaching adulthood. Looked after children, young people with disabilities, and carers are often among the groups of people with the lowest life chances.
- Multi-agency professionals should work together in a coordinated manner around each person to raise their aspirations and achieve the outcomes that matter to them. Transition assessments should provide young people and their families with information so they know what to expect in the future and can prepare for adulthood.

## Think Child, Think Parent, Think Family

***'Children's social workers must know they can make safeguarding adults alerts when faced with any situation in which an adult in need of care and support is deemed to be at risk in their own right'***

- The wellbeing of children and their families is best delivered through a multi-agency approach with different services working effectively together. 'Think Family' means securing better outcomes for children, young people, adults and families by coordinating the support they receive from services.
- Be aware of the heightened risks to both children and vulnerable adults from parents or carers who are themselves victims of abuse and be alert to any signs of more widespread abuse. Consider the child behind the adult *and* the adult/s behind the child.
- Do not forget: the 'hidden harm' of parental risk factors (mental health, substance misuse and domestic abuse) which places children and others in the household at increased risk of abuse and neglect.
- Parenting capacity is best assessed with the joint input of workers from adults and children's services, with support where appropriate from services with specialist expertise. Where this is an issue for families, domestic violence services must be routinely involved in the child protection process from initial conferences through assessment and planning to provision of services.
- Share information between agencies working with different members of the family unit.
- Be aware of the risk that parents' needs, behaviours and presentation can move the focus away from the child.

SOMERSET SAFEGUARDING ADULTS BOARD

# Learning Lessons - Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

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| Your name | |
| Agency | |
| Date | |

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| This briefing was cascaded to:<br>(e.g. all district nurses; duty social workers etc.) |
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| This briefing was used in:<br>(e.g. supervision with X number of staff; team meeting; development event etc.) |
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| Action taken as a result of the learning: |
| |
| Other feedback / discussion points |
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