Issue 11, Sept 2019

Newsletter

Working in partnership to enable adults in Somerset to live a life free from fear, harm or abuse

This is the 11th edition of our newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read. Since the publication of our last newsletter we have finalised and published our strategic plan for 2019-22 and published our Annual Report for 2018/19. We've also had our annual conference at the beginning of May which you can read about on page 4.

To the new subscribers who've recently signed up to receive copies of our newsletter, a very warm welcome and our thanks for your interest in being part of our local safeguarding community in Somerset.

We always welcome any suggestions for improvement, requests for future content or any contributions you'd like to make.

In this issue:

News from the SSAB

June 2019

The SSAB has met once since the last newsletter was published, on 06/06/2019.

Agenda highlights include:

- Safeguarding Personal Case Study presented by NHS Somerset Clinical Commissioning Group's Continuing Health Care team;
- Receiving an update on the Mental Health Crisis Concordat;
- Receiving a presentation on the Outcomes from SSAB Self-Audit and Peer Challenge Day;
- Having a detailed in-depth discussion about the issues raised by the BBC Panorama Broadcasts about alleged abuse at Whorlton Hall Hospital in County Durham and the two episodes about the 'Crisis in Care' (Episode 1, Episode 2) that featured the work of Somerset County Council's Adult Social care Service;
- Received and commented on a draft of our 2018/19 Annual Report;
- Receiving a progress update on our Strategic Plan from the Executive Group;
- Receiving an update on Stop Adult Abuse Week 2019

We're recruiting for a new Independent Chair

After six years as SSAB Independent Chair Richard Crompton recently wrote to members of the Board to let them know that he had decided to stand down at the end of his current three-year term saying that it had "been a great privilege and I believe we have established a strong partnership and achieved much over the years. It is, however, time for a fresh pair of eyes and I am writing to let you know that I intend to stand down at the end of the year"

A recruitment process is underway, and we hope to include an update in our next newsletter.

Richard Crompton, SSAB Independent Chair

Stop Adult Abuse Week 2019

As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote a different area of safeguarding work to maximise the reach of this work during 'Stop Adult Abuse Week' with the SSAB focussing on information for care and support providers. This year all five Boards agreed to focus on the Mental Capacity Act (2005), during the week we also promoted:

- Presentations from our recent conference (read more on page 4)
- An Introduction to the Mental Capacity Act
- A set of images used for a Mental Capacity Act Myth Buster (zip file)

SSAB Annual Self-Audit Launched

To support local organisations, the SSAB has adopted an Organisational Adult Safeguarding Self Audit Tool to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development. The tool has been reviewed by our Quality Assurance Subgroup which added new questions relating to the implementation of learning identified from local Safeguarding Adult Reviews.

The tool is designed to support local organisations in their continuous improvement of adult safeguarding work.

We do not publish the results of individual organisations or use the information provided to compare organisations. Instead, areas of generic learning are identified to inform the SSAB's strategic development of safeguarding. The tool is an important component of the SSAB's Quality Assurance framework.

SSAB partner organisations are required to complete the self-audit on an annual basis and submit to the Quality Assurance subgroup for monitoring and assurance purposes. For the 2018/19 self-audit the SSAB Quality Assurance Subgroup established a new 'peer challenge' element to the process following the receipt of returned audits. This took a constructive approach to ensuring that the results were consistent, and that any variations in responses were understood. It is intended that a similar process will be undertaken for the 2019/20 Self Audit.

SSAB partner organisations are required to complete the self-audit on an annual basis (every year, between August and October), and submit to the Quality Assurance subgroup for monitoring and assurance purposes. In a change to previous years we are trialling the template that is used by other Safeguarding Adults Boards within the Avon & Somerset Constabulary footprint this year, and would welcome any feedback on how this tool compares to that used in previous years.

We actively encourage other agencies / bodies to complete the tool to support their adult safeguarding arrangements and identify both strengths and areas requiring development.

Further information

Read more about our self-audit

Somerset Violence Reduction Unit

In March 2019, the Chancellor announced a £100m Serious Violence Fund for use during the 19/20 financial year to tackle serious violence and after a successful bid, Somerset has been allocated £362,225 to establish a Violence Reduction Unit (VRU). In this exciting development, the VRU's function is to offer leadership and, working with all relevant agencies operating locally, strategic coordination of the local response to serious violence, supporting a 'public health' approach.

The VRU must produce a Problem Profile and Response Strategy and utilise spends to plan and implement interventions that are focussed on prevention of serious violence, based upon current evidence.

The VRU will be co-located in County Hall in Taunton in the Public Health team, and the team will be made up of management, a coordinator, analytical work, a police sergeant, a nurse and an adolescent worker; with some of these roles are already in place. The team will use data to identify who and where to focus their attention.

At this time, the project is time limited, with all spends to be spent by the end of March 2020, but it is hoped that there may be further announcements about longer term investment to this national priority.

Annual Conference 2019

Our annual conference was held on 01/05/2019 and was well attended by safeguarding leads from across a broad range of organisations that work with adults in Somerset. Sessions from the day included:

- Sexual Consent
- Female Genital Mutilation
- Disability Hate Crime
- The Mental Capacity Act
- Current scams and rogue trader practices
- Street deaths thematic review and week of action
- The Liberty Protection Safeguards
- Domestic abuse and coercion and control

The SSAB's Learning and Development Subgroup is about to start planning for the 2019/20 conference. One of the areas that people have also asked is included is the new Liberty Protection Safeguards, but if you have any other areas of adult safeguarding work that you would like to be considered for included on the agenda please let us know.

Further information

View presentations from the day

Mental Capacity Act e-learning programme launched

Mental Capacity Act 2005

Health Education England e-Learning for Healthcare has worked with organisation including the Office of the Public Guardian, Academy of Medical Royal Colleges, Department of Health and Social Care, Care Quality Commission and Ministry of Justice to develop an e-learning programme for health and care professionals about the Mental Capacity Act.

The Mental Capacity Act 2005 (MCA) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to prepare for a time when they may lack capacity in the future. When a person lacks capacity, for example to consent to or refuse treatment, the MCA lays out who can make decisions in the person's best interests, and how such decisions must be made.

Mental capacity is the ability to make a specific decision at the time it needs to be made, with help if necessary. It has been estimated that over two million adults and young people may lack mental capacity at any time (due to dementia, acquired brain injuries, learning disabilities, acute delirium and other conditions).

The MCA lays out how an individual can retain power over decisions that have to be made in the future, if they should lose capacity. Whether or not a person has taken such steps, it is by following

the MCA that professionals ensure they are acting lawfully and respecting the human rights of people who may lack capacity to consent to interventions that are proposed.

The e-learning programme comprises of the following 11 e-learning sessions:

- Mental Capacity Act as Part of Human Rights
- Assessing Mental Capacity
- Planning Ahead using the Mental Capacity Act
- Best Interests
- Restraint
- Deprivation of Liberty
- Relationship between the Mental Capacity Act and the Mental Health Act
- Mental Capacity Act and Young People aged 16 or 17
- Research involving People who Lack Capacity
- Mental Capacity Act and Adult Safeguarding
- Settling Disputes and Disagreements.

Each e-learning session takes approximately 20 to 30 minutes to complete and is made up of factual knowledge, case scenarios, short interviews and self-assessment questions to test your knowledge.

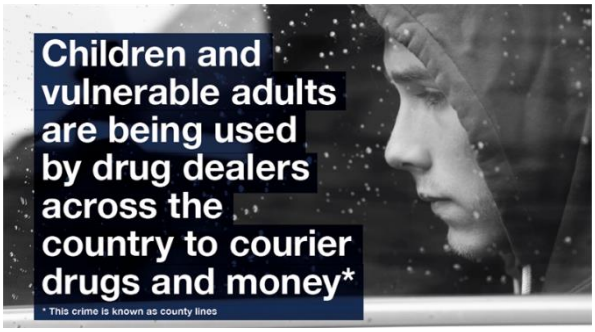
Further information

Access the e-Learning

County Lines

What does county lines mean?

County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs out of bigger cities into one or more smaller towns in the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence and weapons.



Exploitation of young and vulnerable people

Young and vulnerable people are being exploited by drugs gangs in our communities. It's happening right now, in Yeovil, Taunton, Weston-Super-Mare and other areas of Avon and Somerset, places often thought of as quiet towns.

Detective Chief Inspector Kerry Paterson, Avon and Somerset Police's force lead on county lines said: "County lines gangs based in big cities such as London and Birmingham, are exploiting young and vulnerable people and sending then into small towns across our region, to sell and store class A drugs on their behalf.

"The majority of young and vulnerable people who get involved in county lines are expertly groomed by ruthless gangs who sell them a dream: money, trainers, flashy cars and watches – all in easy reach for a teenager who is willing to run a few errands.

"Some young people don't even need grooming – they have seen the You Tube videos which glamorise the gangster lifestyle and will approach dealers and ask to work for them, believing that they will earn protection, respect and a better life.

"The reality couldn't be more different. Children as young as 12 can find themselves enslaved in 'trap houses', cutting and selling drugs 24/7, in disgusting conditions, unable to wash, sleep or eat properly, under the constant threat of violence, with dangerous people coming and going. They earn little money and lose all ties with their friends and families.

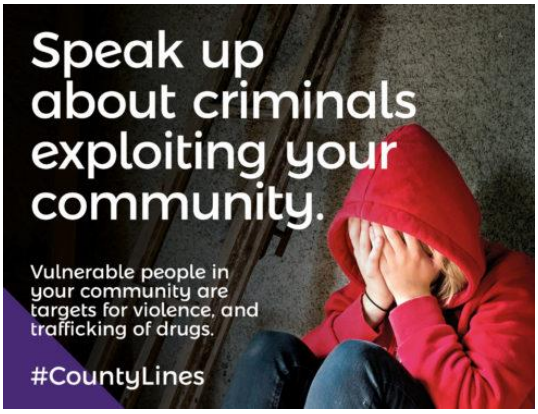
"This behaviour is a significant threat to our communities and we are committed to reducing its impact. But we need your help: spot the signs and act on your concerns. Your voice will be heard and will make a difference."

What are Avon and Somerset Constabulary doing to tackle county lines?

The police work closely with partner agencies in housing, drug and alcohol support services and local authorities to identify and support those at risk, identify the perpetrators, disrupt the enterprises and bring offenders to justice. The South West Regional Organised Crime Unit (SW ROCU) monitors and targets county lines that cross regional borders, linking in with the National Crime Agency to ensure a UK-wide response.

What can you do to help?

We need you to help us tackle county lines criminality by spotting the signs and reporting drug dealing or exploitation of a vulnerable person. Many people would not recognise the signs that a vulnerable person is being groomed or exploited. By raising awareness, we hope more people will feel comfortable in reporting information to the police. Your call could save lives.



Grooming and exploitation – know the signs

- Has a child or young person gone missing from school or home?
- Are they meeting with unfamiliar adults?
- Have you noticed a change in their behaviour?
- Are they using drugs and alcohol?
- Has there been a breakdown in relationships with family and friends?
- Have they suddenly acquired new possessions such as trainers / clothes / phones or other gadgets?
- Do they have unexplained injuries?
- Young people seeming unfamiliar with your community or where they are?

This could be a sign that they are being coerced and controlled to commit crime. Call 101 to report it or contact Crimestoppers anonymously.

Cuckooing

Drug dealers will often take over the homes of vulnerable people who may also be addicted to drugs, and use it as a base to deal drugs in the area. The vulnerable person may be being kept inside against their will.

- Have you noticed more people calling or staying at an address? Sometimes at unsociable hours?
- Have you noticed a neighbour has not been seen for a while?
- Are there suspicious smells coming from an address?
- Are there suspicious or unfamiliar vehicles outside the address?
- Are there new or regularly changing residents (e.g. different accent compared to local accent)?

Cuckooing could be taking place. Look out for your neighbours and report suspicions anonymously online to Crimestoppers or by calling 0800 555 111. No personal details are taken, information cannot be traced or recorded and you will not go to court or have to speak to police when contacting Crimestoppers.

Alternatively, you can call the police on 101. If you think someone is at immediate risk of harm, always call 999.

Adapted from information published by Avon & Somerset Constabulary

Business Manager Blog


Stephen Miles SSAB Business Manager

Events conspired against me in getting this issue of the newsletter out before people started departing on their summer holidays, but now that everyone is back it's an opportunity to reflect of the work of the Board as it has begun working to its new 3-year strategic plans and also looks to recruit a new Independent Chair to fill the very substantial shoes that will be left by Richard Crompton when he stands down towards the end of the year.

We're in early days for the plan, but the fundamental thing for me is how we can as a system enable people to keep themselves and those that they care for safe, recognise when something isn't right and, when it isn't, do something about it *before* it becomes a safeguarding concern. Those of you who follow the @SomersetSAB on twitter will have noticed we tweet a lot about scams – including posting copies of scam communications that we receive – because we recognise the impact that being scammed can have on someone often goes far beyond any financial loss that they may suffer. Both Trading Standards and Friends Against Scams are great sources of information which I would urge everyone to take a look at both professionally and personally. As an example, I was recently working at home for a day and had five different calls, each one professing to be from my Internet Service Provider, and if I'm getting them then vulnerable people in our communities will be too. We have also highlighted information form the Office of the Public Guardian, in particular about lasting powers of attorney, as we are aware that many people presume that the person they identify as their 'Next of Kin' has certain rights and duties when in reality the term does not have any legal decision-making authority.

The day-to-day work of the board has included work on our Annual Report on our work during 2018/19. We have also published a revised version of our Safeguarding Adults Multi–Agency Policy which we share with five other Boards in the region and have also been working to revise a number of key documents. These include our self-neglect practice guidance, which will be published shortly alongside a revised version of our Adult Safeguarding Risk Threshold Tool, which will be retitled to reflect the fact that it is a tool to support staff in making decisions. Our Quality Assurance Subgroup has been working on preparing for our annual self-audit, which you can read more about on page 3, and our Learning and Development subgroup has been developing a Framework for all organisations to use to understand the safeguarding knowledge that staff at different levels of their organisations should have. A big focus of our Mental Capacity Act

Subgroup has, unsurprisingly been the new Liberty Protection Safeguards, which we expect to feature more information about in future newsletters. We have also continued to keep our website up to date and added new content, with more to come in the future.

Finally, I wanted to write about the three episodes of BBC Panorama that the Boards discussed when it last met. I personally found the alleged abuse highlighted at Whorlton Hall Hospital shocking even as someone who has worked in the sector for well over two decades. The sense of anger I felt at seeing a young vulnerable person allegedly tormented in the way that was shown on screen was something I have experienced only twice before – when I watched the BBC Panorama investigation in to Winterbourne View and, unfortunately, close to home, when I moved in to my current role and read early draft of the Mendip House Safeguarding Adults Review. Abuse of the nature alledged by BBC Panorama should have no place in any part of our society, let alone a service for its most vulnerable members, but as we have unfortunately seen on too many occasions over too many years that it can and does happen where cultures take root that do not respect people as valued individuals. This is something we all need to be vigilant of and, if we see them, challenge these types of dehumanising, abusive attitudes and cultures that have been highlighted again and again.

A week later the work of Somerset County Council's Adult Social Care Teams and staff working for organisations providing care and support feature in two BBC Panorama episodes highlighting the 'Crisis in Care' (Episode 1, Episode 2). Fortunately for viewing public I managed to steer clear of the cameras, but it was fantastic to see the great work of so many staff working within our local system to support people. All the people featured in the programme had very powerful stories, but I found that of Martine particularly so, and I was extremely sad to hear that she had sadly passed away last week. My condolences go to her family.

I look forward to continuing to work with you.

Learning Lessons

Local: Mr D - Domestic Homicide Review

Background

The review examines the circumstances surrounding the death of Mr D (pseudonym) who was 36 years of age and had lived in Taunton, Somerset for many years but at the time of his death he was of no fixed abode.

Mr D was a bisexual gentleman who had had relationships with men in the early 2000s however more latterly with a female named Miss E. He was an opiate drug user and had been for a number of years. He was known to the Somerset Drug and Alcohol Service and had been released from Her Majesty's Prison on license in January 2016.

Mr D and Miss E had been in relationship since January 2016 following his release from prison. There had been a number of third-party reports to the police between January 2016 and April 2017, all from Miss E's address, some categorised as domestic abuse related and others anti-social behaviour.

As a result of Mr D's drug use he was also known to the police, his GP, and local hospital trust because of his poor health. Mr D did not disclose to any agencies that his girlfriend Miss E was

abusing him, however there was one occasion in January 2017 where Mr D reported he had been assaulted by Miss E. Domestic incidents were identified by agencies, however not all possible action was taken.

In early April 2017, a third party reported to the police that they could hear violence and banging coming from Miss E's flat, the caller also added that they could hear the female being violent and shouting. Police attended the address and it was reported by Mr D to the officer that they had been arguing about Mr D's drug use. He advised that he had tried to leave however, Miss E didn't want him to. No physical violence was reported by neither Mr D or Miss E. Mr D was advised by the officers to leave the address for a 'cooling off' period.

The next day Mr D's body was found hanging from a tree. The police were called and shortly after their attendance, Miss E advised officers that Mr D had used a recipe of drugs that day including heroin and 'base' and that they had had an argument the previous day but after a walk around the block he usually returns but hadn't on this occasion.

Key Learning

The fact that Mr D was not regarded as the victim, despite third party reports, did not enable conversations and appropriate risk assessments to be undertaken with him. The DHR Panel also felt that because he was a male there was an assumption made that he was the perpetrator of abuse for the domestic incidents reported to the police, therefore summarising that gender stereotypes were most probably at play during this time.

It was felt that at most contacts Mr D had with agencies it was surface level conversations about his offending, drug use or clinical needs; not investigative or holistic in seeking further information about the situation and life he was leading. This resulted in the Panel concluding that more awareness raising and training was required by practitioners on how to engage with individuals with complex needs and ask sensitive questions.

Despite the complexities which Mr D had; poor mental health, chaotic drug use, involvement in repeated domestic incidents reported to the police, homelessness and his licence conditions from prison there was no coordination of information held by all of the agencies to discuss and agree what additional actions/support could be offered to Mr D. Mr D was a vulnerable individual as a result of these complexities and should all of the information been shared, there may have been a greater chance of one agency being able to engage with him and support him with some positive steps forward. However, he did not fit an obvious multi agency strategy discussion process therefore this would have had to has been a bespoke complex case needs meeting.

Further information

Read the Review

Regional: SAR Z

Background

The Review focused to the death of Adrian, who had developed the symptoms of Schizophrenia around his 20th birthday. He tried to live independently in his early twenties, but his family report that he was often exploited by "friends". Adrian would remain at risk of exploitation through his adult life, the risk of such exploitation was regularly evidenced in risk assessments. His life became chaotic, he was living in common lodging houses, sometimes homeless, and had a serious drug problem. Around 2000 Adrian took up residence at a local residential home for adults with mental health issues. He was able to develop a more stable lifestyle there and his family report that he enjoyed strong relationships with fellow residents and held down various jobs. He moved to a

supported housing service in 2011 where he remained living until he left in September 2013 to live more independently in a flat. The flat was in a housing association complex for people over fifty-five, and residents are reported to be predominantly older adults.

Adrian was 51 years old when he died. On the 6th October 2015 police were called to his home where they discovered his body. A fire had occurred in the room. A forensic post mortem held on the 15th October established that Adrian had suffered significant trauma injuries not consistent with a fire, and a murder enquiry was instigated.

On 17th October 2015 SH was arrested on suspicion of Adrian's murder. He was later charged with the murder of Adrian between 2nd and 6th October 2015. SH was found guilty of murder on 14th June 2016. The court heard that SH had met Adrian on the 18th September 2015, had moved into Adrian's accommodation, and had exploited him for money and his possessions. Adrian had received significant injuries all over his body, his death was caused by head and brain injuries. SH had set fire to his body. SH was given a life sentence.

At the time of his death Adrian was being supported by a care agency and was seen regularly by a Recovery Coordinator and a Psychiatrist according to his Care Programme Approach (CPA) plan.

The review noted that a focus on Adrian's use of drugs had the effect of obscuring his other essential vulnerabilities and resulted in no contingency plans being made with Adrian on how to get support if exploited once living independently. It also resulted in Adrian perhaps being distanced from his previous supporters, unwilling to let them see that he was struggling and, under SH's influence, taking drugs again.
The review also noted that changes in the structure of local probation services around the time of the introduction of Community Rehabilitation companies had a profound effect on how the risks SH presented were identified and managed.

Key Learning (Adrian)

- Before an adult moves accommodation or their circumstances change significantly, it is essential for the appropriate agency to proactively undertake a new holistic assessment to inform plans around any needs, risks, and challenges in the new situation. Such assessments must be multi- agency and reflect historical information, and include the perspectives, concerns and expressed outcomes of the adult. The adult's strengths and the supports within the system around them including their family must be considered alongside behaviours that may increase risk.
- In situations where substance misuse is a significant factor in the life of an adult with severe and enduring mental health issues, specialist advice must be sought by the person reviewing the assessments and plans.
- Long term work with an adult on a CPA pathway must be characterised by a Partnership approach between agencies with each agency aware of and acting according to their role and responsibility. How each partner shares information should be discussed with the adult, agreed and acted upon. Individual's contingency plans should ensure that provider agencies are aware of how to obtain early help in the absence of a (Recovery) Coordinator.
- Even when families or other supporters are not formally involved in all reviews and planning, consideration must be given whether and how an adult's family can be involved at key transition points in their lives, with the adult's consent.
- Agencies need to promote their own and the awareness of adults and their families/carers about exploitative friendships or "Mate Crime". Strategies to combat exploitation or "Mate Crime" need to be discussed with adults before such situations arise and, if an adult has a history of being exploited as Adrian had, a contingency plan about who to contact and how, will be invaluable.

- Each contingency plan will be unique to the adult's circumstances, but particular attention should be paid to ensuring that the adult is confident to report their experiences, even if they have been persuaded by the exploitative person to act against their own best interests. With the adult's consent, those who support the adult, i.e. their family, friends, or advocates, can be involved in drawing up a contingency plan so that they can give support and discuss options as needed.

Key Learning (SH)

- Thorough and timely identification of risk and shared understanding of the indicators of escalated risk, as well as an agreed plan for managing risk, must be informed by exploration of historical information as well as information sharing protocols between all agencies working with offenders. This is particularly pertinent when offenders move between areas and information is not easily available.
- As the Responsible Authority for MAPPA (Multi Agency Public Protection Arrangements), Police and Probation Services must consider using the MAPPA process for Category 3 offenders, i.e. offenders who do not meet the criteria for either Category 1 or Category 2 but who are considered by the Responsible Authority to pose a risk of serious harm to the public which requires active multi-agency management. Identification and consideration of MAPPA by Devon police staff needs to be improved, non-specialist police officers may need particular awareness of the potential of a referral to MAPPA.
- All Probation services need to be aware of how risk indicators to Adults at Risk are manifested, actions that must be taken and agencies that must be informed. This awareness must be reflected in all assessments and plans and be an integral part of all recording on safeguarding. Probation services must evidence their awareness and application of statutory obligations as defined in the Care Act 2014. Training in Adult Safeguarding needs to become part of the national curriculum for qualifying as a Probation Officer.
- Organisational transitions, at a small or large scale, will always risk a level of systems failure. The level of organisational transition encompassed sector wide structural change, cultural change and systems change, the impact of undertaking such a programme of change within a relatively short period should not be underestimated. There are a number of well documented change management measures which can reduce the risk of system failure.

Further information

Read the Review

National: Jo-Jo

The Safeguarding Adults Review focused on what happened to Jo-Jo during the last year of her life.

Jo-Jo was 38 when she died. She was born with Downs Syndrome and she had two younger sisters. Her Mother cared for Jo-Jo throughout her life helping her through school into adulthood. Jo-Jo needed help with many daily living tasks including personal care, eating the right things, managing money and personal relationships. Throughout all of this her Mother was her main carer.

Since childhood Jo-Jo had suffered from eczema which often caused her distress and discomfort. It would sometimes get better but then it would come back again. Her Mother was the main person who applied the creams or dealt with any other medicines.

In 2013 Jo-Jo was diagnosed with crusted scabies. This is a severe form of scabies (which is very different to eczema). Scabies is an infestation of the skin by the human itch mite which burrows

into the skin where it lives and lays its eggs. This is also called Norwegian Scabies. The Norwegian Scabies seemed to go away, but in 2015 Jo-Jo's skin problems came back. At that time the Hospital said that it was eczema. Because of this, all the treatment that was then prescribed was to treat eczema, though the GPs did question if this was correct. Throughout this time the local authority provided services for 6 hours a week to support Jo-Jo to go out twice a week. The purpose of this was to give Jo-Jo an opportunity to go out for a coffee or to the shops.

There were many times when Jo-Jo did not want to go out because her skin condition was so bad and people looked at her, many times she could not go out because the scabs and infection on her feet made it too painful to walk. At those times the services for Jo-Jo were cancelled and this was not picked up by either social care nor was her GP told how bad things were getting.

No-one really asked Jo-Jo what she wanted because everybody left her Mother to care for her, sort out her skin condition and look after her. No-body asked her Mother if she was OK.

Jo-Jo's skin condition became very bad indeed in December 2016 and it the report said that that her mother found it very difficult to apply any of the medication and creams because it hurt Jo-Jo too much. Jo-Jo often tried to stop her Mother trying to treat her, which made life difficult. No-one really picked this up, so her Mother and the family were left to 'soldier on'.

A District Nurses did visit in January 2017 and said Mother and Jo-Jo could continue to apply the medication. It was clear that Jo-Jo was in a lot of pain, but this was not followed up.

Jo-Jo's skin condition became very bad with most of her body infected and she became quite poorly. On 9th March 2017 Mother called the GP to see Jo-Jo at home who was by this time lying on the floor and not able to stand. Her skin condition was very bad. The GP had two choices at that time: one was to get Jo-Jo to hospital immediately through A&E which the report says would have involved a lot of hanging about and Jo-Jo might then have been sent home. The second option was to get Jo-Jo seen urgently by a skin specialist the next morning. The report says that Jo-Jo's GP quite understandably chose the second option and also said this was not eczema but that it was Norwegian Scabies. So, the GP spoke to the consultant doctor and made an emergency appointment for the next morning.

The ambulance came the next morning and took Jo-Jo to the hospital clinic where she suffered a cardiac arrest and sadly died that morning.

This Review is all about what had happened with Jo-Jo between 1 April 2016 and March 2017.

In addition to the Safeguarding Adults Review (SAR) a Learning Disability Mortality Review (LeDeR) was also undertaken.

Key Learning

- Jo-Jo's Mother cared for her daughter according to her own skills, abilities and understanding. Jo-Jo was not differently cared for in the family because of her disability. Indeed, it is clear that she was unconditionally loved for the person she was.
- The evidence and information gathered in the SAR and LeDeR sets out that both Jo-Jo and her Mother, as the main carer, were let down by a number of gaps, things that were not done and missed opportunities by health and social care agencies on many occasions:
    - Many simple straightforward communications/basic activities were not carried out,
    - No one was putting together Jo-Jo's care,
    - Good practice was often ignored,
    - Policy and current learning was ignored, and

- Jo-Jo's Mother was left virtually unsupported to provide daily care for her Jo-Jo's skin condition which was wrongly diagnosed.

- The review concluded that, Jo-Jo was let down by the agencies that should have supported her health and care, and so too was her Mother. This had nothing to do with resources, rather she (and her Mother) were often left isolated by poor working together and ineffective use of resources.
- It noted that it was not difficult not to conclude that her learning disability played a part in these gaps and omissions, so too perhaps the assumed social standing of her mother.
- It also concluded that Jo-Jo's voice was not heard; that there was no advocacy, contrary to the requirements of the Care Act 2014, and the key tenets of Valuing People. Her mother inevitably struggled to penetrate an unfathomable and disconnected health and social care system.

All the information in the 'Learning Lessons' section has been adapted form the original reports which we thank the commissioning organisations for sharing with us

Further information

Read the Review

Learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the Somerset Safeguarding Children Board, which will shortly become the Somerset Safeguarding Children's Partnership in October as part of the changes introduced in Working together to safeguard children (2018).

Their latest Learning Bulletin, 'Things You Should Know', focuses on what we can learn from examples of good practice and includes a recent safeguarding conversation, and a case study providing a family with early help.

Local & National News and Headlines

September 2019

- Young Friends Against Scams pack launched
- NHS Somerset Clinical Commissioning Group supports world sepsis day
- Modern Slavery Helpline publishes sexual exploitation factsheet
- Somerset's Suicide Bereavement Support Service is being re-launched on World Suicide Prevention Day
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS) launches survey to help develop better support services for women over 55 across the South West
- 39 Essex Chambers: Inherent Jurisdiction cases – two judgments provide important clarification as to the limits of the inherent jurisdiction
- Ann Craft Trust launches Safeguarding Adults in Sport Framework

- BBC Panorama investigates modern slavery
- Kings College London publishes "New Starts: A scoping review of literature on people with criminal records working in social care – current practice and potential for recruitment"

August 2019

- BBC News: 'The new mobile phone scam delivering a problem'
- BBC News: 'Domestic abuse: Killers 'follow eight-stage pattern'
- Campaign launched for more fully accessible toilets or `Changing Places' in Somerset
- Healthwatch Somerset publishes its August e-Bulletin
- Avon & Somerset Police and Crime Commissioner awarded £1.16m Home Office funding to introduce Violence Reduction Units (VRUs) to tackle serious violence.
- Research in Practice for Adults (Ripfa) blog: Safeguarding through a strengths-based lens
- Headway publishes information to assist GPs with diagnosing, managing and appropriately signposting patients and carers affected by the often hidden aspects of brain injury
- Psychology Today: "Why Adult Victims of Childhood Sexual Abuse Don't Disclose"

July 2019

- Charities commission launches survey to help it improve its safeguarding guidance
- NHS Somerset Clinical Commissioning Group publishes it's 2018-19 patient and public engagement report
- BBC News: Direct debit fraud: 'My mother lost £14,000
- Department of Health and Social Care: 'Transitions: why it's so important for social workers to be on time'
- 39 Essex Chambers publishes its July Mental Capacity Report
- Community Care: Safeguarding study reveals knowledge gaps in applying MCA to cases of alcohol-based harm
- Updated Multi-agency public protection arrangements (MAPPA) statutory guidance (version 4.5) released by Ministry of Justice, National Offender Management Service, and HM Prison Service
- 39 Essex Chambers: Capacity and sexual relations – trying to make it personal
- NHS England: Personalised care for veterans
- The Guardian: 'Sex and dementia: the intimate minefield of consent in a care home'
- National patient safety strategy published

June 2019

- The Guardian: Virtual visits: how Finland is coping with an ageing population
- Healthwatch England: What should you expect when it comes to care for your teeth
- Avon and Somerset police Control Room: Don't know where you are in an emergency? If you need the police, our Control Room can use a what3words address to locate you
- CQC publishes report about the common areas of risk when using medicines across health and social care in England
- All Party Parliamentary Group on Dementia publishes Hidden No More: Dementia and disability
- Blogs by Kate Terroni, Chief Inspector of Adult Social Care at CQC and Dr Rosie Benneyworth, Chief Inspector of Primary Medical Services and Integrated Caren at CQC
- Action Fraud: Controls prevent phone fraudsters spoofing HMRC

May 2019

- 39 Essex Chambers: Life-sustaining treatment – what would P have done? And does it make a difference that she is in a 'pro-life' nursing home?
- The Kings Fund: 'The NHS Explained: How the Health System in England Really Works'

- BBC News: Scam victims to be refunded by banks
- BBC News: Whorlton Hall: Ten arrested over abuse allegations
- The Learning Disabilities Mortality Review (LeDeR) publishes its third annual report
- CQC Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism
- Full text of the Mental Capacity (Amendment) Act 2019 published
- New guide launched to help staff in financial services and utility companies act more consistently when they see powers of attorney and deputy court orders
- SomersetLive: What we can learn from five fire deaths in the last year
- The All-Party Parliamentary Group on Adult Survivors of Childhood Sexual Abuse publishes its first enquiry report exploring survivors' experience of accessing support services and the criminal justice system
- BBC News Gaslighting: The 'perfect' romance that became a nightmare
- Updated version of "Must knows adults: safeguarding" for councillors published by the Local Government Association

April 2019

- The Office of the Public Guardian publishes its safeguarding strategy 2019 to 2025
- Healthwatch Somerset: Somerset's adult safeguarding service to be improved based on new feedback
- Somerset Community Connect website launched
- Is my resident well? Ten everyday questions to help care home staff and carers, recognise signs of residents becoming unwell
- Number of identified male victims of modern slavery in UK has increased five fold in the last five years
- Child exploitation disruption toolkit published by the Home Office
- International Journal of Law and Psychiatry: Advance decision-making in mental health – Suggestions for legal reform in England and Wales
- NHS Safeguarding Annual Update for 2018/2019 published
- Community Care: Identifying and assessing dementia in adults with learning disabilities

Training and Development

It is the responsibility of all organisations to ensure they have a skilled and competent workforce who are able to take on the roles and responsibilities required to protect adults at risk and ensure an appropriate response when adult abuse or neglect does occur. The SSAB does not provide any single or multi-agency training.

Social Care Institute for Excellence: e-learning

(please note that SCIE have recently begun charging for this content)

- e-learning: Adult Safeguarding Resource
- e-learning: Mental Capacity Act

Other resources

- Health Education England e-Learning Mental Capacity Act e-Learning
- Unseen Modern Slavery training
- Home Office Prevent e-learning
- Home Office FGM (Female Genital Mutilation) e-learning

Real Safeguarding Stories is a learning tool dedicated to raising awareness of safeguarding issues. By telling compelling stories based upon real life events, it helps professionals understand

these complex issues. Understanding and relating to these stories is the first step towards individuals and organisations being better able to support those at risk. On this website you will find a series of videos, each exploring different aspects of safeguarding – including child and adult safeguarding, and domestic abuse. These are based on the experiences of professionals working in the field and from interviews with victims of abuse. The videos are then scripted and filmed using actors in a realistic context, with each video supported by guidance to support wider training or awareness activity. Visit: http://realsafeguardingstories.com/

Useful Safeguarding Adults Links

Get the SSAB Website on your phone or tablet

Secure professionals e-referral form

Joint Safeguarding Adults Policy

Somerset Adult Safeguarding Guidance

National Safeguarding Adults Review (SAR) Library

Get in touch

If you have any suggestions for future topics or comments about this newsletter, please contact us via:

ssab@somerset.gov.uk

Alternatively call our Business Manager, Stephen Miles, on:
01823 359157

If you are worried about a vulnerable adult, don't stay silent

Phone: **0300 123 2224**
Email: **adults@somerset.gov.uk**

Or complete a secure
Professionals e-referral form

In an emergency always contact the police by dialling 999.
If it is not an emergency, dial 101

SOMERSET SAFEGUARDING ADULTS BOARD