Issue 12, Dec 2019

Newsletter

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

This is the 12th 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 appointed a new Independent Chair, Keith Perkin and published our new Somerset Adult Safeguarding Learning Framework and a Practice Briefing from a serious case with accompanying guidance. We have also updated a number of documents on our website including our Adult Safeguarding Risk Decision Making Tool, Service Monitoring Checklist, Self Neglect Practice Guidance and the South West Region Adult Position of Trust Framework which we have adopted.

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.

As in 2018 we will be using social media to raise awareness of adult safeguarding using #12DaysOfSafeguarding over the festive period, but in the meantime we wish all our readers a happy Christmas and a healthy and safe New Year.

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

October 2019

The SSAB has met once since the last newsletter was published, on 08/10/2019.

Agenda highlights include:

- A detailed briefing on Hate Crime in Somerset from Stand Against Racism and Inequality;
- Considering national learning regarding use of restraint and self-neglect and fire risk;
- Considering a Practice Briefing and associated guidance (see page 8);
- Signing off the Somerset Adult Safeguarding Learning Framework (see page 3);
- Receiving an update on the establishment of Violence Reduction Unit;
- Receiving a progress update on our Strategic Plan from the Executive Group.

Introducing our new Independent Chair

After six years as SSAB Independent Chair Richard Crompton will be stepping down at the end of December. At its October meeting the Board thanked Richard for his work over the last six years, emphasising the significant progress that the Board had made during this period and offered him its best wishes for the future.

Following a recruitment process the Somerset Safeguarding Adults Board is pleased to announce that Keith Perkin has been appointed as the new Independent Chair of the SSAB, and will begin working with us in January 2020. Keith is looking forward to meeting with both the Board and organisations working in Somerset once he takes up the role and would like to be begin by introducing himself:

Keith Perkin (left) and Richard Crompton (right)

"There can be no more challenging, complex or rewarding work than safeguarding adults who need care and support in their lives. As a previous Head of a Public Protection Unit for Devon and Cornwall Police, and member of the Devon Safeguarding Adults Board, including Chair of its Safeguarding Adult Review Group, I have witnessed directly the passion, commitment and professionalism across agencies that is vital to keeping people safe. We can only do this by working effectively in collaboration with others.

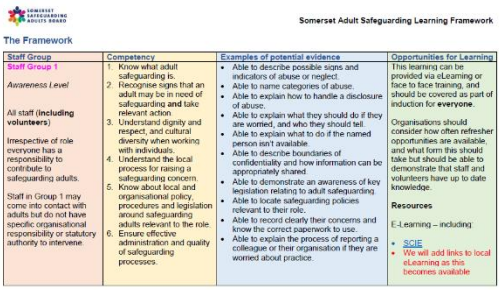
Somerset is a lovely place to live and work in, but as the local Policing Commander for Torbay and South Devon, I recognise the challenges that working in a mix of rural, coastal & urban areas can bring.

Before I joined Devon & Cornwall Police, I was a teacher in Yeovil. It is also the county where I met my wife, so Somerset is a special place for me.

The Somerset SAB has a good reputation and I look forward to working with you to further improve the valuable service you provide together to those who need support."

Somerset Adult Safeguarding Learning Framework Launched

To support local organisations in developing adult safeguarding expertise the SSAB has developed a new Somerset Adult Safeguarding Learning Framework which was signed off by the SSAB Board at its October Meeting.



Somerset Adult Safeguarding Learning Framework

The Framework

Staff Group	Competency	Examples of potential evidence	Opportunities for Learning
Staff Group 1 *Awareness Level* All staff (**including volunteers**) Irrespective of role everyone has a responsibility to contribute to safeguarding adults. Staff in Group 1 may come into contact with adults but do not have specific organisational responsibility or statutory authority to intervene.	1. Know what adult safeguarding is. 2. Recognise signs that an adult may be in need of safeguarding **and** take relevant action. 3. Understand dignity and respect, and cultural diversity when working with individuals. 4. Understand the local process for raising a safeguarding concern. 5. Know about local and organisational policy, procedures and legislation around safeguarding adults relevant to the role. 6. Ensure effective administration and quality of safeguarding processes.	• Able to describe possible signs and indicators of abuse or neglect. • Able to name categories of abuse. • Able to explain how to handle a disclosure of abuse. • Able to explain what they should do if they are worried, and who they should tell. • Able to explain what to do if the named person isn't available. • Able to describe boundaries of confidentiality and how information can be appropriately shared. • Able to demonstrate an awareness of key legislation relating to adult safeguarding. • Able to locate safeguarding policies relevant to their role. • Able to record clearly their concerns and know the correct paperwork to use. • Able to explain the process of reporting a colleague or their organisation if they are worried about practice.	This learning can be provided via eLearning or face to face training, and should be covered as part of induction for **everyone**. Organisations should consider how often refresher opportunities are available, and what form this should take but should be able to demonstrate that staff and volunteers have up to date knowledge. **Resources** E-Learning – including: • SCIE • We will add links to local eLearning as this becomes available

The learning framework incorporates national standards; supports local strategic aims and promotes the need for cultural change for agencies who support adults at risk. It applies to all organisations, professionals and staff in Somerset who do not work to the "Adult Safeguarding: Roles and Competencies for Health Care Staff" Intercollegiate Document published by the Royal College of Nursing.

The learning opportunities outlined in the framework are based upon minimum standards and what outcomes specific groups of staff should be capable of achieving. The levels of competence those groups of staff should hold remains the responsibility of each organisation to measure with their own performance management and compliance processes.

The framework profiles five groups of staff who may have different levels of responsibility to safeguard adults, listing the types of job roles within each group (please note that this is not intended to be exhaustive). Each grouping is a guide and some roles may overlap, and each organisation therefore needs to identify the necessary capability that staff may require in their organisation.

The five levels identified within the Framework are:

1 **Awareness**: This level applies to all staff, including volunteers

2A **Responder**: This level includes staff who are in regular direct contact with people who may be an 'adult at risk' and who may need to raise a safeguarding concern and/or complete a safeguarding adults referral form

2B **Responders and Specialist**: This level includes staff who have the responsibility for making decisions for concerns raised. They will hold key roles within safeguarding adults, in particular Section 42 enquiries within the Care Act (2014).

3 **Decision Makers**: This level includes staff who are responsible for ensuring that the management and delivery of safeguarding adult services is effective and efficient. They will have oversight of the development of systems, policies and procedures in accordance with national, local and organisational policies and procedures

4 **Organisational Leaders**: This level includes staff who are responsible for strategic leadership, policy and planning of services for adults at risk.

5 **Organisational Leaders without a direct reasonability/accountability for safeguarding functions**: This includes those who are responsible for the governance of the organisation its compliance with good safeguarding practice, although unlike group 4 they do not have a direct responsibility and/or accountability for this function and may not be employees of the organisation (for example trustees).

Further information

Read more about the Safeguarding Learning Framework

Let's make this Christmas a bad one for scammers

Christmas is a time when scamming activity often increases, and different types of scam are emerging all the time.

What is a scam?

Scams are crimes. They are fraudulent activities designed to cheat people out of their money or obtain their personal details for illegal purposes. They can include everything from bogus lottery or competition wins, through to miracle cures and chain letters. Scammers may seek to trick people online, on the telephone, through information sent in the post or in person.

Scams target people of all ages, backgrounds and income levels. No one is immune, but people can be better enabled to keep themselves safe with information so that they can be alert to this type of crime.

Financial scamming can have seriously damaging consequences on the person that has been scammed and society. Unfortunately, the impact is often underestimated and becoming involved with a scam can be a life-changing event, and can be a major factor in the decline of health and independence in older people

What can the impact be on individuals?

Scams can cause long lasting or permanent damage to an individual's health and quality of life. Many individuals experience injury to their confidence and trust, and some people are left with the psychological effects of stress, anxiety, fear, depression and shame. Individuals may deny their involvement and others may blame them.

Remember:

- Financial scamming **is a crime** and can affect anyone. It is vastly under reported and the true scale of the financial loss and other impacts is unknown.
- Enabling people to keep themselves safe from scammers can be beneficial to people's health and independence
- Factors such as loneliness, social isolation, poverty and cognitive impairment can make people more vulnerable to responding to financial scams or fraudulent schemes.
- Older people are targeted by certain types of scams such as doorstep, mail, telephone, pension and investment scams.
- Cognitive impairments, such as dementia, can interfere with an individual's capacity to identify a scam. Those with dementia may not have the skills to judge risk and can find it more difficult to apply precautionary measures to decision making which puts them at increased risk of responding to a scam.

Some of the most prevalent scams at the moment include:

- iTunes gift card scam
- Romance and dating scams
- Advance fee fraud
- Identity fraud and identity theft
- Contactless card fraud
- Online shopping and ticket scams
- Callers, emails or websites claiming to be a government agency when they're not
- Pension scams
- Investment scams, including cryptocurrency investment fraud
- Subscriptions traps or free-trial scams

- Computer scams
- Council Tax re-banding and business rates scams
- 'vishing', 'phishing', and 'smishing' – these are types of phone, text message and email scams.
- Invoice scams
- Social media scams

Further information

The Devon, Somerset and Torbay Trading Standards Service

Friends Against Scams

Employers across Somerset urged to support campaign to provide support for victims of domestic abuse

An estimated 1.9 million adults aged 16 to 59 experience domestic abuse each year. Often workplaces are the only safe place for victims, offering hope of escaping abuse if the signs are spotted - or if employees feel able to disclose abuse to colleagues.

Between 25 November and 10 December 2019 organisations, including the SSAB, marked the international 16 days of action movement by reminding employers across the region of their duty of care to provide a safe and effective work environment for employees.

Preventing and addressing domestic abuse is an integral part of this duty of care – it is a hugely destructive problem and we have a collective responsibility to tackle it. The good news is that Public Health England has partnered up with Business in the community (BiTC) to produce 'Domestic Abuse: a toolkit for employers'. The toolkit provides organisations of all sizes and types with practical advice on how to respond to the risk of domestic abuse and build an approach that ensures all employees feel supported and empowered by their workplace to deal with domestic abuse.

Research commissioned by the Vodafone Foundation has revealed that awareness of domestic abuse has increased and that employers want to do more but need support to put policies in place. It is thought that only five per cent of organisations currently have a specific policy or guidelines on the issue.

You don't have to run or work for a large organisation in order to put a policy in place that helps protect and provide a safe space for employees. The toolkit encourages employers to consider three key actions:

- Acknowledge your responsibility to address domestic abuse. Enable colleagues to openly discuss this topic, and provide a supportive workplace
- Respond by reviewing your policies and processes to ensure you are providing a supportive workplace and can respond to disclosure. Make sure the policies and processes are implemented correctly
- Refer and provide access to organisations who can help employees affected by the issue.

Further information

Download a copy of the toolkit from the BiTC website

Identifying the signs of modern slavery

Today slavery is less about people literally owning other people, but more about being exploited and completely controlled by someone else, without being able to leave.

Someone is in slavery if they are:

- Forced to work – through coercion, or mental or physical threat;
- Trapped and controlled by an 'employer', through mental or physical abuse or the threat of abuse;
- Dehumanised, treated as a commodity or bought and sold as 'property';
- Physically constrained or have restrictions placed on their freedom of movement.

Forms of modern slavery

- Forced labour – any work or services which people are forced to do against their will under the threat of some form of punishment;
- Debt bondage or bonded labour – the world's most widespread form of slavery, when people borrow money they cannot repay and are required to work to pay off the debt, then losing control over the conditions of both their employment and the debt;
- Human trafficking– involves transporting, recruiting or harbouring people for the purpose of exploitation, using violence, threats or coercion;
- Descent-based slavery – where people are born into slavery because their ancestors were captured and enslaved; they remain in slavery by descent;
- Child slavery – many people often confuse child slavery with child labour, but it is much worse. Whilst child labour is harmful for children and hinders their education and development, child slavery occurs when a child is exploited for someone else's gain. It can include child trafficking, child soldiers, child marriage and child domestic slavery;
- Forced and early marriage – when someone is married against their will and cannot leave the marriage. Most child marriages can be considered slavery.

Possible indicators that someone may be a victim of modern slavery

- **Physical Appearance**: Victims may show signs of physical or psychological abuse, look malnourished or unkempt/untidy, or appear withdrawn and neglected. They may have untreated injuries.
- **Isolation**: Victims may rarely be allowed to travel on their own, seem under the control or influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work.
- **Relationships which don't seem right**, for example a young teenager appearing to be the boyfriend/girlfriend of a much older adult.
- **Poor living conditions**: Victims may be living in dirty, cramped or overcrowded accommodation, or living and working at the same address.
- **Few or no belongings**: Victims may have no identification documents, have few personal possessions and always wear the same clothes all day, every day.
- **Restricted freedom of movement**: Victims may have little opportunity to move freely and may have had their travel documents retained, such as passports.
- **Unusual travel times**: They may be dropped off or collected for work on a regular basis, either very early in the morning or late at night.
- **Reluctance to seek help**: Victims may avoid eye contact, appear frightened or hesitant to talk to strangers. They may fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family. They may be accompanied by someone else who speaks for them.

- **Grooming**: Children may not always demonstrate outward signs of distress and may have a 'bond' with those exploiting them and have been groomed to not disclose their abuse – however, they are likely to be very scared and traumatised.

If you believe a person is a victim of modern slavery you should report it straight away using one of the methods on page 16.

Further information

Unseen
Anti-Slavery international

Business Manager Blog


Stephen Miles SSAB Business Manager

The festive season is nearly upon us and while many will be looking forward to some time off I know that for many thousands of people working across health, social care and public protection in Somerset (and many other essential services) this will be a far from relaxing time, and I wanted to begin by saying thank you to each and every person who will spend the festive period away from their loved ones to keep some of the most vulnerable people in our community safe

Unfortunately, the festive period also appears to be a very busy time for scammers so please read the updated information we have provided in the article on page 3. My email can certainly attest to it, apparently I've won a couple of lotteries, companies I've never done business with have found a problem with my account that I urgently need to click on a link to resolve, a company with a name one letter different to a well-known retailer have an order update for me and apparently I really need to consider a miracle cure for a skin blemish I never knew I had! The problem is that scammers only need a tiny fraction of recipients of these messages to respond in order to make a lot of money and, unfortunately, those who do so often become increasingly vulnerable to further scams. If you only make one New Year's resolution please look at the online learning produced by Friends Against Scams and encourage others to do so to, I know everyone is busy but it may be 20 minutes that your or someone you care for benefits from greatly in the future.

As the year draws to a close the Board is about to go through a big change with Richard Crompton standing down as Independent Chair at the end of December. I've only had the privilege of working with Richard since staring in this role in 2017, but I wanted to take this opportunity to publicly thank him for his leadership of the Board, and on a personal level for how much I have learnt from him. Our new Independent Chair, Keith Perkin, will take on the role in January 2020 and I'm really looking forward to starting to work with him, and seeing the Board continue to flourish under his leadership. We have already met to begin introducing him to the work of the Board, and Keith will be chairing his first Board meeting in early February.

In October I had the new experience of being interviewed by BBC Somerset about the progress made since the publication of the Mendip House Safeguarding Adults Review. While we have seen progress there is still work to do, particularly where people are placed by in to Somerset by other Local Authorities and Clinical Commissioning Groups. We also continue to receive referrals for Safeguarding Adults Reviews in order to identify learning from other serious cases. One of these was for Kevin which, while not meeting the criteria for a Review under the Care Act, was felt by the multi-agency group that considered his case to contain valuable learning for the local system. You can read more about on page 8, but the one thing I wanted to do here was to 'bust the myth' that we have seen emerging recently that a safeguarding referral needs to have been made to, and

accepted by, Somerset County Council's Safeguarding Service for a multi-disciplinary discussion to be initiated. It does not, nor does the Safeguarding Service need to coordinate or be involved in a discussion of this type unless there are specific concerns that mean it needs to be. If you or your organisation are worried about someone a discussion with other professionals and organisations can often provide an opportunity to take a multi-disciplinary approach to resolving a concern early, before the point is reached where a safeguarding referral needs to be considered and, as emphasised in a recent workshop I was involved in led by @safeguardingsom, there is nothing in the Care Act that gives the Safeguarding Service a magic wand to resolve complex issues that other professionals or organisations can't. For example, when the concern is about someone who is self-neglecting those who they know best are often best placed to make a difference, and the intervention of someone they are unfamiliar with can frequently be counter-productive. To this end, alongside the Practice Briefing we have published new guidance called "What to do if it's not Safeguarding", and while we appreciate that organisations may sometimes have their own perspective on what is or isn't safeguarding as a Board we are clear that all organisations should be working to the Care Act and its supporting statutory guidance. I know it's a statement that is regularly repeated, but safeguarding really is everybody's business, and I hope that this guidance will help to provide a framework to enable multi-disciplinary discussions to take place where they aren't already happening, as well as a route to resolving some of the issues that partners have told us can sometimes exist when trying to initiate them.

I hope that you all manage to take at least a little time to enjoy the festive season and I look forward to continuing to work with you in the New Year.

Learning Lessons

Local: Kevin

Background

The details of this case have been anonymised in order to protect Kevin's privacy, however the multi-agency group that reviewed it agreed that there was learning for the local system that needed to be shared. The key features of Kevin's case are:

- Kevin was middle aged when he attempted to take his own life, shortly after he death of his partner, which had a life changing impact on Kevin's health
- Prior to their death Kevin had made unsubstantiated allegations of domestic abuse by his partner. Professionals involved in Kevin's case felt that it was unclear whether abuse had taken place at all or, if it had, who the abuser was.
- Kevin had a history of very high-intensity contact with his GP surgery, with often multiple contacts per day, and the Emergency Department at his nearest hospital.
- Kevin had made references about potentially wanting to end his life on occasions over the period of more than a year that was considered by the multi-agency group before he attempted to do so, but had consistently declined to engage with local mental health services.
- No concerns were identified with regard to assessments of Kevin's capacity undertaken, nor was Kevin identified as having Care and Support needs as defined by the Care Act (2014), prior to his attempt to take his own life.
- A number of months later, while Kevin was a patient in hospital recovering after the attempt to take his own life, new concerns were identified regarding allegations of possible financial and

material abuse of Kevin by a member of his family.

Key Learning

- A high intensity of presentations at one or more services is an indicator of an unmet need that should be explored and further understood, and this is often best done through a multi-disciplinary perspective.
- Meetings that discussed Kevin's frequent attendance at the Emergency Department of his nearest hospital did not include his GP surgery or other professionals from outside the NHS, nor did they consider his wider needs within the community in which he lived.
- Concerns raised with organisations prior to Kevin's attempt to take his own life were dealt with in isolation and, because of this, patterns were not recognised by any of the organisations involved.
- The involvement of an Independent Domestic Violence Advocate (IDVA) may have been useful to help explore what the situation actually was regarding Kevin's allegations of domestic abuse by his partner prior to their death.
- While Kevin did not have care and support needs that would have resulted in involvement from Somerset County Council's Safeguarding Service prior to the attempt to take his own life, this did not mean that a multi-disciplinary discussion could have not been arranged by one of the organisations that was involved in Kevin's case to discuss the concerns that professionals had.

Examples of good practice identified

- A Health Coach employed by Kevin's GP surgery was the primary point of contact for Kevin's frequent contacts with surgery, including the last contact before he attempted to take his life. The multi-agency group that reviewed Kevin's case identified that the support provided by Health Coach, over the period of over a year that it considered, was exemplary.
- The discharge process from hospital following Kevin's attempt to take his own life considered the ongoing safeguarding concerns regarding alleged financial and material abuse by a member of Kevin's family, recognised specific risks to Kevin in association with these concerns and took agreed actions with Kevin to mitigate them in line with the principles of Making Safeguarding Personal by ensuring that Kevin's home was a secure environment for him to return to.

Recommendations for all organisations and professionals to ensure effective practice

- Recognise that a high intensity of presentation at one or more public services may be a symptom of an unmet need that requires further exploration.
- Recognise that a concern does not require a safeguarding referral to have been made to, or accepted by, Somerset County Council's Safeguarding Service for a multi-disciplinary meeting to be arranged, nor does the Safeguarding Service need to coordinate or be involved in such a meeting unless there are specific concerns of a nature that would suggest that involvement should be sought (please refer to the SSAB Adult Safeguarding Risk Decision Making Tool for guidance).
- Consider the involvement of an IDVA where domestic abuse may be a factor in the concerns that are held about an individual.
- Consider using a virtual meeting room approach, such as that offered through Somerset Choices, to assist in sharing information securely to avoid silo working.
- Consider how an approach based on the principles of Making Safeguarding Personal, as seen in this case, can be utilised within discharge processes to facilitate a successful discharge where there are ongoing safeguarding concerns.

- Where an individual has expressed a wish to end their own life consider whether a safety plan could enable the person them keep themselves safe.

New Guidance - What to do if it's not Safeguarding?"

Following the consideration of Kevin's case the Somerset Safeguarding Adults Board has produced new guidance entitled "What to do if it's not Safeguarding?" for use by for professionals on responding to people with complex needs or circumstances who do not require an adult safeguarding enquiry under Section 42 the Care Act (2014), or where it has been determined that a non-statutory enquiry is not required.

Further information

Read the Practice Briefing

Read the "What to do if it's not Safeguarding?" guidance

Regional: Atlas Care Homes

Background

Atlas was a provider that was commissioned to provide specialist care for adults with learning disabilities whose support needs were described as "complex" and "challenging." In total 33 people were placed within 7 care homes operated by Atlas in Devon. One person was also in receipt of support from the Atlas Personal Care Agency, and in total 12 different commissioners were involved.

A police investigation began in October 2011 and Atlas entered administration in April 2012. Following on from the police investigation the prosecution of former employees began in May 2016 and appeals concluded in October 2017.

The criminal court proceedings revealed that Atlas residents were subjected to:

- systemic neglect
- seclusion in rooms without food, drinks, heating or access to toilets
- physical assaults
- orders from staff to undertake housework and gardening tasks which were "tests" to establish their compliance.

Two of the homes which received media coverage during the trial were geographically isolated former farmhouses.

A Serious Case Review (SCR) was commissioned at the outset. The SCR was submitted to Devon's Safeguarding Adults' Board during February 2013, but was not published because the criminal proceedings had not concluded. After conclusion of the trial, the Devon Safeguarding Adults' Board undertook to set out its findings and bring the 2013 SCR up to date in a Safeguarding Adults Review that was published in September 2019.

Review findings

- **Relationships between host and placing authorities**

  There needs to be a mandatory notification system which would advise a local authority that an adult with a Learning Disability was to be placed. Notification(s) by placing authorities should encompass information concerning a person's support needs, including their physical health status since this impacts on local generic and specialist services. The host authority must have a mechanism to capture or use this information.

There remains an urgent need to reconsider the continuing use of out of area placements to localities where the capacity of host authorities to use notification data and hold providers to the specifications set out by the placing authorities is not known.

- **Analysing risk of harm in organisations**

  There remains a reliance on Care Quality Commission (CQC) reports however commissioning authorities' processes and procedures are more attentive to the quality of provider services and the risks associated with particular placement than they were in 2013.

  Inspections on their own cannot improve care; it can only tell us what it is measuring. There needs to be consideration of the role of CQC and how local intelligence information is shared. The creation of a repository of "intelligence" about providers which is accessible to commissioning bodies should be encouraged as well as the development of a tool to assist analysis of indicators of harm in organisations.

  The interface between complaints and safeguarding requires attention if the safeguarding procedure is invoked on behalf of an individual making a complaint.

- **Assessing quality of care in commissioned services (commissioners, including commissioners of out of area placements)**

  There was a lack of oversight of the quality of care delivered by commissioning agencies and a fundamental lack of challenge to the provider. The quality control of residential provision cannot be transferred to the provider.

  There needs to be a system for sharing and collating concerns about providers. The interface between activities which seek to assure the quality and effectiveness of a commissioned service and the resident reviewing process should be recognised.

  There needs to be new specificity in contracting most particularly in re-contracting services for people with learning disabilities and autism. It is during the post-award period that poor contract performance is likely to emerge.

- **Market sufficiency and risk profile**

  The fundamental shift in commissioning anticipated by "Valuing People" and "Valuing People Now" (Department of Health 2001; HM Government 2009) had not impacted on the lives of the Atlas residents or their families. Shortcomings of strategic planning, commissioning and inspection practices cannot be remedied by adult safeguarding.

  There needs to be ongoing scoping of existing provision, future demand and supply of care provision to support people in local area/reduce out of area placements.

  All commissioning bodies are immersed in efforts to shape the market to reduce the likelihood of people being moved away from their areas of origin.

- **Reviewing how care and support needs are met**

  The need for, in some cases, an alternative to episodic / once a year reviews and instead, continuing complex case management with a strong advocacy role. The importance of professional curiosity in all activities.

  Care Managers/those reviewing how care and support needs are met must have clear goals which hinge on understanding the aspirations of people with learning disabilities and their families for ordinary lives.

- **Absence of relationship**

  There was an absence of relationship with and a lack of understanding of family involvement and each family's context. Their views relating to how they perceived their loved one to be at his placement were not actively sought. Their expertise was not recognised. Commissioning bodies should consider testing their system to determine how a family might challenge a professional who appeared duped by Atlas employees.

Recommendations resulting from the Review

The Review makes six recommendations, some of which are very similar to those that were made in the Mendip House Safeguarding Adults Review that was published by the Somerset Safeguarding Adults Board.

1. Recommend that the Department of Health, NHS England and the Local Government Association:
   - incentivise commissioning bodies to engage in "close to home" Regional Commissioning for adults with learning disabilities, autism and mental health problems – a small population whose needs are not being met locally - and determine, for example, how much support at home, supported living, housing with support, care home, care home with nursing and assessment and treatment is required pro rata;
   - assert a new requirement to discontinue commissioning placements at (a) residential services which would not be registered by CQC in line with 'Registering the Right Support' policy and (b) placements which "take anyone";
   - make mandatory the notification by commissioning authorities of prospective placements to the host authority;
   - assert the requirement for specific funding for essential monitoring, reviewing and safeguarding should this be necessary; and for residents' access to local health services, most particularly community health services.
2. Commend the replacement of episodic/once a year reviews with continuing, complex case management with a strong advocacy role.
3. Incentivise the creation of a repository of "intelligence" about providers which is accessible to commissioning bodies. This should include a company's response to complaints, inspections and compliance matters. This will require funding if good data from all parts of the system is considered on a continuous basis.
4. Ensure that where people receiving specialist care their health, wellbeing and need to be protected from harm and danger is explicit in enforceable, individual contracts and support plans.
5. Review impact on corporate governance of the care of large numbers of adult residents and the public sponsorship involved.
6. Promote proceedings under the Company Directors Disqualification Act 1986 being considered when residents are harmed and a company's inattention to outcomes for them is recurrent.

Further information

Read the Review

Adapted from the Atlas Care Homes Safeguarding Adults Review published by the Devon Safeguarding Adults Board

National: Large-Scale Modern Slavery

In 2014, Lincolnshire Police commenced a major investigation into suspected labour exploitation by an organised crime group. The investigation was named Operation Pottery and concentrated on sixteen members of one family, Family A.

Police had been investigating the criminal activity of Family A. Family A were part of the traveller community and had exploited the mobile element of that lifestyle to recruit victims. These victims all had vulnerabilities that Family A took advantage of in order to financially exploit, manipulate or intimidate into carrying out fraudulent criminal behaviour and forced labour.

Operation Pottery involved sixty potential victims and was carried out by Police Officers working with multi-agency partners. Much of the focus was on people living on two traveller's sites in Lincolnshire.

In all, Operation Pottery lasted for two years. Of the sixty potential victims, twenty-two supported a prosecution. Of these, eighteen people were referred via the National Referral Mechanism (NMR) and all received a Conclusive Grounds decision of trafficking. The other four victims had been victims of financial exploitation. It was this group of twenty-two that were the focus of the review.

Victim's circumstances left them vulnerable to exploitation. Risk factors were:

- isolated and socially excluded,
- low self-esteem and troubled histories,
- learning disability or mental health needs,
- homelessness,
- substance and alcohol addictions,
- poverty,
- immigrants who were dependent due to language, cultural literacy or control over passport.

However, many of the victims presented just under the threshold of needing the active involvement of agencies and the added protection this would afford them. This was exploited by Family A and helped their activity stay below the radar of agencies.

The Review found examples of good practice where agencies worked with tenacity to overcome the barriers to disclosure and identifies exceptional multi-agency work, led by Lincolnshire Police, to bring the perpetrators to justice and the compassionate support the victims during and following the Court process.

It also highlighted weaknesses in systems that resulted in limited, poorly coordinated restorative care for many of the victims. For some of the victims the actions taken, and the support provided, has transformed their lives. Others have not been so fortunate.

Further information

Read the Review

Adapted from the Large-Scale Modern Slavery Safeguarding Adults Review published by the Lincolnshire Safeguarding Adults Board

SSCB Newsletter

Learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the

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

December 2019

- The Learning Disabilities Mortality Review (LeDeR) programme publishes its December bulletin
- Somerset Intelligence publishes its December newsletter
- The Guardian "One in three over-80s 'provide vital unpaid care for loved ones' in UK"
- Community Care: "The Family Secret documentary and what social workers need to know about sibling sexual abuse"
- Community Care: 'Care Act safeguarding caseloads reach record levels following sharp rise in reported concerns'
- We Matter Too!, a project that addresses the needs of disabled young people facing domestic abuse, launched by the Ann Craft Trust
- Cyber Protect: "Got a smart device in your home? Check out these smart tips on how to protect the smart devices in your home"
- The Guardian: "Half of all homeless people may have had traumatic brain injury"
- Community Care: "How leaders must put values into practice to make safeguarding personal"
- Mental Capacity Law and Policy "Taking capacity seriously: ten years of capacity disputes before the Court of Protection"

November 2019

- Blog post by Dr Suzette Woodward: Safety myths
- The Guardian "Violence traps scared kids in county lines gangs. They need help before it's too late"
- National Working Group launches updated toolkit for criminal, civil and partnership disruption options for perpetrators of child and adult victims of exploitation
- NHS Digital publishes "Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2018-19"
- HMRC published tips on avoiding Self Assessment tax scams
- Solihull Safeguarding Adults Board: 'Facebook and How to be Safe: Learning Disability'(YouTube)
- 39 Essex Chambers November Mental Capacity Report
- United Response publishes Disability Hate Crime Training Resource in partnership with West Yorkshire Police

- Mental Capacity Law and Policy: "The MHA, force-feeding and best interests"
- Blog by Rob Assall-Marsden, CQC Deputy Chief Inspector of Adult Social Care, on restraint, seclusion and segregation in hospitals and care services
- New supporting information for inspectors and Mental Health Act reviewers addresses the risk factors of closed environments
- Community Care "Social workers need to confront prejudices in order to work effectively with people with hoarding issues, expert says"
- The Lewisham Safeguarding Adults Board publishes guidance on risk assessment for smoking in care homes.
- Department of health and Social Care "All inpatients with learning disability or autism to be given case reviews"
- Joint Committee on Human Rights "Human rights of many people with a learning disability and/or autism are being breached in mental health hospitals"

October 2019

- Safer Somerset Partnership publishes the October edition of the Somerset Domestic Abuse Newsletter
- Community Care: "Assessment failings and self-neglect challenges: lessons about homelessness from case reviews"
- Local Government Association published a new briefing on Making Safeguarding Personal for commissioners and providers of health and social care
- Headway: "Managing impulsivity and disinhibition following brain injury"
- The National Council for Voluntary Organisations launches free online safeguarding resources
- Home Office published 2019 UK annual report on modern slavery
- Avon & Somerset Constabulary: "Do you really know what your short-term rental property is being used for?
- CQC publishes "State of Care" report
- Mental Capacity Law and Policy "Inherent jurisdiction guidance note"
- Ripfa blog by Jessica Eaton: "The quest to understand the sexual exploitation and mental health of adults"
- The Safer Somerset Partnership publishes its Autumn 2019 Community Safety in Somerset Briefing
- BBC: "Disability hate crime: Number of reports rising"

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 are now 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

Secure professionals e-referral form

Joint Safeguarding Adults Policy

Somerset Adult Safeguarding Guidance

Practice guidance and resources

Get the SSAB Website on your phone or tablet

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