Issue 13, June 2020

Newsletter

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

This is the 13th edition of the Somerset Safeguarding Adults Board (SSAB) 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, like everyone else, we are having to work in a very different way and some of our activity was reduced during the peak of Coronavirus public health crisis. This included delaying this edition of our newsletter, which was originally planned for the end of March, and which we have used to focus on self-neglect, domestic abuse and scams all of which remain areas of concern during the ongoing public health crisis.

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

February 2020

Since the last newsletter was published the SSAB has met twice on 12/06/2020 and 07/02/2020. Agenda highlights include:

- Discussing learning for the adult safeguarding system in Somerset from the COVID-19 public health crisis
- Reviewing and agreeing actions from a recent South West Audit Partnership audit of SSAB activity and a recent SSAB Member Survey
- Hearing about the experience of an individual who was the victim of County Lines activity and the work done by organisations to support them
- Considering issues surrounding Safeguarding and Hospital Discharges as at February 2020
- Receiving an update on Mental Health Crisis Concordat
- Considering opportunities for developing an Intelligent data-led Safeguarding approach
- Receiving a presentation on the establishment of a Violence Reduction Unit for Somerset and plans for further work during 2020/21
- Receiving progress updates on our Strategic Plan from the Executive Group and agreeing arrangements for refreshing it for 2020/21

As a result of the Coronavirus public health crisis our Independent Chair, Keith Perkin, took the decision to temporarily suspend the activity of all our subgroups in order to free up capacity within the system to support the local response. This is similar to the approach taken by many other Safeguarding Adult Boards. We have continued with statutory processes, such as progressing existing Safeguarding Adult Reviews, processing new referrals that we have received, begun work on our annual report, published guidance on professional curiosity and our Executive Group continued to meet, but other work has been delayed. We have developed a 'roadmap' for restarting this work which was agreed by the Board when it met on 12/06/2020. This includes all meetings being held virtually until at least the end of the current financial year and reviewing or reprioritising work in the light of the ongoing public health crisis.

At its meeting in October 2019 the Board made a decision to publish the minutes of Board meetings in full from that meeting onwards, with the exception of redacting confidential information relating to an individual, for example where someone has spoken about their experience of being safeguarded. Notes will be published on the SSAB Website retrospectively following sign-off at the next meeting.

Safeguarding and Coronavirus

While the ongoing public health crisis continues to dominate most people's work across the system it is important to remember that The Coronavirus Act 2020 does not affect the safeguarding protections in the Care Act (2014), particularly at Section 42 of the Care Act. Safeguarding is everyone's business, so it is important that we remain alert to possible abuse or neglect concerns and work together to prevent and reduce the risk of harm to people with care and support needs, including those directly affected by Coronavirus and those whose vulnerability to abuse and neglect may have been increased by public health measures taken to control it.

SSAB Audit and Members Survey

During the spring of 2020 the SSAB was independently audited by the South West Audit Partnership, and also conducted a survey of members. While the audit highlighted a number of areas for improvement the overall finding was that the Board has satisfactory arrangements across key areas to ensure that it operates as an effective partnership, and at the Board meeting on 12/06/2020 members agreed actions to take work forward to address the findings.

The members survey highlighted strong confidence that Board members worked in an atmosphere and culture of cooperation, mutual assurance, accountability and ownership of responsibility. A few responses highlighted that some of our communications activities could have been better in terms of keeping people informed about what the Board does and how it does it. We will therefore be working on how to address this as part of a broader communications plan, and would welcome any feedback that readers have about how the board could enhance information about its work. For example, one of the things we have continuously sought to do is to focus the majority of our newsletter content on information about adult safeguarding rather than the Board itself, but have we done this to such an extent has left readers wondering what the Board is for? If we have, please let us know what types of information you would like to see.

Further information

Tell us what you think

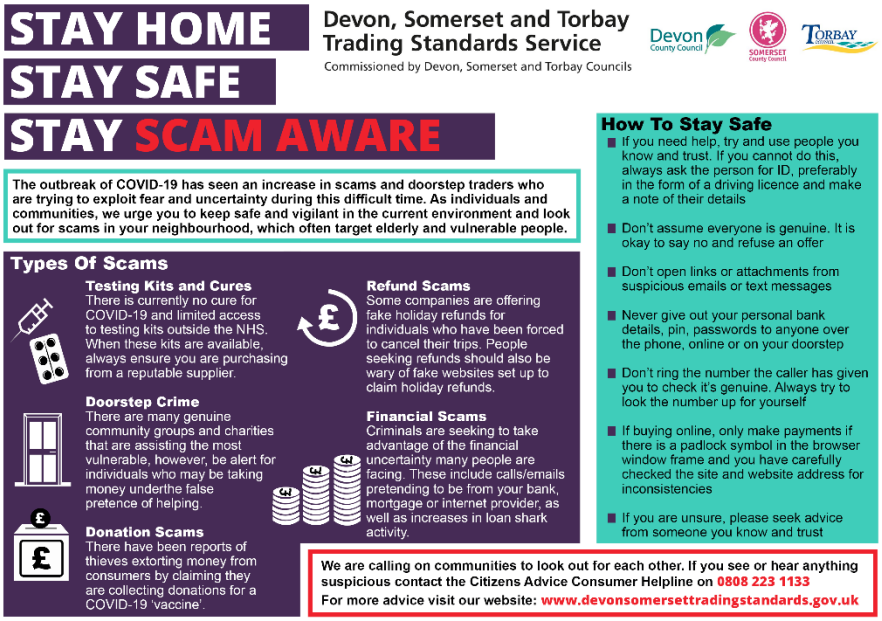
Coronavirus Scams

The outbreak of COVID-19 has seen an increase in scams and doorstep traders who are trying to exploit fear and uncertainty during this difficult time.

As a Board, we urge everyone to keep safe and vigilant in the current environment and look out for scams which often target elderly and vulnerable people.

Types of scams

- Test and Trace scams. Scammers pretending to be contact traces working for the NHS Test and Trace Service contact people claiming that they need to pay for tests or need other personal or financial information
- Testing kits and cures. There is currently no cure for COVID-19 and limited access to testing kits outside the NHS.
- Doorstep crime. There are many genuine community groups and charities that are assisting the most vulnerable, however, be alert for individuals who may be taking money under the false pretence of helping.



Click to view printable version

- Donation scams. There have been reports of thieves extorting money from consumers by claiming they are collecting donations for a COVID-19 vaccine.
- Refund scams. Some companies are offering fake holiday refunds for individuals who have been forced to cancel their trips. People seeking refunds should also be wary of fake websites set up to claim holiday refunds.
- Financial scams. Criminals are seeking to take advantage of the financial uncertainty many people are facing. These include calls/emails pretending to be from your bank, mortgage or internet provider, as well as increases in loan shark activity.

How to stay safe

- If you need help, try to use people you know and trust. If you cannot do this, always ask the person for ID, preferably in the form of a driving licence, and make a note of their details.
- Don't assume everyone is genuine. It is OK to say no and refuse an offer.
- Don't open links or attachments from suspicious emails or text messages.
- Never give out your personal bank details, pin or passwords to anyone over the phone, online or on your doorstep.
- Don't ring the number the caller has given you to check it's genuine. Always try to look the number up for yourself.
- If buying online, only make payments if there is a padlock symbol in the browser and you have carefully checked the site and website address for inconsistencies.
- If you are unsure, seek advice from someone you know and trust.

If you are contacted by a contract tracer they will never:

- Ask you to dial a premium rate number to speak to them (for example, those starting 09 or 087).
- Ask you to make any form of payment.
- Ask for any details about your bank account.
- Ask for your social media identities or login details, or those of your contacts.
- Ask you for any passwords or PINs, or ask you to set up any passwords or PINs over the phone.
- Ask you to purchase a product.
- Ask you to download any software to your device or ask you to hand over control of your PC, smartphone or tablet.
- Ask you to access any website that does not belong to the Government or NHS

Adapted from information produced by the Devon, Somerset and Torbay Trading Standards Service and The Metropolitan Police

Further information

The Devon, Somerset and Torbay Trading Standards Service

Friends Against Scams

The Metropolitan Police: Test and Trace – How to Stay Safe

#NoClosedDoors2020

Though now easing, restrictions imposed because of the pandemic may heighten domestic tensions and increase domestic abuse, and for some people home is not always the safe place it should be.

Whilst it has been essential that the vast majority of people stay at home, the government has acknowledged that the advice to stay at home has cause anxiety for those who are experiencing domestic abuse. Therefore, the guidance has always said that you are allowed to leave your home

to flee an abuser and seek help – local support services and the police remain, and will continue to remain, available.

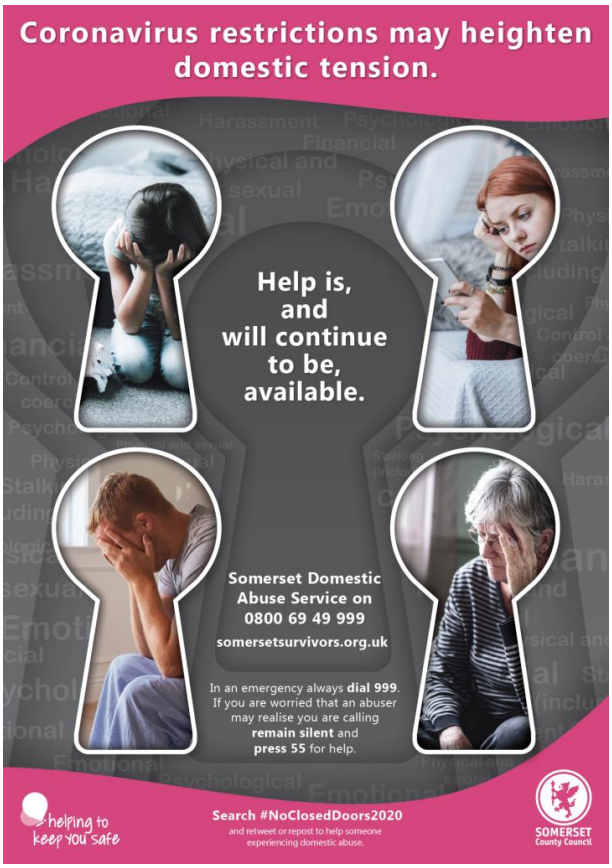
Domestic abuse is unacceptable in any situation, no matter what stresses people are under – there is no excuse for abuse.

Domestic abuse is not always physical violence. It can also include:

- Coercive control and 'gaslighting'
- Financial/economic abuse
- Online abuse
- Verbal abuse
- Emotional abuse
- Sexual abuse

If you are experiencing domestic abuse or are worried or suspect that someone you know, including a colleague, is experiencing or may be at risk of experiencing domestic abuse, then help is available at www.somersetsurvivors.org.uk or by telephoning 0800 69 49 999.

There is also information on the website to advise managers, colleagues and friends what to do if they suspect someone is experiencing domestic abuse and support available if you are worried about the impact of your own behaviour towards others.



In an emergency you **should** always dial 999, if you are worried that an abuser may overhear your call you can remain silent and dial 55 for help.

Can you help spread the word?

With restrictions gradually easing clients of businesses that have previously been closed, such as hairdressers, barbers, beauticians and tattooists, may disclose domestic abuse that they have experienced during this time. Resources are available in the #NoClosedDoors2020 Media Centre that you can use to promote the campaign via social media.

Further information

More information about the coronavirus and domestic abuse can be found here: http://www.somersetsurvivors.org.uk/covid-19-support/

Self-neglect

What is meant by 'Self-neglect'?

The term Self-neglect covers a wide range of behaviour including where and adult is neglecting to care for their personal hygiene, health or surroundings, and also includes behaviour such as hoarding. Self-neglect can happen anywhere, including in care environments and assumptions should therefore never be made that someone is protected by virtue of where they live or the type of service they receive. The reasons why someone may be self-neglecting are often complex, and it is therefore important to try to engage with the person in a way that works for them and explore why they are behaving in the way they are. Self-neglect guidance advises that trauma can also be

a factor that leads to self-neglect, that this level of trauma can be very difficult to overcome and can therefore require recovery support over a long period of time.

Identifying self-neglect

Self-neglect is often defined across three domains – neglect of self, neglect of the environment and a refusal to accept help. Neglect of self may include:

- Poor hygiene
- Dirty/inappropriate clothing
- Poor hair care
- Malnutrition
- Medical / health needs unmet (e.g. diabetes – refusing insulin, treatment of leg or pressure ulcers)
- Lifestyle behaviours leading to harm
- Alcohol / substance misuse
- Social isolation (in the current context this would be beyond that required by COVID-19 advice and guidance)
- Situations where there is evidence that a child is suffering or is at risk of suffering significant harm due to self-neglect by an adult

Neglect of the environment may include:

- Unsanitary, untidy or dirty conditions which create a hazardous situation that could cause serious physical harm to the individual or others
- Hoarding
- Fire risk (e.g. smoker with limited mobility / hoarder)
- Poor maintenance of property
- Keeping lots of pets who are poorly cared for
- Vermin
- Lack of heating
- No running water / sanitation
- Poor finance management (e.g. bills not being paid leading to utilities being cut off, unexplained money drawn from bank/savings account)

The above is usually accompanied by a refusal to engage with services. This may be because of:

- Not recognising the concern at all, or not seeing it as significant
- Pride
- Not wishing to accept that there has been a decline in their ability to self-care
- Fear about what might happen if they do engage

The need for professional curiosity

Professional curiosity should be used when supporting an adult where there is a concern that they are self-neglecting. Self-neglecting behaviours should not be dismissed as a 'lifestyle choice' nor should generalised assumptions be made, as they may be the symptom of someone experiencing a problem with an aspect of the physical or mental health or within their wider environment. For example, an adult who is not eating because they have no food in their house may be experiencing abuse from other members of the community when they try to go shopping or alternatively may have an undiagnosed dementia. Each adult's history, individual risks and mental capacity should be considered, however, in doing so the right balance needs to be found between respecting a person's autonomy and meeting their duty to protect the person's wellbeing. All those working

with people who self-neglect also need to be reflective of how their own values might affect their judgement.

Working with people who self-neglect

Research highlights the importance of:

- A person-centred focus which attempts to establish a relationship of trust and cooperation that can facilitate greater acceptance of support
- Gaining insight into family background and work by professionals to explore the motivation and understanding behind decisions to decline services
- Not accepting superficial refusals of support, which leaves professionals working reactively to each crisis rather than proactively engaging with repeated refusals of support. This includes maintaining contact and offering opportunities for the person to contact services when they feel ready to do so.
- Monitoring changing needs in order to be ready to respond when the individual did recognise the need for help and may be prepared to engage.
- Ensuring that capacity is assessed and recorded thoroughly on a decision specific basis and reassessing capacity over time.
- Developing legal literacy and recording the legal basis for decisions.

Professor Michael Preston–Shoot speaks of the 'Care Frontational' approach to people who self-neglect – challenging them sensitively to consider the implications of self-neglecting behaviour and what the results may be. It is also important to move from a position of 'tell me' to 'show me'. This is because many people who self-neglect will say the right thing but may be unable to put this into practice. This moves the interaction from 'tell me what you are going to eat today?' to 'show me how you will buy the food and cook it.'

Mental Capacity and Self-neglect

Findings from reviews nationally have highlighted that the Mental Capacity Act (MCA) requirement to assume capacity can sometimes be used by a professional faced with a person who is self-neglecting and refusing to engage to reach a superficial conclusion that the person has capacity; meanwhile the supporting evidence that a degree of harm is occurring may indicate a need for a closer look.

- The MCA Code of Practice says that, if a person repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character, although this may not necessarily mean that the person lacks capacity, there might be need for further investigation taking into account the person's past decisions and choices. For example, have they developed a medical condition or disorder that is affecting their capacity to make particular decisions? Are they easily influenced by undue pressure? Or do they need more information to help them understand the consequences of the decision they are making?
- In cases of self-neglect, it is essential that a person's capacity to make informed choices about their personal and domestic care is assessed carefully. Capacity is a complex attribute, involving not only the ability understand the consequences of a decision but also the ability to execute the decision. Without more in-depth assessment of capacity, there is a risk that an absence of executive functioning may not be recognised, and the person may be deemed to be making a capacitated choice when in reality they are not able to carry through the necessary actions to keep themselves safe.

- With regard to people who hoard there may be underlying mental health disorders such as obsessive-compulsive disorders which impact on their decision making ability with respect to their hoarding.
- Capacity assessments can overlook the decision specific nature of capacity, with the result that apparent capacity to make simple decisions is assumed in relation to more complex ones.

Adapted from SSAB Self-Neglect Practice Guidance

Further information

SSAB Self-Neglect Practice Guidance

Business Manager Blog


Stephen Miles SSAB Business Manager

After two aborted attempts it's great to finally get this newsletter finished. Like pretty much everyone else I've had to adjust to a completely new way of working and living over the last few of months. While I already had arrangements in place to work at home one day a week, switching to doing so full time while sharing a hastily set up office in our spare room with the rest of the family – and combining it with home schooling - has certainly been challenging at times. But that challenge pales into insignificance compared to those that our hospitals and care providers have been facing, and the heart-breaking situations they continue to face every day. The commitment of staff working across the system has been phenomenal, with examples of people separating themselves from their families in order to keep them safe or isolating themselves with people who are vulnerable to the virus who they care for. I've read posts on social media about people feeling that the thanks that have been expressed many not be genuine, but in terms of myself and every member of the Board that I've spoken to in the last few of months we all really mean it when we say thank you to you all for everything you have done, and continue to do.

For the last three months almost everything has been dominated by Coronavirus; this was really underlined to me when I was putting together the local and national news section of this newsletter and how noticeable it was that there has been very little other news from mid-March onwards. Much of my time over recent months has been spent supporting the system response to COVID-19, initially through work to identify the likely level of demand for Personal Protective Equipment (PPE) at a time when its availability was scare and getting scarcer by the day. The SSAB has also been hosting information for providers on COVID-19, as well as providing more general information for the public and professionals via the practice guidance section of our website. We have also continued to highlight information that the public and professionals may find useful. One of these has been around scams, which has been a repeated topic for this newsletter over the last few years. While this may in some ways seem repetitive I make no apology for us doing so. This is because the scammers are continuously adapting what they are doing – you only have to look at the speed at which COVID-19 scams emerged to see that – and because of the impact that being scammed can have on an adult, making them not only more at risk of being scammed again but also to poorer long term outcomes overall.

Throughout the period of lockdown, while subgroups have not been meeting, the SSAB has continued to carry out its legal duties. Our annual report has been drafted, a revised strategic plan that is reflective of the fact we were working in very different environment to just four months ago is in the process of being signed-off, and we have also continued to process new referrals for Safeguarding Adults Reviews (SARs) and progress those that were already underway. All our meetings have moved to being held remotely via Teams, and this looks set to continue for the

foreseeable future. As we move to a 'new normal' way of working our newsletter will also hopefully be back on schedule with the next issue due in September.

Whist, at the time of writing, we have not seen any significant patterns of concern emerge locally yet talking to colleagues the three things we are worried about as we emerge from lockdown are: people who have been experiencing domestic violence, people who have been scammed and people who have self neglected. As lockdown eases I'm increasingly seeing more activity in my local area, but also (reassuringly) people continuing to be following national guidance in the main as the virus has not gone away as every one of us is only as safe as the least safe person we come in to contact with. Stay safe.

Learning Lessons

National: Robyn (Cumbria)

Background

Robyn was an 85-year-old lady who had repeated involvement with a number of agencies between 2015 and the date of her death in December 2018. This included numerous safeguarding concerns relating to her care. In 2015, Robyn suffered a fall when she sustained a traumatic head injury from which she was not expected to survive. During her hospital stay which followed, an artificial feeding tube was inserted and she was later discharged home to the care of her son with whom she lived. At the time of discharge Robyn was in a minimally conscious state. However, Robyn survived at home for a further 3 years.

The review found that the insertion of the artificial feeding tube was not fully supported by all family members. This included conflict of opinion regarding whether a decision should be reached to cease life sustaining treatment in line with what was believed to be Robyn's previously held wishes.

In 2017, North Cumbria CCG pursued a decision relating to this matter at the High Court in London. The High Court ruled in December 2018 that life-sustaining treatment in the form of assisted nutrition and hydration should be stopped. Robyn died peacefully shortly afterwards in a local hospice

Summary of learning

- **Adult Safeguarding**
  - When individuals present at Accident & Emergency Units, there should be a system in place to alert clinicians that the individual is or has been, the subject of Safeguarding concerns.
  - When individuals present at hospital in Accident & Emergency and there is suspected abuse or neglect, the necessary safeguarding enquiries must take place.
  - There should be an effective process to manage repeat safeguarding concerns, which is applied consistently.
  - Where there is an accumulation of concerns about an individual that have not led to an enquiry, there should be a process for review of the previous concerns raised.
  - Staff should understand and be clear about what constitutes abuse or neglect and the process for raising any concerns. This should include suspected injuries post hospital admission.

- Multi-agency guidance should be available for staff so they understand their role in safeguarding and the formal route to raise concerns which also promotes formal safeguarding strategy or planning meetings.

- **Discharge Planning**
  - An effective discharge planning and management process should be in place which includes all professionals involved, records of discussions are retained and there is consideration of any risks or safeguarding concerns.
- **Advance Decisions**
  - There should be improved awareness and understanding of the process for making Advance Decisions ensuring wishes are clear and comprehensive.
  - Advance Decisions should be shared (with consent) to ensure that all professionals have access.
  - Professionals should obtain a copy of Advance Decisions and where necessary seek support to interpret ensuring that the person's wishes are respected.
- **Mental Capacity Act (Best Interests)**
  - Professionals should understand their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and be clear in what circumstances a Best Interest decision is required.
  - Professionals should apply the guidance contained in the MCA Code of Practice, including consideration of who should be consulted and when a meeting is required. Clear and accurate records of the meeting and decision must be documented and kept on the persons' record.
- **Working with Family Carers**
  - Practitioners should be aware of when it would be appropriate to offer a carers assessment and triggers that should prompt a review.
  - Practitioners should understand the complexities involved supporting a carer who is resistant to help.
- **Resolving Professional Disagreement**
  - Practitioners should have access to a process for escalating issues when dealing with complex cases with multi-agency involvement and understand how to resolve professional disagreement.
- **Coercive Control**
  - Practitioners should have an understanding of coercive control and domestic abuse, including how to recognise this in familial or caring relationships.
- **NHS Continuing Health Care (CHC)**
  - Assessments under the CHC framework should meet quality standards and criteria.
  - Professionals should be aware of the need to revisit cases where support needs change and in cases previously assessed as being ineligible.

Adapted from Robyn Safeguarding Adults Review published by the Cumbria Safeguarding Adults Board

Further information

Read the Review

National: Ms F and Mr G (Norfolk)

Background

Ms F lived with dementia as did Mr G. The two residents were not related to each other in any way, and their cases are quite different. However, there are overlaps in a number of the learning

themes, and it was agreed that both cases would be reported in a joint report.

Ms F lived in a Norfolk care home. She had lived in the care home for a number of years. The focus of this SAR begins in June 2017 after a male resident (Mr Z) moved into the care home as a private placement. Soon after Mr Z arrived at the care home he began to demonstrate challenging behaviour, including resistance to personal care, shouting and verbal aggression. Within a short time, this developed to include violence towards staff members, and then to other residents. Violent behaviour included hitting or punching residents in the face/head. In December 2017 he pushed over Ms F who hit her head as she fell to the floor and fractured the neck of her femur.

Ms F was taken to hospital for surgery, where she remained over the Christmas period. Mr Z was detained under the Mental Health Act 1983. Ms F returned to the care home in January 2018. By this stage, the incident and subsequent surgery seems to have set in motion a chain of deterioration in Ms F's physical and emotional health. Although it was not for the SAR to consider causation of Ms F's death, it noted that Ms F's death occurred some weeks afterwards at the care home on 31 January 2018.

Although the care home described Mr Z's violent behaviour as unpredictable, evidence from the review indicates these incidents could have been better understood and more effectively responded to. The home explained that they did not commonly look after residents demonstrating violent behaviour, and the staff team agreed that Mr Z's needs exceeded their capacity throughout much of the admission.

Mr G was an elderly man with dementia and a range of other health conditions. In June 2017 Mr G was admitted to an acute Norfolk hospital following an incident in a previous care home which led to him falling and sustaining an injury (not a fracture). While in hospital his behaviour became more challenging, leading to his detention under the Mental Health Act 1983. Mr G was admitted to a psychiatric hospital outside of Norfolk as there was not a bed available at the time in Norfolk.

Shortly after arriving at the psychiatric hospital Mr G was admitted to the local acute hospital with a suspected infection and dehydration. After treatment there was a rapid improvement in the behavioural elements of his presentation. Overall, despite it being an out of area placement, Mr G appears to have had a relatively positive experience of care. In mid-August 2017 Mr G was transferred back to a Norfolk psychiatric hospital and his experience of this hospital also appeared broadly positive. Hospital staff seemed to understand well Mr G's care needs and demonstrated an ability to develop and implement an appropriate plan for managing his physical health and behaviour.

In the second week of November 2017 Mr G was discharged from the psychiatric hospital to the care home. This arrangement was made under a local 'Discharge to Assess' (DTA) pathway which provides 28 days of funding to assess clients in a less restrictive environment. However, this DTA pathway does not apply to patients detained or admitted to any mental health hospital. Mr G's bed was held open first for 7 days, which then increased to 14. This would have allowed him to return at any point if necessary. The care home, believing that Mr G was discharged under the DTA process, reported that they were not aware Mr G could return to the psychiatric hospital (although several occasions where such information was conveyed to the care home are noted).

The care home had significant difficulties in effectively managing Mr G and providing him with adequate care. Personal care was often refused by Mr G, or delivered under challenging conditions. The local Dementia Intensive Support Team (DIST), who remained in contact with Mr G, noted concerns about the care home's ability to safely manage Mr G, but this was not flagged as a safeguarding referral. Despite their concerns, DIST proposed to discharge Mr G to the care of his GP, based on an apparent improvement in his presentation. The relationship between Mr G's

family and the care home broke down over the next 3 days regarding Mr G's care. There was significant concern for Mr G's physical health and a paramedic was called who arranged for Mr G to be admitted back to hospital.

The ambulance crew who admitted Mr G to hospital were so concerned about Mr G's physical state that they made a safeguarding referral, querying the possibility that Mr G had experienced abuse and neglect. The care home has disputed the concerns documented by the ambulance service, stating that these concerns were simply those relayed by the family.

Mr G sadly died in hospital 3 days later on 22 November 2017.

Summary of learning

The Review highlights concerns resulting from broad issues in inter-agency working and communication between professionals and organisations

The review also raises concerns about the process by which care needs were assessed in a hospital environment, including an over focus on the person's presentation on the day in question.

- The review noted that practitioners might have demonstrated more professional curiosity in triangulating information and requesting contextual information from the care home, but equally the care home could have provided more detailed information about the context and wider picture, and a clearer and more consistent narrative about their inability to safely manage Mr Z.
- Challenging behaviour should be understood primarily through a behavioural/functional/ psychological approach. This should include consideration of recommendations which have de-emphasised the role of using psychotropic medication as a first-line approach to the management of challenging behaviour. This will mean that services will need to be supported in the development and use of data, which is meaningfully recorded, but also the development of tailored, comprehensive management plans which are rigorously followed within the care team. It also requires appropriate training of staff in wider skills such as de-escalation, as well as relevant additional specialist workplace resource to support this process. the way in which challenging behaviour is assessed and managed
- There were some practice issues in the recording of safeguarding reports, which were sometimes only recorded against the victim. This meant that if there was one perpetrator with multiple victims, this safeguarding issue would not be immediately obvious to the safeguarding practitioner.
- The Review highlights widespread gaps in practice in applying principles of the Mental Capacity Act including a broad concern that a number of decisions with regards to Mr G's care do not appear to be made with any formalised assessment of Mr G's best interests. This includes very serious decisions, including concerning Mr G's residence. Most prominently, it is noted that there did not appear to be any formal consideration of Mr G's best interests in either the transfer of care between hospitals or in the transfer of care from hospital to the Care Home. Mr G did not have a Lasting Power of Attorney and the report states that there is little question that he would have lacked capacity to make decisions about his residence at both of these times. Therefore, these decisions could only have been made for and on his behalf in his best interests, but they do not appear to have been.

Adapted from the Ms F and Mr G Safeguarding Adults Review published by the Norfolk Safeguarding Adults Board

Further information

Read the Review

Somerset Safeguarding Children 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

Given the rapidly changing position with Coronavirus we tried to focus on other news in this section. For up-to-date information and guidance on Coronavirus please see Coronavirus updates for Somerset Adult Care Providers and the Coronavirus section on our website.

June 2020

- CQC: Our work on closed cultures
- Community Care: Government tells sector 'not to prioritise' Liberty Protection Safeguards preparations
- Office of the Public Guardian: Lasting power of attorney your voice, your decision
- 39 Essex Chambers June Mental Capacity Report
- Mental Capacity Law and Policy: Advance decisions to refuse treatment – getting it right
- Community Care: Capacity, consent and sexual relations: how latest case may help social workers navigate challenges

May 2020

- The Learning Disabilities Mortality Review (LeDeR) programme publishes its May bulletin
- Citizens Advice: Get emotional support if you've been scammed
- ActionFraud: Shopping online safely
- Community Care: Online safeguarding: the risks of hard and fast rules that restrict disabled people's digital use
- Mental Capacity Law and Policy: Deprivation of liberty – getting it right shedinar
- Mental Capacity Law and Policy: Advance care planning – in conversation with Dr Mark Taubert

April 2020

- Somerset Safeguarding Children Partnership: Safeguarding children at risk of neglect toolkit
- ActionFraud: Criminals preying on our financial worries as they spoof government websites to take your money
- The Learning Disabilities Mortality Review (LeDeR) programme publishes its April bulletin
- The Guardian: Gangs still forcing children into 'county lines' drug trafficking
- Mental Capacity Law and Policy: DNACPR and Advance Care Planning – getting it right

March 2020

- The Law Society: Close to home: spotting elder abuse

- LGA: Adult Safeguarding and Homelessness: a briefing on positive practice
- CQC publishes independent review into its regulation of Whorlton Hall between 2015 and 2019
- Barnardo's: 6 things you should know about child sexual abuse
- 39 Essex Chambers March Mental Capacity Reports
- ARC England and FPLD publishes an assessment tool and action plan for organisations
- to improve the quality of life for people with learning disabilities as they grow older
- Disclosure and Barring Service launches a video explaining the process for a standard and enhanced DBS check
- Mental Capacity Law and Policy: New guidelines on Prolonged Disorders of Consciousness
- Child Safeguarding Practice Review Panel: Safeguarding children at risk from criminal exploitation
- NHS England: Easy read information: Sepsis
- bild: About my friend for friends of people with Down's syndrome and dementia

February 2020

- Community Care: Safeguarding adults who refuse support: how antisocial behaviour legislation may help
- Somerset Intelligence network publishes the February edition of its SINePost newsletter
- CQC: Monitoring the Mental Health Act in 2018/19
- Teeswide SAB: Incidents between Residents
- CQC publishes a review of sexual safety and the support of people's sexuality in adult social care
- ActionFraud: Cyber criminals send victims their own passwords in new sextortion scam
- BBC News: 'I didn't know it was abuse until I nearly died'
- Mental Capacity Law and Policy: Refusing food, (in)capacity and coming to court
- Police call on public to sign up to free counter terrorism training

January 2020

- ACPPLD: Standards of Practice for Physiotherapists Working with adults with a learning disability
- BBC News: Domestic violence prevention work 'should focus on offenders'
- Mental Capacity Law and Policy: Serious Medical Treatment – Practice Guidance
- Blog from Miles Sibley, Director for the Patient Experience Library: Changing the culture of learning from deaths
- Heathwatch England: Shifting the mindset: a closer look at NHS complaints
- BBC News: One in five adults experienced abuse as children - report
- Independent: Care home company fined £50,000 after elderly woman suffers serious burns

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 but has published a Somerset Adult Safeguarding Learning Framework.

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

- FutureLearn Safeguarding Adults Level 3 Training
- Friends Against Scams Practitioner E-Learning
- 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