Issue 4, Mar 2017

Newsletter

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

Welcome to the 4th edition of the Somerset Safeguarding Adults Board (SSAB) newsletter

The financial year is almost at an end, and we're now busy finalising plans and setting out our ambitions for the new period ahead. We were delighted to learn from a recent evaluation report that our 'Thinking it? Report it' publicity campaign activity has reached ***over 2.9 million people*** across the various communication channels used to date, thanks largely to the strong network of connections the Board now has, and the support and cooperation of the stakeholders involved. To find out more about the campaign, or download leaflets/posters, please visit: http://ssab.safeguardingsomerset.org.uk/protecting-adults/thinking-it-report-it-campaign/

This is the 4th 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. To the 85 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 the local safeguarding community. We welcome suggestions for improvement, requests for future content or any contributions you'd like to make.

Contents

Chairman's blog

Safeguarding & quality of life: a question of culture

"What's the point of making someone safe if in doing so you just make them miserable?"

Mr Justice Munby's famous 2007 judgement in the case of MM and Local Authority X is well beloved of safeguarding commentators. Or rather, they quote just this one sentence of his 168-paragraph judgement.

This lack of context leaves me uneasy. This was a complex case involving the welfare of a young woman with a troubled history and a mix of mental illness and learning disability wishing to maintain a relationship with a man who has been physically abusive, manipulative and exploitative.

The full judgement considered a range of issues concerning the woman's capacity in areas such as who she would have contact with, where and with whom she could live, whether she could marry, have children and consent to sex.

Ultimately, it clarifies the responsibilities of the local authority to take suitable action to protect the woman's rights to a private life under Article 8 of the European Convention on Human Rights, in circumstances where other rights are being restricted in the interests of safeguarding her.

The judgement raised profound questions of human rights and public policy, and how to balance safety against wider aspects of personal welfare.

So I think that it is important to see the sentence within the context of the whole judgement or at least the whole paragraph, which reads: "A great judge once said, "all life is an experiment," adding that "every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge" (see Holmes J in Abrams v United States (1919) 250 US 616 at pages 624, 630).

The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare.

The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness.

What good is it making someone safer if it merely makes them miserable?"

So maybe the answer to Munby's rhetorical question is to say: if someone lacks the mental capacity to make a decision, then for their greater good and safety, it may be justifiable to prevent them from doing something, even if in doing so you make them less happy.

But when you do this your decision needs to be balanced against a range of other considerations to do with their welfare, and you must always be aware of their wishes, whether or not they have capacity.

Good safeguarding decisions can be complex. They raise profound questions concerning individual rights, the capacity to make decisions, make mistakes and take risks, and the moral and legal duty of an organisation – or the state through its institutions – to protect the vulnerable from harm.

That is a pretty heavy responsibility, and to help people make the right decisions the workforce needs good policy that gives proper guidance, appropriate training – particularly in the area of mental capacity, good management, and a culture that builds openness and transparency. Mistakes should be seen as opportunities to learn and improve. The rights of the people we support must be respected, and their wishes should always be at the forefront of our thinking.

Intervention to safeguard and protect should be proportionate to the risk presented and sensitive to the need, where appropriate, for people to make their own decisions, even when that involves some risk. That culture must also ensure involvement and empowerment, and must stress the importance of finding out the wishes of those who lack capacity.

This is crucial because in this uncertain and risky world of safeguarding there is one thing that we can be sure about: without the right culture, good safeguarding can never happen.

Source: [Learning Disability Today, January 2017]

SSAB Meeting, March 2017

On our agenda this month:

- An introduction to the work of Devon & Somerset Trading Standards from a new Board member, and opportunities for greater joint working in the year ahead
- An update on progress in establishing a local, multi-agency Mental Capacity Act Forum in Somerset
- A report on Deprivation of Liberty Safeguards (DoLS) locally and review
- A review of latest developments with the Mental Health Crisis Concordat Plan
- A proposal to make use of district-based Social Exclusion Panels to assist in supporting the management of complex self-neglect cases, particularly where hoarding exists
- A closer look at the Board's refreshed Business Plan for the new financial year ahead, and an ongoing commitment to concentrate on Prevention, Making Safeguarding Personal, Think Family, and Board effectiveness as our overarching priorities.
- Updates from the Board's subgroups.
- Organisational updates and developments from member agencies.

Safeguarding Adults Collection (SAC) 2015/16

On 5th October 2016, the national Safeguarding Adults Annual Report was published for the period 1st April 2015 – 31st March 2016 using experimental statistics from the Safeguarding Adults Collection. The report presents information about adults at risk for whom safeguarding concerns or enquiries were opened during the reporting period.

How does Somerset compare to the national picture?

- Nationally, 60% of individuals with Section 42 enquiries were female, and 63% of individuals at risk were aged 65 or over. *This is similar to the Somerset picture, where 60% of enquiries related to women and 61% involved people aged 65 plus.*
- Nationally, for enquiries that concluded during the year, the most common type of risk was neglect and acts of omission (34%), followed by physical abuse (26%). *In Somerset, physical abuse was the most commonly identified risk type (27%), followed by psychological abuse (24%), and then neglect and acts of omission (22%).*
- Nationally, the location of risk in concluded enquiries was most frequently the home of the adult at risk (43%) or in a care home (36%). *This is true also of our local area; however, in Somerset the person's own home accounted for 54% of locations of risk, 32% in care homes.*
- Nationally, people known to the individual but not in a social care professional capacity were the most commonly identified source of risk, accounting for 51% of concluded enquiries. *In Somerset, this figure is significantly higher, at 87%, demonstrating the ongoing importance of raising awareness of recognising and responding to safeguarding concerns across the general public.*
- Nationally, 60% of individuals with Section 42 enquiries were female, and 63% of individuals at risk were aged 65 or over. *This is similar to the Somerset picture, where 60% of enquiries related to women and 61% involved people aged 65 plus.*
- Nationally, the risk was removed / reduced in 67% of cases where safeguarding action was taken. *In Somerset, the risk was removed / reduced in 83% of cases.*

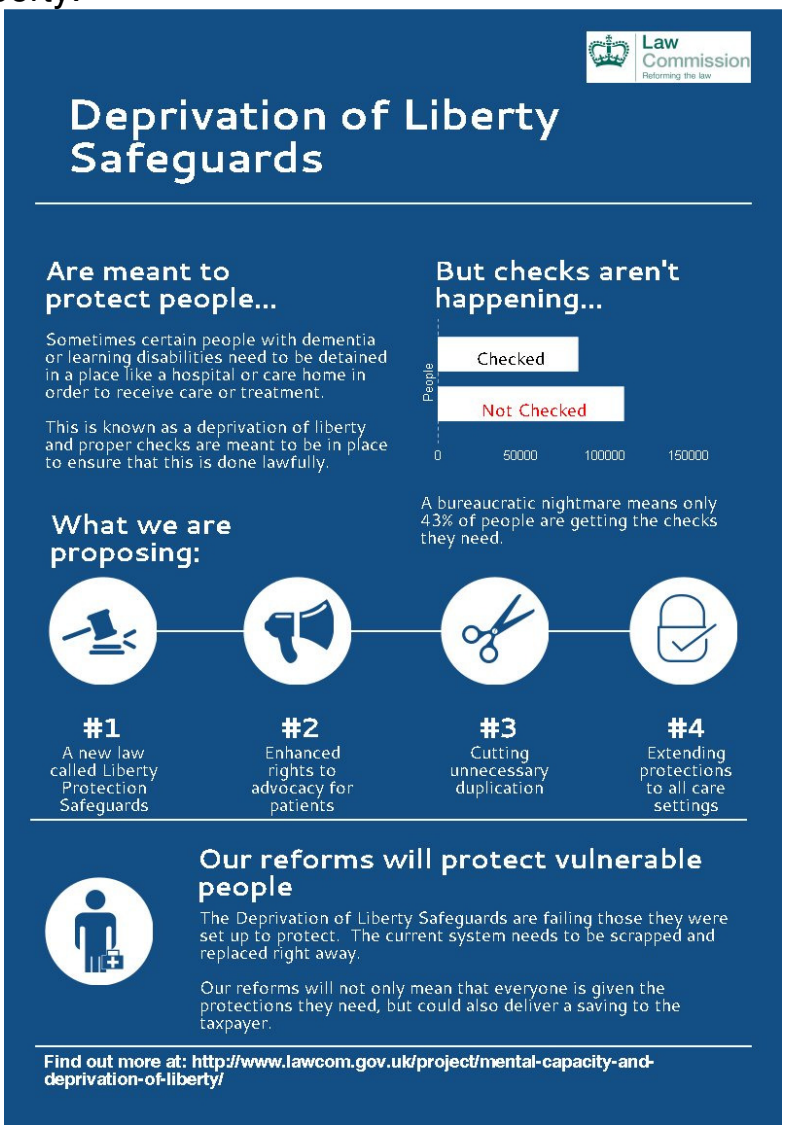
Planning for WEAAD 2017

The SSAB is busy preparing for World Elder Abuse Awareness Day (Thursday 15 June 2017), and for our 'Stop Abuse' week commencing 12th June. This year we will be concentrating our efforts on helping people to stay safe at home. Further information will follow in our next edition. In the meantime, you can find out more via:
http://elderabuse.org.uk/world-elder-abuse-awareness-day/

Law Commission reveals DoLS replacement

On Monday 13 March 2017 the Law Commission delivered its final recommendations to ministers on replacing the Deprivation of Liberty Safeguards (DoLS). The commission has now published its final report and draft legislation for a new system to authorise care placements involving deprivation of liberty for people lacking capacity, which can be read here:
http://www.lawcom.gov.uk/wp-content/uploads/2017/03/lc372_mental_capacity.pdf

The final report and draft Bill recommends that the DoLS be repealed with pressing urgency and sets out a replacement scheme for the DoLS, called the Liberty Protection Safeguards (LPS). In addition, the draft Bill makes wider reforms to the Mental Capacity Act which ensures greater safeguards for persons before they are deprived of their liberty.



Think Family

The 'Think Family' agenda recognises and promotes the importance of a whole-family approach, and aims to:

- Improve coordination between adult and children's services
- Ensure services working with both adults and children take into account family circumstances and responsibilities;
- Provide support that is tailored to need;
- Build on family strengths, in order to promote resilience and help people to build their own capabilities.

The SSAB is committed to support this area of work as one of its core priorities over the coming year. One way we are achieving this is by strengthening our links with the Somerset Safeguarding Children Board (SSCB). Over the last year, we have combined our efforts to deliver a series of 'Think Family' practitioner events, which have explored issues around effective transition across children's and adult services, and on leaving care. The SSAB will also be contributing to the Children Board's Child Sexual Exploitation (CSE) subgroup with a view to better supporting adult victims of CSE, and those who may continue to be abused by perpetrators once they become an adult. You can read Somerset's Quick Guide to CSE here.

Working together to Safeguard Children

Safeguarding and promoting the welfare of children is defined in 'Working Together to Safeguard Children (2015)' as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

Professionals or agencies working with adults have a key role in identifying children and young people who need safeguarding, and adopting a 'think family' approach to their practice. If a professional or agency working with adults becomes aware that a child is or may be at risk of harm, they have a duty to safeguard and promote the welfare of the children.

Everyone must be aware that in situations where there is concern that an adult at risk is or may be at risk of abuse and neglect ***and*** there are children in the same household, they too could be at risk.

Reference should be made to the Somerset Safeguarding Children Board Procedures Manual if there are concerns about abuse or neglect of children and young people under the age of 18.

Adult services and services working with children should work jointly to safeguard the adult at risk and/or children and young people.

If there are concerns regarding the safety or welfare of children in the household, or you are worried about a child or young person who could be in danger, please contact:

- Children's Social Care on 0300 123 2224
- Email: childrens@somerset.gov.uk
- Or the Police by dialling 101 or, in an emergency, call 999.

The Interagency Referral Form can also be used to share information with your local office. More information on how to make a referral can be found here.

Pre-birth Protocol to Safeguard Unborn Babies

Research evidences that young babies are particularly vulnerable to abuse but that robust early assessments, interventions and support carried out in the antenatal period can help to minimise harm if there is effective care. When agencies are able to anticipate safeguarding risks and vulnerabilities to an unborn baby, such concerns should be addressed through a pre-birth assessment. The aim of this assessment is to ensure that:

- The risks and vulnerabilities are identified as early as possible,
- Appropriate and timely actions are taken to protect the baby (and any other existing siblings),
- Parents are robustly supported in caring for the baby safely.

The success of pre-birth work lies in the quality of multi-agency involvement and partnership working, corroboration of risk and protective factor information, together with meaningful engagement and involvement with families. This is always true of safeguarding practice in general, but is particularly relevant in relation to pre-birth practice. The family GP, Midwife, and Health Visitor all have critical roles to play in relation to vulnerable expectant mothers, alongside other statutory agencies and organisations working with adult family members.

You can access the pre-birth procedure via the following link:
http://www.proceduresonline.com/swcpp/somerset/p_prebirth_sg_unborn.html

Somerset Safeguarding Children Board

Website	www.sscb.safeguardingsomerset.org.uk
Twitter	https://twitter.com/SomersetSCB
SSCB Newsletter	February 2017 SSCB Newsletter
Learning Bulletin	February 2017 Things You Should Know

Spotlight on: Care Act Advocacy

If you receive or need care and support services, you have rights under the Care Act 2014.

If you have difficulty with being involved in your care and support, you may be entitled to a Care Act advocate.

Care Act Advocacy is free, confidential and independent of all other services.

Who can get a Care Act Advocate?

- An adult who receives care and support, or is likely to need care and support services
- A carer of an adult who receives care and support services
- Anyone having substantial difficulty in being involved in their care or support planning.

What does substantial difficulty mean?

'Substantial difficulty' means that you might:

- Find it hard to understand the information about your care or support
- Find it hard to make decisions about your care and support
- Find it hard to tell people what you want
- You are not able to 'weigh up' the benefits and burdens of a decision
  and
- You don't have any family or friends who are able to support you.

What can an Advocate help you with?

- A Needs assessment
- A Carer's assessment
- Preparation of care, or care and support plans
- A review of care, or care and support plan
- A safeguarding enquiry
- A safeguarding review
- Making an appeal against a decision made by the Local Authority.

What will the Advocate be able to do?

- Meet and talk with you in private
- Help you to understand the care and support assessment or review process
- Help you communicate your views and wishes
- Assist you to make your own decisions and/or help you challenge decisions made by the local authority

- Explain what your rights are and how you can exercise them
- Support you through an adult safeguarding process
- Talk to others who might be able to help on your behalf
- You have a right to decide not to have an advocate at any time
- An advocate will always ask your consent before doing anything on your behalf.

swanadvocacy
changing lives

For more information:

Call 0333 3447 928 Monday to Friday during office hours

Email somerset@swanadvocacy.org.uk

Visit www.swanadvocacy.org.uk or www.somerset-ias.org.uk

Swan Advocacy
Hi Point
Thomas Street
Taunton, Somerset
TA2 6HB

Signposting

Adult Social Care Community Connect Drop-ins

Local Community Connect drop-ins have been taking place across West Somerset to make it easier for people to have a conversation and get quick and useful advice.

The innovative pilot has also seen adult social care services working closely with community agents, local care and support providers and community groups to share information and identify opportunities to improve services in the local area for people.

This way of working promotes independence and encourages people to fulfil their potential and live the life they want to live. Some people's needs can be best met by community support. Regular socialising, physical activity or a small home adaptation can make a big difference to keep someone healthy and well – without the need for traditional social care support.

To see all Community Connect drop-in dates and venues, visit: https://www.somersetchoices.org.uk/adult/information-and-advice/information-about-social-care/drop-in-for-advice/

Drop-in service for male victims of domestic abuse opens in Taunton

Who is it for?
The drop-in service is available to all adult (18+) male victims / survivors of domestic abuse.

How can it help?
Staff will support you, listen to you, and provide impartial information on a one-to-one basis. Independent Domestic Violence Advisers can discuss options with you to help you stay safe.

How do I use this service?
You don't need to be referred to use the service – simply drop-in to its weekly session.

To find out more, visit:
http://www.mankind.org.uk/somersetdropin/

You can also call the confidential helpline, open weekdays 10am-4pm 01823 334244

Always call 999 if you are in immediate danger

Domestic Abuse Awareness

Referring to Somerset Integrated Domestic Abuse Service (SIDAS)

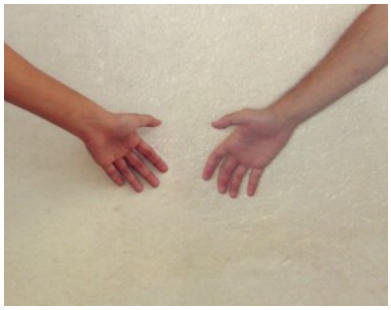
www.somersetsurvivors.org.uk

Freephone support line: 0800 69 49 999
Quick guides for professionals available on website

If someone discloses they are a victim of domestic abuse:

- **Assess their risk using the DASH Checklist available on this website**
- **Refer to SIDAS**
- **Consider using the Multi-Agency Risk Assessment Conference (MARAC)**

Somerset Suicide Bereavement Support Service



- Available to anyone bereaved by suicide in Somerset
- Helpline open 24 hours a day
  0300 330 5463
  bereaved@mindtws.org.uk
- Monthly Suicide Bereavement peer support group

http://mindtws.org.uk/somerset-suicide-bereavement-support/

Somerset's 'Prevent' Webpage now live: Somerset County Council's website now offers information on what is known as the'Prevent Duty' - supporting community safety by addressing the safeguarding concerns of those vulnerable to radicalisation and extremism.

The Prevent Duty requires local agencies in Somerset to recognise the potential for individuals to be drawn into radicalisation by taking and planning steps to prevent it. These steps include ensuring relevant staff are trained to identify the signs of radicalisation, and be able to raise awareness of how potential radicalisation cases can be referred, and making sure there is a multi-agency plan for the safety of vulnerable individuals.

The Prevent webpage – www.somerset.gov.uk/prevent – is a useful source of information and training for local practitioners and partner agencies, including details on who to contact for help and support, and more detailed information about Channel.

Home Fire Safety Checks The Devon and Somerset Fire & Rescue Service offer free home fire safety checks / visits and are particularly keen to support those who may be concerned about their safety or who are subject to threatening or abusive behaviour. Research highlights that fire death risk links very closely to vulnerability and specific lifestyle or behavioural factors, such as living alone, substance misuse, mental ill health or limited mobility. The SSAB has explored a number of cases where self-neglect and hoarding has been a key feature – home safety checks / visits are a useful option to keep in mind in such scenarios.

To book a home fire safety visit contact 0800 05 02 999 (Freephone) or visit this webpage

Learning Lessons

National

Learning from Safeguarding Adults Reviews

RiPfA and SCIE have recently announced a new piece of work commissioned by the Department of Health aimed at improving the quality and use of Safeguarding Adults Reviews (SARs). The initial phase of work will run from March 2017 to March 2018 to draw together and develop an online library of open access resources on the SCIE website containing reviews, reports, guidance and tools to support practitioners working in safeguarding. National safeguarding networks will be involved to ensure that stakeholder views and knowledge are represented in the development of the resources. The space will provide open access to SAR reports alongside a search function to support easy navigation. There will be analysis of the reports to identify trends and emerging issues, and translation of this analysis into user-friendly materials containing key messages for practice.

Learning from Significant Case Reviews in Scotland

In August 2016, the Scottish Care Inspectorate published a retrospective review of (children's) serious case reviews for the period covering 2012-15.

Of particular interest to those working within adult services, the report:

- Highlighted particular difficulties when parents presented as being articulate and assertive in their communications with professionals – *"staff in adult services tended to expect that parents who they believed were being open about their difficulties would be equally candid with colleagues responsible for children".*

- Raised the need for all staff working with adults who are parents to consider the child's circumstances and proactively share information across services so that any potential risks can be fully appreciated and analysed by all the involved staff

- A lack of understanding of the importance of violence between adults in a household as a child protection risk factor, and consequent failure to share information about it

- The importance of recognising the impact of childhood loss and trauma on adults' capacity to make strong attachment relationships and parent safely

- Highlights the risks presented by transition to adult services

- Comments on some practitioners working with adults in the field of mental health not sufficiently considering the potential impact of the individual's difficulties on their role as a parent.

'Damien' Practice Briefing Note published, March 2017

Damien had diagnoses of Asperger's Syndrome and ADHD. He had a mild learning disability and misused a variety of substances causing him to come into frequent contact with the police and mental health services. His vulnerability was exploited by others who stole from him and misused his home for their own purposes. Meeting the dual requirements of protecting both the public and Damien from harm, at the same time as treating him as capacitous and allowing him to live his own life with only the necessary oversight and control, tested services in Somerset. In the last fifteen months of his life, he was detained under Section 2 of the Mental Health Act on three occasions. He was also made subject to MAPPA arrangements. Damien died in hospital in July 2015 following an incident of self-strangulation in the residential unit that had been his home for two weeks following discharge. A **Practice Briefing Sheet** has been produced by the SSAB with support from Damien's family. ***We actively encourage all staff to make use of this briefing in team meetings, supervisions or training sessions, and use the feedback form to tell us how it will develop your practice.***

Service Monitoring Checklist tool published and promoted

In December 2016, the SSAB published a service monitoring guidance document (see overleaf) to support provider safeguarding enquiries and enhance the effectiveness of review processes. The prompt sheet resulted from the wider learning to emerge from the Mendip House Safeguarding Enquiry that concluded in November last year, and captures risk indicator examples that practitioners should be mindful of when undertaking assessments or reviews of both service quality/provision or safeguarding enquiries within settings.

This month, the Somerset Safeguarding Adults Board confirmed the appointment of Dr Margaret Flynn to undertake an independent Safeguarding Adults Review (SAR) following the local multi-agency Whole Service safeguarding enquiry process into Mendip House. Mendip House was a care home in the grounds of Somerset Court, Brent Knoll, run by the National Autistic Society (NAS) and catering for six autistic residents. The care home was rated as inadequate by the Care Quality Commission (CQC) following a series of inspections in May and June last year. Inspectors found there were a number of allegations of abuse, neglect and degrading treatment of people with one staff member coming directly to the inspectors as they had no confidence the provider would take their concerns seriously. Dr Flynn has a wealth of knowledge of adult safeguarding and undertook the review into the physical and psychological abuse suffered by people with learning disabilities and challenging behaviour at Winterbourne View Hospital in South Gloucestershire. The SAR will build on the extensive review activity from 2016 and draw together the critical learning that resulted from the enquiry process, considering what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm.

Service Monitoring: Potential indicators of concern: the following areas of care may highlight that care is neglectful and could be harmful to residents

LEADERSHIP & MANAGEMENT	STAFF BEHAVIOUR & ATTITUDES	BEHAVIOURS & INTERACTIONS OF RESIDENTS
• The manager doesn't provide appropriate leadership or direct staff to do their job properly • The manager is often unavailable • There are insufficient staff to meet the needs of residents • There are high levels of staff turnover • There is a high reliance on agency staff • The service accepts residents whose needs they cannot meet • The manager does not inform commissioners when they are unable to meet the needs of specific residents • Policies and procedures are not readily available, accessible or do not appear to be being followed • Problems are not proactively recognised or responded to by the management of the service • Safeguarding alerts in relation to the service are unusually high/ low • Complaints in relation to the service are unusually high/low • Internal incident reporting (e.g. hospital admissions, pressure areas, instances of choking) is unusually high/ low • External incident reporting/communication not completed appropriately – e.g. CQC, Police, Commissioners • Provider fails to audit/review the service quality	• Staff appear to lack knowledge of the individual needs of the people they are supporting (e.g. specific behaviours, individual interests or communication needs) • Members of staff use judgemental language about the people they support • Members of staff are controlling and there is little or no choice available • Communication across the staff team is poor, either written or verbal • Risks arising from abusive behaviour between residents is not recognise, adequately addressed or managed • Staff fail to treat service users with dignity or respect • There is a lack of documentation to demonstrate that Best Interests decisions are being made and adequately documented • Staff are not working to the principles of The Mental Capacity Act	• Residents' behaviours change without rationale or explanation about how this has been achieved • Residents' skills change – for example they become less independent, self-care or continence management deteriorates. • Residents appear distressed in the presence of certain members of staff or other residents • Residents behave differently in different environments (e.g. Day Centre) • Residents who appear distressed are either ignored or experience unacceptable delays in having their emotional support needs met • Residents who require it are not supported to eat their meals / drinks • Residents may appear hungry or thirsty and show signs of dehydration • Residents express a desire to move to a new placement
ISOLATION & LACK OF OPENNESS	**SERVICE DESIGN, DELIVERY & MAKE UP**	**ENVIRONMENT & BASICS OF CARE**
• There is little input from outsiders/professionals • Individuals have little contact with family or people who are not staff • Appointments are repeatedly cancelled • Members of staff do not maintain links between individuals and people outside the service • There is little contact with outside professional mainstream services • Appropriate referrals are not made (e.g. Speech & Language Therapy; GP; Dietician; CPN) • Management and/or staff demonstrate hostile or negative attitudes to visitors, questions or criticisms • It is difficult to meet residents privately • It is difficult to see the resident's bedroom • Family contact is supervised • The service is defensive and does not respond effectively to complaints • People who complaint experience reprisal or are unwilling to complain because they fear reprisal for their loved one	• Residents' needs are not being met as agreed and identified in care plans • Care plans are of poor quality and do not represent an accurate record of the care needs of the individual • Care plans and risk assessments are not reviewed / updated to reflect increased needs or changed risks • Agreed staffing levels are not being provided • Staff do not carry out actions recommended by professionals • The service is 'unsuitable' but no better option is available • The resident group appears to be incompatible • The diversity of support needs of the group is very great. This may lead to physical assaults on residents which should be reported to appropriate agencies and families • Safeguarding policies and procedures are not present or applied • Limited or no evidence of The Mental Capacity Act being applied	• Residents' rooms are not personalised • There is a lack of care of personal possessions • Personal possessions are lost or stolen • Support for residents to maintain personal hygiene is poor • Residents appear unkempt • There are insufficient bathroom facilities to meet the personal care needs of residents • Essential records are not kept effectively • The environment is dirty/smelly or of a poor quality with potential hazards (e.g. trip hazards) • There are few activities or things to do • Residents' dignity and privacy is not being promoted or supported • Residents are dressed in the wrong clothes • Resident independence and skills are not promoted. • Medication is not properly provided or recorded

National News and headlines

February 2017

- **Early deaths among care leavers revealed** Young people who have grown up in care are far more likely to die in early adulthood than other young people, Freedom of Information figures reveal – ***see also*** *Somerset's learning review into the deaths of vulnerable young adults*
- **Social workers issued guidance on coercive control** The Department of Health has funded a set of tools to help practitioners respond to the issue which experts say underpins domestic abuse and can be a heightened risk among people with care and support needs
- **Supporting adults with learning disabilities to have positive sexual relationships** RIPFA briefing focused on how practitioners can support people to have positive relationships and minimise the risk of exploitation
- **Hate crimes rise by up to 100% across England and Wales, figures reveal** Police are planning to increase protection for vulnerable groups
- **Care worker imprisoned after death of a service user** Case highlights the importance of maintaining focus when caring for vulnerable people
- **Three face slavery charges after nuclear bunker cannabis find** Three men appear in court on slavery charges following discovery of a cannabis factory in a former nuclear bunker

January 2017

- **Council to pay out £4,000 after woman left 'severely malnourished' in care home** Ombudsman tells councils they 'cannot contract out responsibility' for care commissioned from third party providers after investigation

December 2016

- **Learning, candour and accountability – How NHS Trusts review and investigate the deaths of patients in England** CQC report focused on the actions taken by NHS trusts when a patient dies in hospital which considers how they investigate and learn from the deaths of patients under their care. The report makes several recommendations for change which have been accepted by the Government and will come into force on 31 March 2017

November 2016

- **New guidelines issued on questioning of vulnerable witnesses in court** Guidelines say children and people with learning difficulties should not be subject to unnecessarily harsh questioning
- **Carers UK publishes guide outlining carers' rights** The guide also provides an overview of the practical and financial support available
- **CQC publishes information for people on their visiting rights in care homes** and expectations of providers responsible for ensuring people are supported to maintain relationships that are important to them

October 2016

- **CQC warns fragile adult social care at a 'tipping point'** The social care sector is increasingly unstable putting further pressure on the health service, the CQC has said in its annual State of Care report
- **More safeguarding investigations leading to reduced risks** Latest NHS Digital figures on adult safeguarding shows the risks were reduced in 47% of cases, up from 40% in 2014-15

September 2016

- **Deprivation of Liberty Safeguards (England) Annual Report 2015-16** published 28 September. Councils reported receiving nearly 200,000 DoLS applications during the year; the most since the DoLS introduction in 2009. Official statistics found variation between regions.
- **Councils will 'struggle to meet basic statutory duties over next five years:** Report by the Kings Fund and the Nuffield Trust warns government measures not sufficient to close gap between needs and resources
- **Scamming and its effect on vulnerable individuals:** House of Commons Briefing Paper for backbench business debate on 8 September.

- **Slavery reports rise fivefold, Salvation Army says:** The Salvation Army says it has seen a fivefold increase in the number of slavery victims it has helped in England and Wales since 2012.
- **Women's mental health needs 'not considered adequately':** This is despite the rising rate of female suicide, campaigners have warned. "Women facing poor mental health are among the most vulnerable people. The majority have experienced violence and abuse and many report needing women-specific spaces to feel safe".

August 2016

- **NICE guidance published on Transition between inpatient mental health settings and community or care settings:** aiming to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way its planned and carried out.
- **Mendip House, Somerset, rated as Inadequate:** The Care Quality Commission rated Mendip House, Highbridge, as inadequate following a series of inspections in May and June 2016. Inspectors found people living in the service had not been kept safe.

July 2016

- **Keep on caring: supporting young people from care to independence:** Cross-government strategy to transform support for young people leaving care: looking at how to improve services, support and advice for care leavers and making recommendations for local and national government, and wider sectors of society.

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

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

Other resources

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/

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, Niki Shaw, on:
01823 357014

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

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

Or complete the new 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