Issue 6, Oct 2017

Newsletter

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

Welcome to the 6th edition of the Somerset Safeguarding Adults Board (SSAB) newsletter

As we head towards the end of the calendar year, we are now busy finalising plans and setting out our ambitions for the new period ahead, which will include a review and refresh of our strategic plan. We are also busy planning for our annual conference which will take place on **Friday 9th March 2018 in Taunton**. If you are a safeguarding lead within a local organisation, please save the date as we are putting together what we feel will be a really interesting and engaging programme for the day. Further detail will follow.

This issue contains the findings from a local Serious Case Review recently published into child sexual exploitation, which has some significant learning for services supporting vulnerable adults who may also be at risk of becoming victims of this type of criminal activity.

Our annual report was published in September, and formally presented to the County Council's Scrutiny Committee the same month. The report outlines the work of the Board during the the 2016/17 financial year. The report is available on the SSAB website for all partners, interested stakeholders and members of the public to access.

This is the 6th 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 all 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 the local safeguarding community. We always welcome suggestions for improvement, requests for future content or any contributions you'd like to make.

In this issue:

Chairman's blog: Listening to families is a human right

Article 8 of the European Convention on Human Rights provides the right to respect for one's established family life. This includes close family ties, although there is no pre-determined model of a family or family life.

It includes any stable relationship, be it married, engaged, or de facto; between parents and children; siblings; grandparents and grandchildren.

I am the independent chair of two adult safeguarding boards, Somerset and Wiltshire, and the parent of a young woman with Down's Syndrome.

Anyone who has been the parent or carer of a person with a learning disability will have a horror story to tell.

Not being believed, not being listened to, being ignored, being patronised. For many, a constant battle from the word go, as you negotiate the world of health, education and social care. At best you might be lucky enough to find one or two exceptional people who help you through a faceless, impersonal system.

A system where, at times, you can't help but feel that families are seen as a bit of a nuisance, getting in the way of the "professionals" who know what is best for your child.

If, as a young person or adult, your child moves into other settings of care and support, it can feel even more difficult to be heard.

It can feel that years of experience and deep understanding are viewed as being valueless.

For some it would appear, families are pushy, difficult, overprotective, unreasonable, or even at times I'm afraid, toxic.

As the independent chair of two adult safeguarding boards I look at all of this through a slightly different lens.

I have found myself working alongside people who certainly don't fit that stereotype. People who understand the importance of family.

But in truth, I have also seen family members kept at arm's length, their knowledge and expertise largely ignored, whilst their loved one spirals into ever greater risk with tragic consequences.

I have also seen the real discomfort, often deserved, of professionals, as the stark reality of the family experience is played back to them.

In fairness, I have seen a significant effort to change – to be more open to dialogue with families when it is most needed, not just after the event. It's difficult, and requires an effort and investment in relationship building. But, for those with safeguarding responsibilities, listening to those voices just might be the thing which prevents a tragedy.

For the people we support and their families, it is a human right.

News from the SSAB

Autumn 2017

The next meeting of the SSAB is not until 7th December but our sub-groups have been busy meeting to progress the work of the Board. Highlights include:

- Finalising the SSAB's Annual Report (2016/17);
- Tracking the progress of work undertaken since the publication of the "Tom" Safeguarding Adults Review, and planning our annual SSAB Conference that will take place on 9th March 2018;
- Considering new referrals and ongoing work on Safeguarding Adult Reviews;
- Monitoring Safeguarding Adults data and service user feedback;
- Receiving updates on the LeDeR programme, South West Regional SAR Thematic Review, and the development of a National SAR Library.

In addition, each sub-group is reviewing its membership and terms of reference.

Hate crimes and hate incidents

A hate incident is when the victim or anyone else thinks an incident, such as bullying or abuse, was motivated by hostility or prejudice based on one of the following things:

- **Disability** (including physical disabilities, sensory impairments, learning disabilities and mental health issues)
- **Race**, skin colour, ethnic origin, nationality (including against gypsies and travellers)
- **Religion or belief** (or lack of religious belief)
- **Sexual orientation** (including homophobia)
- **Gender identity** (including resentment of transgender people, transsexuals and transvestites).

When hate incidents become criminal offences they are known as hate crimes. Any criminal offence can be a hate crime if it was carried out because of hostility or prejudice based on disability, race, religion, transgender identity or sexual orientation.

Reporting a hate incident or crime

If you or someone you know has experienced hate crime, reporting it can stop it happening to someone else. Hate crime and incidents can impact people who are abused, their family and the wider community in many different ways. Telling someone means you can get support and this can help alleviate the impacts. Reporting it also helps the police better understand the level of hate crime in your area and improve the way they respond to it.

Incidents can be reported by victims or witnesses. They can range from verbal abuse, threatening or aggressive behaviour – even through letters, emails or social media – criminal damage to personal property, or physical attacks.

You can do this by contacting the police to report hate crime.

- call 999 if a crime is happening now or if someone is in immediate danger
- call 101 if it's not an emergency
- fill in the online crime form at www.avonandsomerset.police.uk
- visit your local police station.

If you have been a victim of a hate crime and would like support, or support with reporting a hate crime, please contact the hate crime support service in Somerset, which is called SARI.

SARI is funded by Big Lottery to deliver the Every Victim Matters Hate Crime Service for Somerset, Bath and North East Somerset and North Somerset. You can contact them via:

- 0117 942 0060
- sari@sariweb.org.uk
- www.sariweb.org.uk

Emergency SMS service
This service lets people who are deaf, hard of hearing or have a speech impediment contact the emergency service by texting 999. Mobile phone numbers must be registered with the service before it can be used. To find out more, visit the emergency SMS website.

Anti-Slavery Day

Anti-Slavery Day 2017 took place on 18th October.

Modern Slavery is real. It is happening in our communities. We interact with it, often unaware of the forms it takes in nail bars, car washes, or even further down in the supply chains of our smartphone manufacturers and our favourite coffee producers.

Slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service.

Someone is in slavery if they are:

- forced to work through mental or physical threat;
- owned or controlled by an 'employer', usually 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 his/her freedom.

The following definitions are encompassed within the term 'modern slavery' for the purposes of the Modern Slavery Act 2015.

These are:

- 'slavery' is where ownership is exercised over a person;
- 'servitude' involves the obligation to provide services imposed by coercion;
- 'forced or compulsory labour' involves work or service extracted from any person under the menace of a penalty and for which the person has not offered himself voluntarily;
- 'human trafficking' concerns arranging or facilitating the travel of another with a view to exploiting them.

The Centre for Social Justice states that the term 'modern slavery' includes the definitions below:

HUMAN TRAFFICKING

1. Recruitment, transportation, transfer, harbouring or receipt of persons.
2. By means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or

receiving of payments or benefits to achieve the consent of a person having control over another person; (where a child is involved, the above means are irrelevant).

3. For the purposes of exploitation, which includes (but is not exhaustive):
    - Prostitution
    - Other sexual exploitation
    - Forced labour
    - Slavery (or similar)
    - Servitude etc.
    - Removal of organs

SLAVERY

The status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised (129 Convention; approved in defining Art 4 ECHR: Siladin v France (ECHR, 2005).

SERVITUDE

An obligation to provide one's services that is imposed by the use of coercion, and is to be linked with the concept of 'slavery' described above (Siladin v France, ECHR (2005)).

FORCED LABOUR

All work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily.

Find out more about Modern Slavery via:
http://ssab.safeguardingsomerset.org.uk/protecting-adults/modern-slavery/

The LeDeR Programme

Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period; and the programme commenced in Somerset in June 2017.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

A further part of the LeDeR programme is to conduct a series of additional projects. These are:

- Finding out more about the age and cause of death of people with learning disabilities in England by linking different data sets;
- Finding out more about the provision of 'reasonable adjustments' for people with learning disabilities;
- Providing better guidance so that the cause of death written on death certificates of people with learning disabilities is recorded in a consistent manner;
- Establishing a collection of reports about people with learning disabilities from which we can learn more about commonly occurring problems.

Find out more about the LeDeR Programme

Ten Years of the Mental Capacity Act

To mark 10 years of the Mental Capacity Act (MCA) we have reproduced the following article by Ian Burgess, a Mental Capacity Act lead, *first published on 27th September in Community Care*

Mental Capacity Act 2005

On the tenth anniversary of the Mental Capacity Act 2005 coming into force, many of us are looking back at some of the negatives and positives of the legislation.

My biggest complaint about the MCA is that it is still misunderstood or misapplied and used against people. For example, consider section 5 and best interests decisions, where a professional does not incur any liability for an act in the same way that he or she would not be liable if the person did have capacity to consent and had consented.

Alex Ruck Keene, barrister at 39 Essex Chambers, refers to a 'Wild West' approach to section 5. Section 5 of the MCA intentionally does not give us any authority to do something; instead a professional accounting for his or her behaviour can only rely upon it as a defence. Yet Ruck Keene says many professionals behave as though section 5 provides an authority to act.

Worse still, in doing this the professional might be motivated by a desired outcome from the start, followed by the question: 'does this person have capacity?" In effect, some professionals want the person to not have mental capacity, in order to authorise their decision making, conveniently forgetting about principles 4 and 5 of the MCA, and section 5.

The MCA then is frequently skewed in practice, not to enable the person, but to provide a dubious mechanism for going against the person's will.

I daresay retired senior judge, Denzil Lush, perhaps threw the baby out with the bathwater when he would never sign a lasting power of attorney (LPA), because of the risk of abuse, but I welcomed his recent comments on the subject.

While many express concern about vulnerable adults being scammed, in my experience it is more common for financial abuse to happen because of an LPA. For example, siblings fall out and an LPA (usually for property and financial affairs) is created and then used as a weapon against the other family members.

I have also lost count of the number of attorneys who tell me that they have the authority to make large monetary gifts from their relative's bank account, or that they can sell their parents' home and divide the proceeds between themselves. We have a nice chat about the law and invariably the attorney says that 'no one told them that'.

The solutions to this phenomenon surely rest with the Office of the Public Guardian, which should do more to ensure a) the competency of certificate providers in ensuring the donor can make the decision, knows the implications of creating an LPA and is not under any pressure to do so, and b) that the attorney is fully advised of their lawful responsibilities, that they must have the same regard for the MCA as any health and social care professional. Form LP1F says some of this, but we need more safeguards.

‘Easier to challenge’

So much for the negatives, what about the positives of the MCA in the past 10 years?

Social workers in England and Wales now have the legislative framework they need for intervention rather than vague ‘common law doctrine of necessity’, in which decisions were made with no reference at all to the views of the person, nor any agreement on capacity. People were whisked away into care homes with little or no regard for their wishes. It still happens, but now that can be challenged more easily.

Also, I have known people to say they have felt freedom from social services upon finding that they could reclaim their autonomy and decide for themselves what intervention (if any) to accept from us. It is sad that some of my career highlights have been in undoing what some of my predecessors have done to people.

I wonder how many social workers are saying the same about me, undoing the things I did 15 years ago?

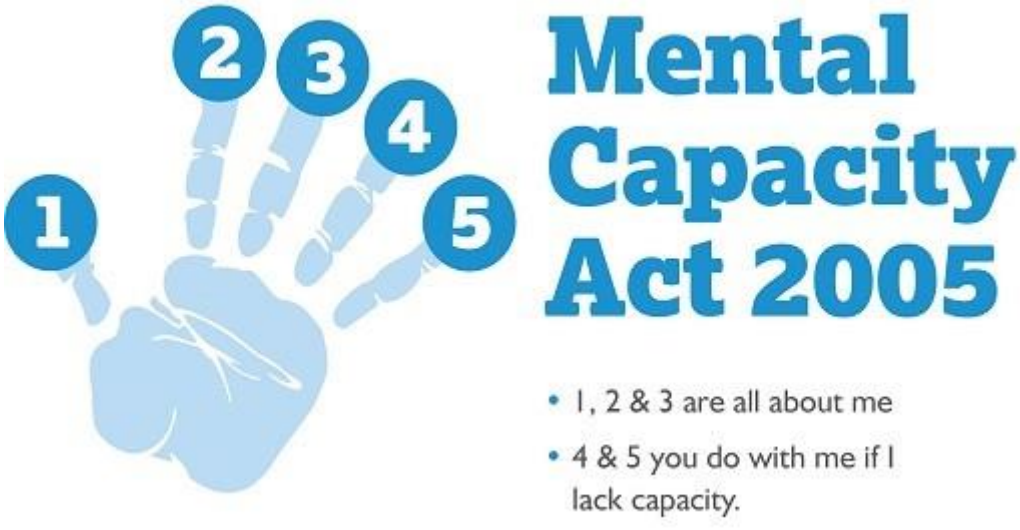
Social workers who have been qualified for more than 10 years might also reflect on how much we refer to human rights these days. I qualified in 2001, the year after the Human Rights Act came into force, yet it wasn’t until the MCA in 2007 that I started to referring to it in reports. Human rights were not mentioned at all in three years at university. But article 8 of the HRA is so deeply embedded in the MCA, and now in adults’ social practice, that I can refer to it here and most readers won’t have to go Googling to see what I am talking about.

‘More relevant and person-centred’

I had not wanted to mention the Deprivation of Liberty Safeguards in this piece, but I do think the Supreme Court judgment of March 2014, especially, has raised the bar in terms of the professional standards expected of social work with adults.

When I first qualified, social work with children sometimes seemed like an elite, while adults’ social work was the poor relation. However, the continuing professional development profile of a social worker with adults will now likely include qualifying as a best interests assessor, or having experience in Re: X deprivation of liberty cases or section 21A challenges, or welfare applications in the Court of Protection.

Writing witness statements, instructing lawyers on the local authority’s position, challenging expert witness reports that find incapacity where you enabled the person to make the decision because of your approach and social work skills – all these things have made social work with adults more relevant and our practice more person-centred. And for that we can, in part, thank the Mental Capacity Act.



Introducing our new SSAB Business Manager, Stephen Miles

I have recently taken over from Niki Shaw as the Somerset Safeguarding Adults Board Business Manager. That's some big shoes to fill!

In terms of my background I started working for Somerset County Council in 1996, working first in finance and information management, then since 2008 strategic commissioning - initially with services for people experiencing mental health ill health, and latterly people with learning disabilities. Before I joined the Council I worked as the quality controller for a manufacturing firm.

Stephen Miles with Niki Shaw

I live in Somerset and have a 9-year-old son; I am the co-chair of governors and safeguarding governor at his school.

One thing that struck me when leaving my old role and thinking about moving to my new one was the times when a single word - "safeguarding" – had been given with little or no further explanation as the rationale for why a practitioner was recommending a particular course of action that was likely to have a profound impact on a person's life. This ranged from why an out-of-county placement, that would mean someone moving hundreds of miles from the people and places that were important to them, was being recommended; through to why someone shouldn't be working towards getting a job in case an employer took advantage of them.

Safeguarding is rightly said to be everybody's business. There is no absolutely no argument from me there. However, there is, and always will be, a tension between ensuring people who are vulnerable are safe, and enabling them to do things that they want to do. To listen to them and the people who are important to them. To be aspirational about the things that they can do. To take risks. To have the same opportunities to be valued members of the community as anyone else.

The work we do as system should always be an enabler for people to live a good life, not reinforce the status quo or be a source of inertia. Yes, a person moving out-of-county from a placement that is breaking down resolves the immediate issue, but as a system could we meet their needs in a different way that enables them to stay in Somerset? Out of county placements have risks too, as highlighted more times than I want to count in reports and reviews nationally (including as outlined further on in this newsletter), and vulnerable people living in communities that they know and which know more often than not leads to better outcomes and reduced safeguarding risks. For the person thinking about getting a job, yes there are unscrupulous employers out there but they are the exception not the norm, and a job coach will be able to enable someone to spot any warning signs in the unlikely event that something starts to go wrong.

As a system, we need to enable vulnerable people, and the communities that they live in, to help themselves to stay safe - and if something doesn't feel or look right then people need to know what to do about it. However, while sometimes it is harder to enable someone take an opportunity that they haven't had before in a way that is safe, we need to try to find a way to make it happen. If we don't, or fail to give someone or their family a rational reason why something can't happen, then we run the risk of safeguarding processes being viewed negatively.

That's something that none of us want or can afford to happen.

I look forward to working with you and the Board

Financial Abuse and Scams

The Association of Directors of Adult Social Services (ADASS), Local Government Association (LGA) and the Adult Principal Social Worker Network have produced the following “Top Tips” on financial abuse and scams:

Ensure that you are aware of scams

There is an excellent on-line training session (which takes no more than 40 minutes to complete) at http://www.friendsagainstscams.org.uk. You could also ask for a member of your local Trading Standards Teams to come and speak at your next team meeting which will give you a real idea of the work being undertaken locally and how you could link in and support this.

Be able to look out for the signs of someone who may be responding to scams

Identifying scam victims can be difficult as they:

- May be unaware of their victim status
- Are instructed to remain quiet by the criminals
- Feel guilt, shame or are in denial
- Fear that they will lose their social or financial independence if they tell friends or family
- Don’t want to lose their ‘friendship’ with the criminals

There are some key signs to look out for by observing a victim’s behaviour or when visiting their home:

- High volume of scam mail
- Hoard large quantities of ‘worthless’ goods & cheap ‘tat’
- Be living in shocking or unsanitary conditions
- Poor personal hygiene
- High usage of chequebooks
- Frequent visits to the Post Office
- Not paying bills or buying food
- Deceitful about scam participation
- Increasing isolation from friends / family
- No support from family / friends or anyone to confide in
- Receives a high volume of phone calls
- Become extremely distressed, angry or aggressive to learn that they are a scam victim
- Feel ashamed or embarrassed at what they have done
- After a period of grooming, have strong emotional ties with the scammer
- Knowing how to talk to a potential victim of scams

If you find yourself talking to a client who you suspect is a victim of scams, the following guidance may help you illicit more information which will help subsequent support:

- Take a conversational approach instead of asking structured questions
- Seek to sensitively obtain more information regarding the scams (e.g. timescales of victimisation / any contact details of criminals etc.) by asking informal and open questions.
- Try and establish if they are the victim of any other scams, e.g. Doorstep Scams, befriending, etc.
- Spend time listening to the consumer; do not judge them
- Refrain from getting frustrated, interrupting them or finishing their sentences
- Use honest, simple and caring language which makes them feel as if they’re being empathised with and taken seriously

Know how to take appropriate action to prevent further financial abuse

If you believe that a client is being targeted by scams, whether or not you know they are responding, seek advice from your local Trading Standards Team. They will probably have well established mechanisms for providing adequate support to break the cycle of victimisation. This will either be through themselves or via established partnerships with other organisations.

Even if you have not yet seen a client who you believe is a victim, it is good to be aware of what your Trading Standards Team does in the area of scams and work together to establish the best means of support. You could offer valuable guidance to them on safeguarding issues.

Knowing about issues of mental capacity, unwise decisions and cognitive impairment

Often victims can be suffering from a form of cognitive decline which makes them more likely to respond to scams. It can be difficult to establish the level of decline and the impact this can have on the client's day to day ability to deal with financial affairs. Carrying out a mental capacity assessment can inform in these situations, together with inviting input from the client, family members and financial institutions as necessary.

You will of course need to give consideration to statutory duties under the care act relating to safeguarding and your local safeguarding procedures and whether a referral needs to be made to safeguarding team for a Section 42.

Read the full document

SCAMS ARE CRIMES | HELP STOP THEM

Learning Lessons

National: Learning from SARs undertaken by London SABs

A project was undertaken to analyse of the nature and content of 27 Safeguarding Adults Reviews (SARs) commissioned and completed by London Safeguarding Adults Boards since implementation of the Care Act 2014 in April 2015, up to 30th April 2017. Of the 30 London Boards, 17 submitted reviews for analysis, in numbers varying between one and four.

Each SAR in this sample demonstrated a unique and complex pattern of shortcomings that impacted on the case under review, each on its own unlikely to be significant in determining an outcome, but which taken together represented features that added up to a 'fault line' running through the case. Typically, weaknesses existed in all layers of the system, from individual interaction through to interagency governance, and beyond to the broader policy and economic context.

Thus learning from SARs is rarely confined to isolated poor practice on the part of the practitioners involved. The repetitive nature of the findings and recommendations within this sample and across other studies suggests that organisational context and interagency collaboration and governance make a crucial contribution. There are structural, legal, economic and policy challenges that affect practitioners and managers across all agencies and boroughs.

The key challenge for SABs therefore, in their mission to prevent future similar patterns from occurring, is certainly to be proactive in implementing recommendations relating to local policy, procedures and practices, but also to involve regional and national policy makers in order to promote whole system contribution to service development.

Read the full report

National: Bristol Safeguarding Adults Board SAR

On 28th September 2017 the Bristol Safeguarding Adults Board today published a Serious Case Review concerning the murder of Melissa, an 18 year old woman who was killed in a Bristol-based independent Care Home in October 2014 by another resident, a 19 year old male.

Both young adults were placed in the Care Home by commissioners from different local authorities a significant distance from Bristol. Neither Bristol's Safeguarding Adults Team nor the Clinical Commissioning Group were informed of them being moved into Bristol despite their complex and multiple needs.

The case has raised significant learning particularly in regards to the commissioning of out-of-area placement, risk assessment, risk management, and transition planning between providers, NHS trusts and commissioners. The review found Melissa's death could have been prevented had better processes been in place.

Melissa lived at home with her parents and sibling for most of her childhood years. At the age of ten she was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and later diagnosed with Autism Spectrum Disorder (ASD). In July 2013 Melissa was admitted to the first of two CAMHS Adolescent Units for a period of in-patient assessment. Subsequently Melissa's home authority children's services, supported by the Adolescent Unit, decided that a residential placement should be sought for her. This view was not supported by her family who expressed concern about her ability to relate to other adults in a residential placement because of her immaturity. Aged 18 Melissa was placed in the Care Home 2 months before her death. During this time she exhibited significant distress and received support from mental health crisis services.

The young man who was convicted of murdering Melissa had been in care since the age of seven. He had lived in multiple placements including foster care and residential schools. The review identified a chronology of sexually motivated violent behaviour to women throughout his adolescence. A forensic assessment conducted in the year before his move to the Care Home identified his significant ongoing risk and recommended a high level of supervision and risk management strategies. These were set out in a report shared with the professionals supporting him at the time. The young man struggled to distinguish between fact and fiction. He enjoyed science fiction films and books such as Marvel Comics and Star Wars and liked time role=playing in these characters.

It was evident through the review that the young man should not have been placed in the same provision as Melissa because of his risk profile. It is vital that providers undertake a compatibility assessment should be undertaken considering the combination of needs of all adults in any group living situation whenever a new adult is placed there. Commissioning authorities should ensure this is completed as standard.

Learning from the review:

- Bristol City Council's Safeguarding Adults Team and the Bristol Clinical Commissioning Group should be informed when adults with complex needs and who pose a significant risk to themselves or others are placed within Bristol.
- Bristol City Council's Safeguarding Adults Team and the Bristol Clinical Commissioning Group should be informed when adults with complex needs and who pose a significant risk to themselves or others are placed within Bristol.
- Any professional involved in commissioning services out-of-area placements for high risk or complex adults must also ensure they notify local Safeguarding Adult Teams and Clinical Commissioning Groups. Providers should seek assurance that this has been completed on accepting a new placement.
- Commissioners and providers must ensure that their understanding of agreed staffing levels are explicit throughout a twenty-four period including at night.
- Assessments undertaken when an adult is moving into a provision must include assessments of compatibility with other residents as well as robust risk assessment. This includes ensuring

that placing authorities provide information in a timely and accurate way.

- Risk management assessments and strategies should be reviewed regularly and ALWAYS reviewed if there is a change in behaviour or new information about risk becomes available.
- All documentation and assessments concerning an adults risk must be provided to providers in a timely manner and their findings must influence placement decisions and the development of robust risk management plans.
- Referrals and professionals undertaking assessments should mitigate against the rule of optimism when conveying and assessing potential risk. The desire to place an individual or ensure they are not stigmatised should not be barriers to effectively sharing information about potentially risk behaviour. These should be conveyed explicitly and factually, reflecting potential groups who may be more at risk if relevant.
- Adults with care and support have a right to an independent advocate to be involved in decision making. Advocates should be engaged at the earliest opportunity.
- Providers should review their General Data Protection Regulations to ensure they include information sharing arrangements for when they accept or managing high risk residents

Read the full report

Local: The Fenestra Serious Case Review

On 2nd November the Somerset Safeguarding Children Board today published the The Fenestra Serious Case Review.

The Somerset Safeguarding Children Board (SSCB) Learning and Improvement subgroup were notified in 2015 about nine children who were victims of child sexual exploitation (CSE) from two men identified through the Operation Fenestra police investigation. These two men are called Perpetrator A and Perpetrator B in this report.

The offences against the children occurred between 2010 and 2014 in Somerset. They were subject to police investigations, in 2011, 2012 and August 2014. This investigation resulted in the prosecution and conviction (in 2016) of the 2 men for sexual offences against 6 victims aged between 14 and 15 (when the crimes were committed) and a 7th victim aged 18. At the time of conviction Perpetrator A was aged 34 years old and was convicted on 2 counts of rape and 7 of sexual assault, and sentenced to 20 years imprisonment. Perpetrator B, aged 29, was convicted of 1 count of rape and 6 of sexual assault and sentenced to 12 years imprisonment.

There are eight findings of which three make direct refernce to adult servioce. These are:

1. Due to difficulty interpreting and reconciling national guidance and the law relating to sexual activity, professionals sometimes find it difficult to distinguish between informed consent for adolescent sexual activity and coercion / 'inappropriate relationships'; this can leave children being at continued risk of child sexual exploitation, especially if they are judged to be 'competent' and/or 'capable' to make such decisions themselves.

   Learning for adult services:

   - This finding looks at the particular difficulties practitioners face when working with older children (aged 13+) in deciding if there any grounds for concern about the sexual activity of children under the age of 18 years old. Practitioners need to be mindful of both the law in relation to age of consent, but also of issues around competency and/or capability in making that decision. This finding also has relevance for vulnerable adults, where the issue of capability / competency can be extremely complex to evaluate.
   - In March 2016, the Somerset Safeguarding Adult Board received the review exploring the care of a young woman with learning disabilities who had been the victim of domestic violence and sexual exploitation at the hands of her partner. These matters came to light early in 2014 against a backdrop of raised alertness to the dynamics of the sexual exploitation of disadvantaged young women by predatory men. Key to these cases were the assumptions made by responsible agencies about the capacity and consent of those

victimised and the assumption that they had entered into these abusive relationships freely.

2. There is a tendency for practitioners to focus on short term intervention for perceived parenting deficits, without taking sufficient time to listen and hear the parents' own worries of risks outside the family. This can lead to the provision of insufficient support to the child and family.

   Learning for adult services:

   - Recent Safeguarding Adult Reviews in the county have also explored the extent to which agencies have responded in a timely and appropriate manner to concerns being raised by family members and carers. One review ('Tom'), published in June 2017, highlighted that 'although (his) family was an obvious source of information….their role with services became one of pleading for engagement and help' and concluded that 'family involvement' be prioritised.
   - The advice from the serious case review panel is that the culture remains difficult to change for both children and adult's services, locally and nationally, in relation to:
     - the focus on the family, to the exclusion of external risks
     - provision limited to short term intervention when a family needs longer term support to respond to concerns and risks of exploitation.

3. Linking information within and between agencies is an integral part of the safeguarding system to protect children from harm: improvements have been made in recent years, but there is scope for further development of this to protect children, especially from sexual exploitation.

   Learning for adult services:

   - This issue is not just a local problem: perpetrators of sexual exploitation access victims across county and national borders, particularly with the ever increasing risks to children and vulnerable adults through the opportunities provided by the internet.

4. Children who have experienced or are at risk of experiencing CSE need accessible, timely and skilled support for their emotional and mental health problems: this is developing in Somerset, but requires further improvement to provide for the range of need

   Learning for adult services:

   - The SSCB should explore the extent to which adult services understand the issue and respond appropriately to those who continue to be abused by perpetrators once they turn 18 or 21, or survivors who are no longer being abused but disclose previous CSE or those that are suffering from the impact of earlier abuse.

Read the full report

Local: Self-neglect in care homes and the community

During Stop Adult abuse week (12th – 16th June) Holly Stockdale, an Advanced Social Work Practitioner in Somerset Care Home Support Team, attended Bristol and South Gloucestershire's annual Safeguarding Adults Board conference. The theme was self-neglect in care homes and the community. Michael Preston-Shoot (one of her social work heroes) delivered the key note speech on self-neglect, which was really interesting and informative. The main learning points were as follows:

- We do not know how big an issue self-neglect is in England, but it is the biggest safeguarding issue in America, and in a recent sample of 10 Safeguarding Adult Reviews from the South West, 5 featured self-neglect.
- Self-neglect is a person's neglect of their care or the environment to the extent that it limits their life expectancy.
- There is no one cause of self- neglect, it is a complex interplay of social, physical, personal, and environmental factors.
- These factors can include negative self-image, differing standards, an inability to self-care, influences from the past, the positive value of hoarding, and circumstances beyond the person's control (e.g. hearing voices).
- Because of the complexity, spending time with the individual and/or their family (if appropriate) to understand the story and a multi-disciplinary approach is required.

- Self-neglect usually involves balancing the person's right to make 'unwise decisions' with the duty of care to protect them from harm and promote their dignity
- Someone having mental capacity re: self-neglect is not an excuse to do nothing.
- The attitude that self-neglect is a 'lifestyle choice' should always be challenged: what makes them think it's inevitable?

Further resources can be accessed on self-neglect from **Social Care Institute for Excellence (SCIE)** and **Skills for Care**

Think Family – learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the Somerset Safeguarding Children Board.

The latest edition includes information about multi-agency 'One Teams' and Early Help, Children Missing Education and much more.

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.

Mate Crime

Mate crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. Mate Crime can become a very serious form of abuse. In some cases victims of Mate Crime have been badly harmed or even killed. Surveys indicate that people with disabilities can often become the targets of this form of exploitation.

Mate Crime may involve financial abuse (such as a perpetrator demanding or asking to be lent money and then not paying it back), physical abuse (the person may be kicked, punched etc. for the amusement of the perpetrator and others), emotional abuse (the perpetrator might manipulate or mislead the person), or sexual abuse (the person might be sexually exploited by someone they think is their partner or friend).

Adults at risk often do not recognise they have been the subject of Mate Crime. The focus of enabling safety needs to be on encouraging an understanding for the individual of their right to make choices, but also their right to remain free from abuse.

National News and headlines

October 2017

- The Independent Inquiry into Child Sexual Abuse has published the report and lecture, 'Victim and Survivor Voices from the Truth Project' which considers some of the accounts of victims and survivors taking part in the Truth Project.
- Let's Nail It campaign prompts three reports of suspected modern slavery
- BBC File on Four investigates County lines – drug trafficking from cities into rural areas by exploited teens.
- Home Office publishes a typology of modern slavery offences in the UK
- Guides published for making reasonable adjustments for people with LD including constipation, substance misuse and dysphagia services
- Snapshot published of safeguarding adults practice and challenges based on SCIE's work in this area
- House of Commons Library briefing published on Deprivation of Liberty Safeguards (DoLS)

September 2017

- Nine in 10 GPs rated good or outstanding
- Not enough focus on perpetrators in domestic abuse cases, inspectors say
- Coercive control: How can you tell whether your partner is emotionally abusive?
- Somerset Safeguarding Children's Board publishes "Child Sam" serious case review

August 2017

- Ship detained in port near Bristol after 'modern day slavery' conditions found on board
- UK family found guilty of enslaving homeless and disabled people
- Modern slavery and trafficking 'in every UK town and city'
- Small-town children at risk of exploitation by criminal gangs, say MPs
- Royal College of General practitioners Safeguarding Adults at Risk of Harm Toolkit published
- The Prevent strategy in practice: Powerful video made by Bristol students in conjunction with police
- Old People's Home for 4 Year Olds review – a moving and uplifting experiment
- Social workers felt 'helpless' in radicalisation case, finds review

July 2017

- Former managers of Winterborne View, where patients were abused 6+yrs ago, are struck off the nursing register
- Concerns that some locked rehabilitation hospitals were longstay wards, risking institutionalising people
- Two arrested and five men safeguarded in modern slavery operation
- Care services 'too often' failing to apply Mental Capacity Act properly, warns ombudsman
- How loneliness in older people makes them more vulnerable to financial scammers.
- Home Office publishes Guidance for frontline professionals on dealing with county lines
- A new £1.5 million service for young vitims of sexual exploitation has been commissioned by Avon and Somerset Police and Crime Commissioner.
- The state of adult social care services 2014 to 2017: Somerset amongst the highest performing

June 2017

- Greater awareness needed to prevent abuse of older people with care and support needs, says ADASS

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, 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 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