Issue 17: June 2022

Newsletter

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

This is the 17th 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.

To the new subscribers who have 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 would like to make.

In this issue:

News from the SSAB

Since the last newsletter was published the SSAB has met on 12/10/2021. Agenda highlights included:

- Learning from a family member in relation to the 'Damien' SAR published in Mach 2021
- A presentation outlining the findings from the Board's 2021 self-audit. A summary will also be included in our annual report when it is published later this year.
- A briefing on a new quality improvement role that is being hosted by NHS Somerset CCG on behalf of the SSAB, Somerset Safeguarding Children Partnership and the Safer Somerset Partnership
- Receiving a briefing from the Board's Performance & Quality Subgroup on the SSAB's Performance Report.
- Further work as a partnership to develop our new strategic plan for the next 3 years

The Board's next meeting is on 16/06/2022

Guidance and leaflets

Since our last newsletter we have published three new seven-minute briefings on:

- **Professional Curiosity**
- **Reviews of Adults Placed in Care Homes and Specialist Hospitals**
- **Vulnerable Dependent Drinkers**

We have also:

- Published new guidance on **Making a Referral for a Safeguarding Adults Review**
- Published new guidance on the **Disclosure of Non-recent Abuse**
- Updated our **Professional Curiosity guidance**
- Updated our **Somerset Adult Safeguarding Learning Framework** that outlines what all staff and volunteers should know about adult safeguarding

Following on from the publication of the **National Analysis of Safeguarding Adult Reviews** that we summarised in our **October 2021 newsletter**, we are also working on a series of leaflets to explain what the different types of abuse are. We will contact all newsletter subscribers to let them know when this has been published.

Feedback on our guidance

As our work moves on from the pandemic, we are in the process of reviewing all our guidance and would be grateful for feedback from our readers on both our website and what is available – in particular any guidance you feel is missing or which could be improved. If you have any feedback, **please email us**.

Professional Curiosity Webinar

We want to thank everyone who attended our webinar on Professional Curiosity in March 2022, and especially those who took the time to complete the brief post-webinar survey to help us shape future webinars, as well as colleagues from NHS Somerset CCG, Somerset NHS Foundation Trust, Yeovil Hospital NHS Foundation Trust and Somerset County Council that both presented and developed the content for it.

The webinar was booked up quickly, with all 240 places being booked well before the closing date. We know that some people were unable to join on the day, and other were not able to book a place, and have therefore published both a recording of the webinar and the slides from the presentation on our website for all organisations to use.

We hope that everyone who attended of has viewed the recording and slides found it useful, and if you have any requests on content for future webinars **please let us know**.

We are also starting to plan for an in-person conference, our first since 2019, that we hope will take place in March 2023. This will be in additional to further webinars, and we will be contacting all newsletter subscribers with details of how to how to book a place nearer the time.

Further information

- **Slides and recording of the SSAB's webinar on 'Professional Curiosity'**

Every Life Matters

Public Health Somerset, in conjunction with Every Life Matters, have launched a series of online 3 ½ hour suicide alertness courses and 90 min suicide awareness courses that will run throughout the rest of the year.

The aim is to reduce the stigma attached to suicide, increase understanding of when someone is at risk of suicide, raise awareness of how to practically support someone, and the range of services and resources available for people in our communities experiencing suicidal thoughts.

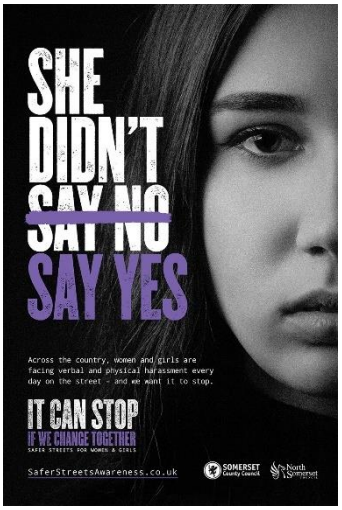
Further information

- **Booking page for on-line training**

Violence Against Women and Girls

Following the tragic murder of Sarah Everard on the 03/03/2021 the government have funded the North Somerset and Somerset Council's Safer Streets program to hear the voice of women around this issue and also help promote safety in public spaces.

As part of this program we are asking partners to upskill staff on this important subject through resources to raise awareness within organisations and communities that are available on the Safer Streets Awareness website



Further information

- **Safer Streets Awareness website**
- **Violence Against Women and Girls Campaign**

National Safeguarding Adults Awards 2022

This year the National Safeguarding Adults Week, coordinated by the Anne Craft Trust, will take place from 21/11/2022 to 27/11/2022, and we are excited to be able to say that, nationally, Safeguarding Adults Boards have agreed to work together to celebrate excellence in the field of adult safeguarding through a series of awards that we are seeking nominations of local excellence to consider for submission nationally.

Do you know a professional and/or team who:

- Are inspirational?
- Go above and beyond?
- Share their skills and expertise?
- Overcome barriers to make a real difference?
- Work in partnership with others?

The awards will cover the following eight categories:

- Empowerment Champion - someone/team who has demonstrated empowering individuals
- Prevention Champion - someone/team who has demonstrated and acted to prevent abuse or neglect
- Proportionality Champion - someone/team who has demonstrated being balanced in their approach to ensure the least intrusive response
- Partnership Champion - someone/team who has demonstrated working in partnership
- Accountability Champion - someone/team who has demonstrated keeping others accountable, including themselves
- Protection Champion - someone/team who has demonstrated protecting adults at risk
- Lifetime Award - includes anyone who has demonstrated more than 20 years of experience in safeguarding adults
- Innovation - includes all areas of where someone/team has been creative and set new ways of working with adults at risk

How to make a nomination

Please send an **email detailing**:

- You details – your name, the organisation you work for (if applicable) and your contact details
- The details of the professional/team you are nominating:
- The name of the professional/team
- Which award category the nomination is for **(one per nomination)**
- Why the individual/team has been nominated. Please be very detailed as to why your nominee should win the award above all other nominees - examples are welcome.
- The nominee's contact details, including their email
- If you have told the nominee that they are being nominated

All nominations should be received by no later than 5pm on Monday 05/09/2022.

What happens with the Nominations?

All Nominations will be considered in their own merit, with awards and acknowledgements made during the National Safeguarding Adults Week in November 2022. The winners of the National Award may be recognised in a press release, photo opportunities and signed certificate.

Please note that this information will be processed by the SSAB for the sole purpose of collating nominations and, for those submitted nationally, the Bexley SAB which is collating all national nominations. Information will not be kept longer than required.

Choking Awareness

Choking refers to a difficulty breathing due to a foreign object obstructing the airway. People with dysphagia (disordered swallowing) are at an increased risk of choking.

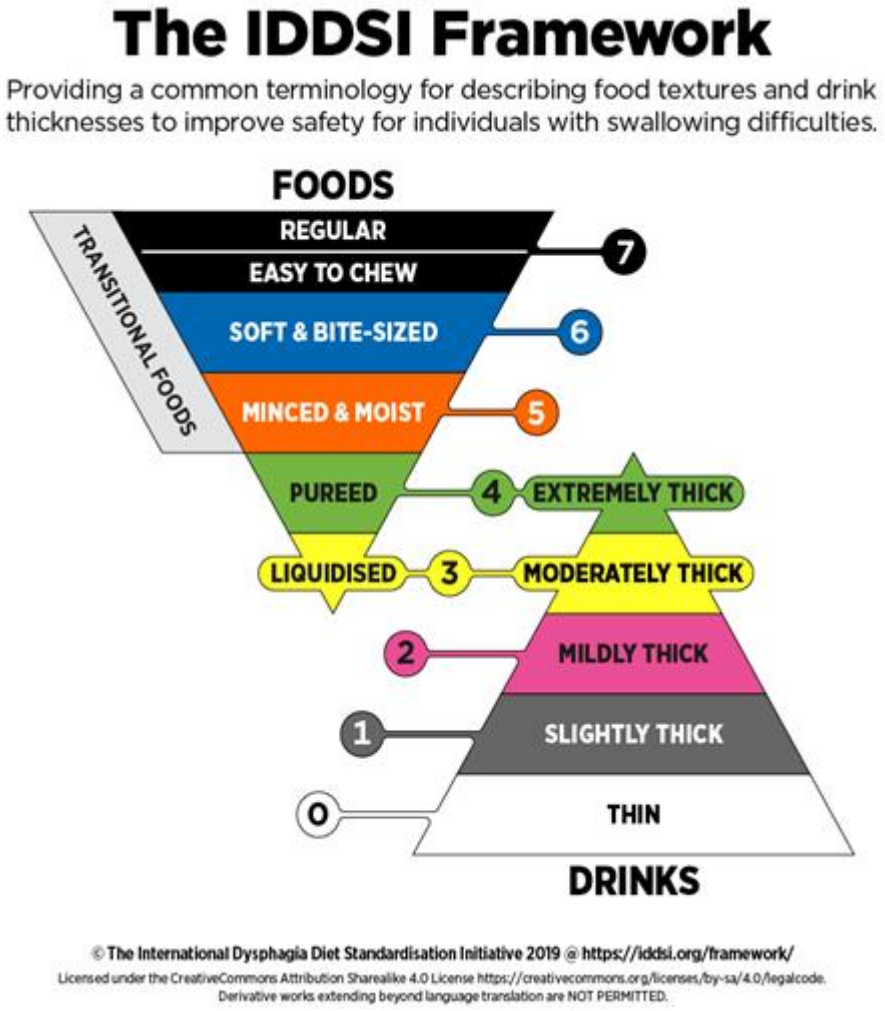
Common causes include eating or drinking too quickly and swallowing before food has been suitably chewed. Signs and symptoms include clutching or pointing to the throat, changes to voice quality post-swallow including a complete inability to speak, coughing, wheezing, facial reddening, eye watering, chest pain and panicked movements.

All staff can take proactive steps to support people and reduce choking prevalence by:

1. **Reducing environmental distractions** and promoting a relaxing mealtime setting. If required, turn off the television or radio and minimise the occurrence of interruptions.
2. **Supporting and encouraging** people to **sit fully upright** for all oral intake, preferably at a table to promote good posture. Discourage eating and drinking while lying down. If the person is unable to sit out during mealtimes, ensure their bed is positioned into a fully upright position and their head supported.
3. Ensuring the person has access to hearing aids, glasses, dentures and any specialised utensils or cutlery if required. Aid the person to clean these **assistive devices** often for peak performance.
4. Checking the person's oral cavity before each meal for **foreign objects** or **residue**.
5. **Offering support** to cut up food into smaller, bite-sized pieces.
6. If assisting a person to eat and drink, offer **one spoonful/forkful at a time**. Give the person **ample time** to chew and prepare each mouthful and ensure he or she has swallowed the last offering before giving another.
7. You **must carefully follow all instructions** written in the person's Speech and Language Therapy eating and drinking **care plan**.
8. If supervising a person with **cognitive difficulties**, consider modelling the right amount of food for each spoonful or using hand-over-hand assistance. Use verbal prompting to encourage the person to slow down or continue chewing as appropriate.
9. **Discouraging** the person to talk while eating and drinking. Do not ask a question until the person has finished chewing and swallowing their last mouthful.
10. Encouraging or assisting the person to **clean his or her oral cavity** after each meal.
11. Ensuring the person remains **fully upright** for at least 15 minutes after eating. This reduces the chance of oral residue falling to the back of the mouth or reflux coming back up and entering the airway.

Certain foods carry a **higher choking risk** and should be avoided by those on texture-modified diets. These include:

1. **Crumbly foods** – biscuits, pie crusts, cereal.
2. **Tough or chewy foods** – steak, bacon, harder vegetables.
3. **Skin, bone, or gristle** for example, from a fish.
4. **Pips, seeds, shells, nuts, and husks**.
5. **Crispy, crunchy, or dry foods**, for example, crisps, pastries, crackers, bread.
6. **Sticky foods** – some cheeses, marshmallows.
7. **Juicy food** where the juice separates off in the mouth – melons.
8. **Leafy foods** – greens, lettuce, spinach.
9. **Mixing solids and liquids** – hard cereal with milk.
10. **Stringy or fibrous foods** – green beans, pineapple.
11. **Round or long-shaped foods** – whole sausages, grapes, boiled sweets.



Further information

If you require any further assistance, please telephone Somerset NHS Foundation Trust's Adult Speech and Language Therapy Service on 01823 617464

NHS Somerset NHS Foundation Trust

Thank you to Somerset NHS Foundation Trust for providing this article

Money Mules

At this time of a cost of living crisis putting increased pressure on everyone's finances, it is important that everyone – both staff and the people they are supporting are aware of the risk this type of criminal exploitation.

Please provide your bank details for payment purposes.

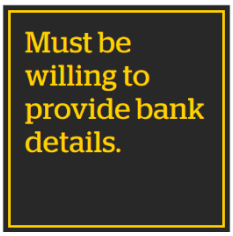
You may have seen an advent like one of those shown in this article before, perhaps on social media or online? It pictures an amazing opportunity, convenient employment, and quick cash. But stop and have a think. Is this too good to be true?

Earn from the comfort of your own home.

The truth may be that, if you respond, fraudsters will ask to use your bank account, promising a percentage of the funds as a form of payment. Moving money through your account on behalf of someone else could mean you are committing financial crime. The consequences of such activity can be very serious.

What is a money mule?

A money mule is someone who transfers criminal proceeds between accounts, while taking a small percentage as their own fee. They may themselves have no knowledge of the wider crime.



Money mules are recruited, sometimes unwittingly, by criminals to transfer illegally obtained money between different bank accounts. This may be referred to as "flipping" the money. Such activity may include a request to transfer money, withdrawing cash or providing your bank card to a third party for a percentage of the funds as "payment". It's also possible to act as a money mule by sharing your login details or allowing someone else to take control of your bank account.

How are money mules recruited?

Recruitment can take place through job offers, posted to legitimate job sites. Such "work" can mention opening a bank account specifically to receive funds, or using a different phone and SIM card to undertake any conversations in relation to the work. It's unlikely to include meeting the employer.

Posts on Facebook, Snapchat or Instagram may offer the opportunity to "make money fast", advertise particular banks they are willing to pay funds to and are likely to target students, young people or other vulnerable groups. Hashtags such as #moneyflipsUK, #EasyMoney and #Flipsanddeets may be included.

Traditionally, criminals have focussed on recruiting mostly younger people and students as money mules. However, there are now signs that middle aged people are being targeted, with the latest data from the National Fraud Database revealing a 34% increase in the number of accounts belonging to 40–60 year olds bearing the hallmarks of money mule activity since 2017.

Such activity can also include moving money as a "favour" or applying for a "loan" on behalf of someone else. There are even instances where funds are received "in error" and requested to be returned to a different bank account altogether.

By doing this, you could be helping move money linked to serious criminal activity including money laundering or terrorist financing, and are committing a crime.

It's often only after having moved the money, that individuals discover the devastating personal and financial repercussions.

The consequences can include:

- Your bank account being closed and struggling to open a new one
- Being denied various forms of credit (including phone contracts and student loans)
- A prison sentence of up to fourteen years

How you can protect yourself and others

- No legitimate company will ask to use your own bank account to transfer their money. Don't accept any job offers that ask you to do this
- Familiarise yourself with the **Take Five campaign** and stop, challenge, and protect your livelihood
- Practice vigilance around international job offers as it may be harder to track their true intentions
- Never give your financial details to someone you don't know and trust and never give anyone access to your bank account
- If you have children, financial education about money muling raises awareness and encourages them from making the wrong choices. Have those conversations now

What to do if you think you've been a money mule

If you think you or someone you care for has been approached to be a money mule or have been caught up in a money laundering scheme, the best advice is to stop transferring money immediately and notify your bank.

You should also **contact Action Fraud**, the national reporting centre for fraud and cybercrime

Further information

- **MoneyMules** website that has been set up by UK Finance and CIFAS.
- **Action Fraud**
- **UK Finance Press release on Money Mules**
- **CIFAS Research on Money Mules**

Adapted from information published by UK Finance, CIFAS and UK Banks

RESTORE 2: Recognises early soft signs, Take observations, Respond, Escalate

RESTORE2 is a physical deterioration and escalation package designed specifically for residential and nursing homes. It can also be used in the domiciliary care sector.

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

RESTORE2 will support you in a residential or nursing home to:

- Recognise when a resident may be deteriorating or at risk of physical deterioration
- Act appropriately according to the resident's care plan to protect and manage the resident
- Obtain a complete set of physical observations to inform escalation and conversations with health professionals
- Speak with the most appropriate health professional in a timely way to get the right support
- Provide a concise escalation history to health professionals to support their professional decision making

The positive impact RESTORE 2 can have on safeguarding

Safeguarding is everyone's business as a care provider / health and social care professional we have a Duty of care to act on safeguarding concerns. A duty of care can be said to have been reasonably met within a safeguarding enquiry if:

- All reasonable steps have been taken
- Reliable assessment methods have been used.
- Information has been collated and thoroughly evaluated.
- Decisions are recorded, communicated, and thoroughly evaluated.
- Policies and processes have been followed.
- Practitioners and managers seek to ascertain the facts and are proactive.
- RESTORE 2 can support with this!

The Analysis of safeguarding adults' reviews: April 2017 – March 2019 recognised that "responding to health" is featured heavily within National SAR's and S42 enquiries as a top theme of poor practice and a top recommendation for improvement. The use of RESTORE 2 can promote improved

responses and outcomes for individuals whose health is deteriorating, getting them the right help at the right time. RESTORE2 can also support providers in their decision making, should there be a concern regarding neglect or acts of omission.

Want to know more?

Somerset County Council's Adult Social Care service has created a **webpage to hold all training resources for Care Home Staff**. This is the **'One Stop Shop'** for Care Home Staff to access training & resources.

Thank you to NHS Somerset Clinical Commissioning Group for providing this article

New NHS Rapid Read Documents

County Lines: An Introduction

A Rapid Read guide has been created giving information about County Lines. This is a quick guide to finding out what County Lines is, the effect it has, signs to look out for and Crimes associated with it.

- **View the County Lines: An Introduction rapid read**

County Lines: Coercive Internal Concealment

This guide provides a definition of Coercive Internal Concealment as well as common terms, the health and safeguarding implications, as well as legal considerations.

- **View the County Lines: Coercive Internal Concealment rapid read**

New online course for victim-survivors

This course has been developed by the SARSAS (Somerset and Avon Rape and Sexual Abuse Support) and is based on a self-help guide and is designed to help victim-survivors understand and process their own personal reactions to experiences of sexual violence.

The course includes information on the impact of trauma on the brain and how this can affect thoughts, feelings, reactions, and relationships.

- **Enrol for the course**

Somerset Open Mental Health Website Launched

Open Mental Health has launched a new website providing a platform where people in Somerset can seek advice and find useful information, about the services the alliance can offer to support those struggling with their mental health.

Open Mental Health is an alliance of local voluntary organisations, the NHS and social care, Somerset County Council, and individuals with lived experience of mental health. Ensuring that people in Somerset get the right support when they need it most.
You can visit their website at www.openmentalhealth.org.uk

- **Visit the website**

Business Manager Blog


Stephen Miles SSAB Business Manager

Spring has most definitely sprung here in Somerset, and springing in comes our latest newsletter, if about a month later than I intended as a result of other work I've been supporting. We're also starting to move to our 'new normal' way of working with our first 'in-person' Board meeting since February 2020 scheduled for June – it will certainly be good to see colleagues from partner organisations who (rightly, as when you're collectively responsible for supporting some of the most vulnerable people in our society you don't take unnecessary risks) I've only spoken to remotely for the last two years. However, life hasn't stopped in that time, with colleagues such as Val Janson who was NHS Somerset CCG's representative on the Board retiring, and only today I've received two emails from colleagues to say that they will shortly be moving on to pastures anew, and I wish them all the very best for the future

On page 3 you can read about the training on suicide prevention that has been made available from Every Life Matters as a result of work by colleagues at Public Health Somerset. As many of you may be aware, much of the work around suicide prevention in Somerset was for many years led by Louise Finnis, who sadly passed away just a few days after retiring at the end of April. I'd worked with Louse on and off since 2008, and will never forget her humanity, enthusiasm, ability to persistently challenge when she didn't think that people were doing enough, and advocacy for anyone who had experienced metal ill-health. The training will have been one of the last things Louise promoted before her death, and I urge everyone who can take part to do so because every life really does matter.

We held the first of what we hope will be a series of webinars covering different adult safeguarding topics in March which you can read more about on page 3. On this first occasion it was on Professional Curiosity, which was one of the most frequently requested topics that we had received requests for. I am particularly thankful to colleagues from NHS Somerset CCG and Somerset County Council who represented on the day, as well as those from Somerset NHS and Yeovil Hospital Foundation Trusts that helped us pull it all together, although I do commiserate those of you who not only had to put up with my voice for the section which I was due to present, but also the start and end after a last minute change to presenters due to illness! Our Learning & Development and Policy & Procedures Subgroup met at the end of May to look at the feedback from the webinar and began planning or next webinar, as well as what will be our first in-person conference in almost three years in March 2023

We have recently made a new permeant appointment, with Tina Kerley starting with us last week to support the work of the Board going forwards, which should not only mean that we can keep to our schedule of things like newsletters, but also increase our overall communication activity which I'm really conscious has dropped in recent months. In terms of ongoing work, we are working to finalise a number of Safeguarding Adults Reviews over the coming months, which will collectively represent significant learning for the local system, as well as our Annual Report all of which we will be circulating to newsletter subscribers on publication.

Thank you to everyone who has, and continue to, support the most vulnerable people in our society as well as the work of the Board, and I look forward to continuing to work with you over the coming year.

Learning Lessons

Local: 'Kathleen' Joint Death Review

Background

Following referrals to both the Safer Somerset Partnership and SSAB that did not meet the criteria for either a Domestic Homicide Review or a Safeguarding Adults Review, it was agreed that it would still be beneficial for an independently chaired review to take place to explore the learning for how agencies worked together for a period of approximately six years prior to Kathleen's (pseudonym) death. This was due to initial fact finding identifying extensive involvement by many agencies that related to domestic abuse and vulnerability.

The final report will not be published. However, a one page briefing has been produced which identifies the following key learning from the case.

Kathleen was 75 years old and her adult grandson lived with her. She had some long-term health conditions, and experienced domestic abuse from her grandson. There was also alleged domestic abuse between her grandson and his same-sex (ex) partner.

Key considerations for practice identified in the review

1. **Professionals To Understand Impact of Domestic Abuse on Family Members**. It is clear that the domestic abuse between her grandson and his (ex) same-sex partner led to Kathleen being also at risk (due to him living with her). Kathleen also expressed fear to professionals about this, but this wasn't taken seriously. Kathleen was asked about support networks, but no information was recorded about other family members and their level of awareness of her grandson's impact on her. It is therefore import and that professionals discuss family support with people about whom safeguarding concerns are raised.
2. **Robust System To Identify When MARAC Referrals Overlooked.** Professionals should escalate and follow up on high risk domestic abuse cases, as part of an improved robust system being put in place to identify when MARAC referrals are overlooked, (overseen by Somerset Domestic Abuse Board).
3. **Agencies to understand impact of coercion on legal interventions.** Professionals should always clarify the current status of any civil/criminal orders. Where a victim has applied to courts independently to remove an order, the impact of coercion on victims, and impact on level of risk they face, should be recognised.
4. **Professionals to ensure safe to close cases.** Professionals should not close cases of domestic abuse victims, without engage with relevant partner agencies to advise them of this and ensure some safety plan can be put into place.
5. **Professionals to complete DASH risk assessments whenever circumstances change.** The risk identified by a DASH is only ever a "moment in time", and should be repeated when circumstances have, or are likely to, change imminently which could increase risk to the victim of domestic abuse.
6. **Increase skill and confidence in completing DASH assessments in familial relationships and document conversations.**
   - Practice completing DASH assessments with colleagues to increase confidence.
   - Fully record in your files, when conversations about domestic abuse have taken place

7. **Professionals to use the SSAB "What to do if it's not safeguarding" guidance when required.** This guidance can be used for multi-agency information gathering, case discussions, and action planning where it has been determined that an adult does not require an adult safeguarding enquiry under Section 42 the Care Act (2014)

Further information

- **Download the seven-minute briefing**

Local: 'Diane' Domestic Homicide Review

Diane (pseudonym) was in her mid-fifties and had recently separated from her husband. She had no children and died as a result of murder by her estranged husband (Jeremy). There had been no reports of domestic abuse to any professionals/ agencies beforehand.

Safer Somerset Partnership
Feel Safe, Be Safe

Key considerations for practice identified in the review

1. **Professionals to explore clients disclosing "relationship difficulties".** Jeremy had disclosed having "relationship difficulties", but these were not explored. Domestic abuse is not necessarily labelled as such by victims and perpetrators, and so professionals should be alert to other descriptors and discuss/respond accordingly.
2. **Professionals to be alert to how rurality affects disclosure.** Diane lived in a rural location that meant disclosure of domestic abuse may have been very difficult, given the tight-knit community she lived in. If professionals are in contact with clients in very rural areas, they should be aware of the additional barriers victims face, and help alleviate these fears of disclosing.
3. **Professionals to consider how mental health issues and alcohol misuse are linked to domestic abuse.** Although Jeremy had a history of depressive symptoms and low mood combined with alcohol misuse, it's not clear these were understood as risk factors, despite "relationship issues" being known.
4. **All professionals to improve understanding of coercive control.** Friends of Diane suggested that she was experiencing coercive control, but didn't label it as such. As noted in point 1 above, exploration by professionals of disclosures of "relationship difficulties" should be made.
5. **Professionals to consider risk and impact of separation on victim.** As Diane sought to look after herself more, and eventually left her husband, her risk increased. Although there was limited contact by agencies with Diane or her estranged husband. The review panel were of the view that separation is not always recognised as a trigger factor for domestic abuse/ homicide.
6. **Professionals to better understand economic abuse as a form of domestic abuse.** The Domestic Abuse Act now defines this as an abuse type and is wider than financial abuse. Do you have a clear understanding of the signs and how to help?
7. **Increase in professional curiosity especially where victims and perpetrators are living in rural locations.**
    - The National Rural Crime Network found in their 2019 report, that rurality and isolation are deliberately used as weapons by abusers.
    - Agencies need to have a greater degree of professional curiosity in order to identify victims and perpetrators and refer to specialist services.

Further information

- **Read the Review (DHR 029)**
- **Download the seven-minute briefing**

Local: 'Penny' Domestic Homicide Review

Penny (pseudonym) was around 40 years old and had recently separated from her husband. Penny had two children and died as a result of suicide. There had been a history of domestic abuse in her relationship, including a criminal prosecution

1. **Professionals to understand impact of domestic abuse on mental health**. Several agencies had contact with Penny but did not appear to find out how she was feeling and coping. Professionals should complete training to understand the link between mental health and domestic abuse and have a thorough understanding of suicide prevention.
2. **Professionals to improve understanding of coercive control**. The intimidation, shaming, and threats (especially around child contact) were not always understood as being domestic abuse. The signs of coercive control and its impacts need to be better understood and acted upon.
3. **All professionals to improve understanding of trauma and domestic abuse**. Penny experienced several traumas including, trying to find somewhere to live, child contact and financial issues. These are all effects of domestic abuse and can impact negatively on a victim's mental health.
4. **Professionals to better help victims access services.** In Penny's case she needed help completing forms to access services, and specialist information. When a victim is experiencing multiple traumas, what would ordinarily be a simple task may prove challenging.
5. **Professionals to consider risk and impact of separation on children and victim**. A breakdown of a relationship can have a negative impact on children, with them unwittingly being used by the perpetrator to coerce and manipulate the other parent (victim) even after separation. Professionals should be alert to this and consider the risks posed by the perpetrator to any children and also the victim.
6. **Professionals to better understand economic abuse as a form of domestic abuse**. The Domestic Abuse Act now defines this as an abuse type and is wider than financial abuse. Do you have a clear understanding of the signs and how to help?
7. **Where children of a domestic abuse victim attend an educational establishment, professionals should work with schools as part of the multi-agency response**. In this case, the school of one of Penny's children demonstrated good practice in supporting a victim and family of domestic abuse. But other agencies either had no or limited involvement with the school, so their information was held mainly in isolation.

Further information

- **Read the Review (DHR 028)**
- **Download the seven-minute briefing**

You can read other DHRs and case summaries published by the Safer Somerset Partnership **here**

National: Manchester Carers Thematic Review

Background:

This thematic learning review was commissioned in Spring 2021 by the Manchester Safeguarding Partnership (MSP), to understand and learn from the events surrounding similar cases where an adult with care and support needs, who was suffering with physical illness, poor mental wellbeing and significant challenges to their mobility and independence, sadly died whilst under the active care of staff working across the Manchester health and social care system.

None of the adults with care and support needs in the 3 cases that have been considered had a learning disability or a diagnosed cognitive or neurological condition that may have impacted on their decision-making and judgement. There were two key similarities in the remaining 3 cases that form the backbone of the review:

1. In all three cases, a family carer was providing significant levels of care and support to an adult family member that shared their home.

   The review notes that caring for a family member with significant health and/or social care needs can be an extremely emotionally and physically demanding experience. Whilst many carers do this willingly and without complaint, sometimes over many years, the impact on their own health, wellbeing and capacity or ability to continue caring can go unrecognised, by themselves and others. When the caring role is very intensive, the family carer may only be able to leave their home for essential reasons, such as food shopping or for medical reasons, which can also lead to social isolation. In one of the cases the extent of input by the family carer was considered to be between 35-50 hours of care per week, in another it was in excess of 100 hours - both included waking overnight to provide care.

2. In all three cases, the adult requiring care and support also showed a pattern of behaviour that implied self-neglect.

   In the cases under review, the most prominent issue was a persistent refusal, directly and indirectly, of offers of medical/clinical care, social care and in some instances aids and adaptations that could assist with mobility and safety around the home. This included declining emergency transport to hospital/admission, not allowing entry to health and care professionals who had arranged to visit the home, declining assessment, and not attending routine GP or outpatient appointments designed to manage and monitor long-term health conditions. In 2 of the cases, it is apparent that there was an abstract mistrust and fear of hospital admission and/or long-term care, coupled with a very strong desire to receive care and support in the family home from a family member. In one of the cases, being financially assessed (in the case of social care) and needing to self-fund or part fund home care was also a barrier. Although this refusal of support was typically initiated directly by the adult needing support, there are indications of the family carer appearing to 'go along' with the wishes of their loved one. It was not possible to fully understand in the course of this review whether the family carers fully agreed with these decisions or felt compelled to respect the position of their loved one, perhaps against their better judgement. The dynamics between the carer and the adult needing support, and the degree to which the carer felt empowered (and was actively empowered by others) to state their own needs and views, was an important feature of this review. Lack of self-care, including poor personal care, failing to eat and drink adequately to sustain good health and avoid malnutrition/significant weight loss, and declining to take prescribed medication were also features of self-neglect present in all 3 cases that form this review.

Key thematic learning points identified in the review

Key learning points from the review are highlighted below, collated under the 4 safeguarding principles that the review considered:

1. **Empowerment**
   - Actively seek to engage the adult with care and support needs, and their family carer(s), to hear and understand their perspectives
   - Explicitly consider using psychologically informed practice, alongside existing
   - strength-based practice, when supporting adults who show self-neglecting or

- other complex behaviour
- Show due regard for the carer as an expert in the care of their loved one
- Actively direct family carers to support that will help them to manage their own
- physical and mental wellbeing
- Support informed but realistic choice and control, especially in cases of self-neglecting behaviour, but balance this carefully with duty of care and safeguarding

2. **Prevention**
   - All practitioners should take active responsibility for earlier recognition and
   - intervention/support for family carers
   - Adopt a more robust and enquiring approach to identifying carer stress, risk of
   - carer breakdown, and reviewing the carer's capacity to provide the level and
   - type of care required
   - For adults whose needs are complex, for example, they feature physical and mental health/wellbeing and disability/mobility issues, initiate early and more joined up care co-ordination - with the involvement of the carer
3. **Protection**
   - Continue to develop greater awareness and support practice judgements in instances where adults with known care and support needs repeatedly do not attend or do not engage with healthcare or social care services, that is, supporting professional and practice judgements to determine at what point nonengagement should become a safeguarding concern
   - Adopt more robust management of safeguarding alerts, ensuring that they are reported and investigated
   - Share the challenges of complex health and care scenarios within supervision, through agency escalation and with other professionals, and agree co-ordinated action, for example, via multi-disciplinary team meetings (MDTs
   - Show explicit consideration of the carers ability to meet the level of care needed, including their ability to undertake care tasks that involve clinical/medical monitoring – discuss with the carer regularly to gauge the potential for unintentional neglect
   - Be aware of the potential for family carers' needs to be overlooked by the person they are caring for, which may sometimes lead to unhealthy emotional control over the family carer which reinforces their isolation
4. **Partnership**
   - Take a whole family approach
   - Adopt truly multi-disciplinary practice, by actively initiating greater levels of discussion/consultation and collaboration with other agencies and practitioners, rather than 'internal' team discussion

Further information

- **Read the thematic review**

Learning from the SSCP

We encourage our readers to have a look at the latest Learning Bulletin from the Somerset Safeguarding Children Partnership (SSCP), **'Things You Should Know',** which in their December edition includes information about their new guidance on 'Effective Support for Children and Families in Somerset' and learning from a recent case in which services worked together to safeguard a toddler living with a mother experiencing domestic abuse.

SSCP Safeguarding Children Forum Week: 13th-17th June 2022

The SSCP are running a week of FREE online events to promote stakeholder engagement and learning across the Somerset Safeguarding Children Partnership in the week commencing 13th June 2022.

The week will be focusing on Somerset children and young people's mental health and well-being - a key priority for both the SSCP, and children and young people across the county.

Book your free place via the links below:

- **Monday 13th June (2-3.30pm) – Working Together: Improving Children & Young People's Mental Health**
- **Tuesday 14th June (10am-12pm) – Supporting Mental Health: Now**
- **Thursday 16th June (1.30-3.30pm) – What We Think: Children & Young People on Mental Health**
- **Friday 17th June (10-11.30am) – Supporting Mental Health: Next**

Local & National News and Information

- **Metro: 'I thought I was too streetwise to fall for an internet scam – then it happened to me'**
- **The Clewer Initiative: 4 Signs that your local hand car wash could be exploiting their workers.**
- **Ann Craft Trust announces theme for Safeguarding Adults Week 2022 – Responding to Contemporary Safeguarding Challenges**
- **Action Fraud: Spot the signs of cryptocurrency fraud**
- **Politics Home: 'STOP SCAMS UK 159 Short Code Number Generates 75,000 Calls'**
- **Avon & Somerset Police: GPS trackers to be made available as part of Dementia Safeguarding Scheme**
- **The Home Office: Tackling Domestic Abuse Plan launched**
- **Action Fraud: Payment diversion fraud**
- **Ann Craft Trust: Safeguarding Adults at Risk Policy or Safeguarding Adults Policy?**
- **Somerset County Council: Somerset support for Ukraine**
- **Nice Guideline: Integrated health and social care for people experiencing homelessness**
- **National Cyber Security Centre: Take your email security to another level**
- **HM Government: Consultation launched on changes to the MCA Code of Practice and implementation of the LPS (closes 07/07/2022)**
- **Avon & Somerset Police: Dementia missing person safeguarding scheme celebrates its seventh year**
- **Professor Michael Preston-Shoot: Using Learning for System Change**
- **Action Fraud: Find out if one of your online accounts might have been compromised via haveibeenpwned.com**
- **Blue Apple Theatre: Free video and educational resources to protect vulnerable people from abuse and exploitation**
- **NICE: Creating a safeguarding culture - A quick guide for registered managers of care homes**
- **Avon & Somerset Police: Support for victims of sextortion**
- **Avon & Somerset Police and Crime Commissioner and team secure over £100k additional funding for sexual violence and domestic abuse services in Avon and Somerset**
- **SCIE: What are Liberty Protection Safeguards?**

- **Independent Age quiz: How clued up are you when it comes to home safety?**
- **Ann Craft Trust: An Introduction to Digital Safeguarding (Promoted as part of Safer Internet Day, February 2022)**
- **Department of Health and Social Care: Revisiting Safeguarding Practice**
- **Preventing charity fraud: Donating through crowdfunding sites**

Your Adult Safeguarding Experience Feedback Form

Somerset County Council's Adult Safeguarding service would like hear feedback not just from people who have been supported by adult safeguarding services, and their carers, but also from those who advocate or support them on a professional basis.

The forms below have been developed with support from Healthwatch Somerset, and Somerset County Council's Adult Safeguarding service will offer support to people in completing these if they are unable to access electronic versions.

- **Adult Safeguarding Service Questionnaire for adults who have been supported by safeguarding services**
- **Adult Safeguarding Service Questionnaire for carers, relatives or friends**
- **Adult Safeguarding Service Questionnaire for Advocates, IMCAs and Providers)**

The information received by the County Council will be reported regularly to the Somerset Safeguarding Adults Board.

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**.

Somerset Survivors: e-Learning (free)

- **Professional e-Learning modules on domestic abuse**
- **Domestic Abuse and Modern Slavery e-Learning modules for the public**

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/**

SSAB Board Meetings

From October 2019 onwards the Board has been publishing the minutes of Board meetings in full, with the exception of redacting confidential information relating to an individual (for example where someone has spoken about their experience of being safeguarded). Notes are published on the **SSAB Website** retrospectively following sign-off at the next meeting.

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