Lambeth

Adult Safeguarding

Lambeth Safeguarding Adults Board
Masterclass Series

Health Innovation Network South London

Safeguarding Adults in Lambeth

Lambeth together

// Contents

Introduction	3
Coercion and control with ‘capable’ adults	4
Self-Neglect and Safeguarding Adults	9
Making Safeguarding Personal	15
Safeguarding Adults Reviews	20
Modern Slavery	26

This booklet is dedicated to the memory of **Chris Guthrie**. Chris worked within the London Borough of Lambeth’s Communications team and was an invaluable source of support to colleagues in Adult Social Care. Chris was committed to improving community engagement and partnership working and helped coordinate each masterclass event, ensuring that everything ran smoothly on the day.

Disclaimer

Please note: the section on each masterclass is a summary (not verbatim) of the input and discussion and is not intended to be nor should be relied upon as legal advice.

// Introduction

Siân has over 40 years' experience in social work, both with children and adults. Latterly and prior to her work as an Independent Consultant, she was Director of Health & Social Care for the City of Cardiff. She has significant experience in both housing and social services in London and the West Country and has served on the Boards of three NHS organisations. Siân retired from full time employment in 2015 and is currently the Independent Chair of the Adult Safeguarding Boards for Lambeth and Devon, and is a Care Commissioner for the Government of Jersey

By Siân Walker, Independent Chair, Lambeth Safeguarding Adults Board

Safeguarding adults is about empowering and protecting adults with care and support needs who are unable to protect themselves. We all have a duty to support and protect people so they can live in safety, free from harm, abuse and neglect and importantly can determine for themselves how they would like such support to be offered.

The Care Act 2014 is part of a much wider legal framework within which practitioners in all agencies must operate to ensure that vulnerable people with care and support needs are empowered. The Care Act determines how local Safeguarding Adults Boards can bring together partnerships from across the public and community sectors; to work together, align policies and practice, and ensure that services to protect and support people can operate in a way which makes sense to citizens in our communities. The Lambeth Safeguarding Adults Board works effectively to achieve this and acknowledges that to ensure services work together seamlessly, staff working within those services should have learning and development opportunities together.

This series of Safeguarding Masterclasses evolved from a successful series initially provided in Kingston in 2017. Lambeth's series ran between September and December 2018. It provided participants with expert knowledge from highly experienced speakers of national renown, covering a wide range of issues. The key content, learning and discussion from each event, is enclosed within this booklet.

The series facilitated the sharing of experiences across partners and also across borough boundaries. The latter is extremely important as many of the Board partners, particularly Police and NHS work across local authority boundaries, so it is important to ensure there are synergies in practice and the opportunity to learn and network together. Participants attended from the boroughs of Southwark, Richmond and Wandsworth, as well as from a wide range of NHS providers servicing this sector of South London. Attendees also came from a wide range of organisations including Police, London Fire Brigade, local care providers, third sector organisations and primary care services.

I would like to thank the Masterclass presenters for leading such informed and engaging sessions and the participants for sharing their experiences, questions and insights. I would also like to thank the South London Health Innovation Network for their funding which enabled us to commission this Masterclass series, and for the support of Kathy Tyler. Finally this series of Masterclasses would not have been possible without the support of the 'Lambeth Together' project. And I would particularly like to thank Janna Kay and Ceri Gordon, who work to support the Lambeth Safeguarding Adults Board, for all their incredible hard work in bringing this together.

Siân Walker
LSAB Chair

// Coercion and control with 'capable' adults

***Speaker**: Alex Ruck Keene, Barrister, 39 Essex Chambers, Wellcome Trust Research Fellow, and Lecturer at Dickson Poon School of Law, King's College London; Visiting Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King's College London*

The first in the masterclass series was led by **Alex Ruck Keene**, a barrister, writer and educator widely regarded as a leading expert on the Mental Capacity Act 2005. Highly knowledgeable about both mental health and mental capacity law, he is involved in policy work and developing legislation in area, providing specialist advice and representation as well as delivering training to front line professionals.

The session explored the methods available for professionals to address coercive or controlling behaviour in the context of adults at risk. A particular focus was on the capability of individuals to make decisions in their own best interests and when coercive behaviour might impact on that capability.

During the session, Alex Ruck Keene set out the various frameworks available, their applicability to different situations, the constraints and considerations around each, and how best practitioners should approach them for a successful outcome. Attendees also examined a case study in detail and shared reflections on professional experience and ideas for how they might address their own cases differently in light of what they had heard.

That there is no single legal framework or act that covers vulnerable adults as a whole was a reoccurring point during the masterclass. Practitioners, therefore, need to be aware of the range of laws and tools that can be applied. Criminal offences that can be brought against people who are controlling or coercing adults include those falling under Section 76 of the Serious Crime Act 2015 and the Modern Slavery Act 2015, a particular focus of the session.

The issue of capacity is a key factor in deciding the most appropriate course of action. When a person can be shown to lack capacity to make a particular decision, the Court of Protection can be used which is designed to allow for a range of interventions and remedies to protect incapable adults.

Where incapacity cannot be evidenced, orders to protect adults at risk may be obtained under the inherent jurisdiction of the High Court but can be more difficult to secure. Determining capacity is a complex issue that was explored in detail throughout the masterclass.

Section 76 of the Serious Crime Act 2015

Section 76 of the Serious Crime Act 2015 defines a new offence of controlling or coercive behaviour in an intimate or family relationship, with a punishment of up to five years imprisonment. The offence closed a gap in the law around such patterns of behaviour, recognising that coercive control underpins domestic abuse. It has the effect of taking away the victim's sense of self, minimising their freedom of action and violating their human rights. Around a quarter of safeguarding adults work relates to domestic abuse.

The offence of controlling or coercive behaviour should be addressed within an overall framework of Adult Safeguarding and Violence against Women and Girls; given that these crimes are primarily committed, but not exclusively, by men against women within a context of power and control. The Code for Crown Prosecutors recognises the gendered patterns and dynamics involved in these cases, stressing the need for this to be understood in order to provide an appropriate and effective response. This does not, however, neglect abuse towards men or abuse perpetrated by women.

The offence only applies in familial relationships or where people are in/have been in an intimate personal relationship. Therefore it is not applicable when the control

or coercion is exerted by a tenant, a lodger or a friend.

Controlling behaviour is defined as acts designed to make a person subordinate or dependent by isolating them, exploiting their resources, regulating their everyday behaviour, or depriving them of the means needed for independence, resistance or escape.

Coercive behaviour is defined as a pattern of threats, assault, humiliation, intimidation or other abuse that is used to harm, punish or frighten.

The types of behaviour associated with coercion and control may or may not constitute a criminal offence in their own right. Examples may include (noting that this is not an exhaustive list):

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- Depriving them of access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise them
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Threats to reveal or publish private information

A successful prosecution would need to prove that the behaviour has had a deleterious effect on the victim. This could include serious alarm or distress, fear of violence or an adverse impact on day-to-day activities. Signs of a substantial effect on the victim may involve:

- Stopping or changing the way they socialise
- Physical or mental health deterioration
- Attendance record at school
- Putting in place measures at home to safeguard themselves or their children
- Changes to work patterns, employment status or routes to work

There is a defence if the defendant believes they were acting in the victim's best interests and can show that their behaviour was objectively reasonable. It should be noted that best interests as a defence do not

need to align specifically with the definition of best interests in the Mental Capacity Act 2015 and that threats of violence can never be considered objectively reasonable.

Since it came into force at the end of 2015, few crimes of coercive control were recorded in its early implementation, and even fewer prosecuted. This shifted in the past year, with double the number of cases recorded in the UK in 2017-18 than in the previous year. However, it is a tool that could, and potentially should, be used more often.

Limitations of offences

An obvious limitation of these offences, for safeguarding purposes, is that they are retrospective; prosecutions cannot be brought until after the offence has occurred. However, the existence of the laws and the threat of prosecutions can sometimes be used to bring an end to controlling or coercive behaviours.

These offences can also be difficult to prosecute and may require special measures in court, for example if the victim is reluctant to give evidence.

While prosecuting offences is retrospective, other routes are available to practitioners to inquire and intervene proactively when they or others, such as GPs, are concerned about an adult at risk.

Domestic Violence Protection Notices

A Domestic Violence Protection Notice (DVPN) is only applicable in limited circumstances. However, it is a useful tool to be aware of in the context of control and coercion because it can be issued even if the potential victim does not agree.

The police can issue a DVPN to anyone over 18 if they believe that person has been violent or is threatening violence towards an 'associated person'. If they co-habit, the notice can require the suspected perpetrator to leave the premises. The issuing of a DVPN triggers a process before the Magistrates Court for a Domestic Violence Protection Order. As a civil breach, it offers short-term protection to the victim, which can lead to 2 months imprisonment for the perpetrator.

Capacity and vulnerability

Taking cases to the Court of Protection is the best route where possible, because the regime has clearly defined roles and powers. However, it is only applicable where the adult concerned lacks mental capacity to make the relevant decision for him or herself.

Determining capacity can be very complex. It must be remembered that it is logically meaningless to say that someone simply lacks capacity. A person's lack of capacity can only be argued in relation to one or more specific decisions, for example where they live, who they live with, where they go or how they spend their money.

The Court of Protection only has a role if the root cause of the incapacity is an impairment or disturbance of the mind. When a person has the capacity to make decisions but is at the mercy of a third party, then the Court of Protection has no role and the case would fall under the inherent jurisdiction regime of the High Court.

Some Court of Protection judges are High Court judges and it is possible to apply for a complex case to be considered by such judges under

both regimes, with the first point to be decided being which jurisdiction the case should be heard under. However, practitioners will want to approach the case knowing which route they are seeking so that they can be fully prepared.

Alex Ruck Keene noted that it is preferable to find – wherever legitimately possible – that an adult at risk of coercion or control lacks capacity to take relevant decisions (such as where they live), since it allows for a wider range of decisions to be taken in the name of their best interests. This was stated with the proviso that this step should only be taken in the best interests of an individual if it is designed to ensure that they gain or regain capacity and their wellbeing is preserved. The ethical basis for a capacity assessment in complex cases of coercion and control needs to be justified by a clear understanding of what is being done to secure that person's autonomy.

The Court of Protection

The Court of Protection was created under the Mental Capacity Act 2005 and has jurisdiction over the property, financial affairs and personal welfare of people who it judges to lack mental capacity to make decisions for themselves.

To get before the court, practitioners need to provide evidence to justify a reasonable belief that an individual may lack capacity in the relevant regard. This can include whether they have the capacity to take part in necessary enquiries. The evidence could be that a practitioner has been unable to see an individual because they have been denied access by a third party.

The court is available 24 hours a day, every day of the year, and it is possible to get in front of the court on limited evidence, but there must be a proper basis for making an application, taking into account the urgency and gravity of the situation. A thoroughly documented forensic approach is crucial, particularly if the court is going to be asked to take a draconian action. Once the court has intervened, it is important that practitioners continue to gather and review evidence as quickly as possible.

After an application has been accepted, the court can make orders to assess capacity particularly if professionals were blocked from accessing the individual to do this. The court has the power to require access to an individual, including for the purposes of enabling a full capacity assessment to be carried out. Proof of incapacity can be assessed by a range of professionals including a psychiatrist, social worker, nurse or occupational therapist.

In cases of potential coercion and control, the key issue for the court will be to determine if it is satisfied that the individual's decisions and choices are genuinely theirs, rather than being imposed by another, regardless of how challenging those decisions and choices may appear.

Inherent jurisdiction of the High Court

The doctrine of the inherent jurisdiction means that the High Court can hear and rule upon any matter that comes before it, unless it is limited from doing so by another rule, law or authority. It has been described as the 'great safety net' and can undoubtedly be valuable in safeguarding. However, by its very nature, the powers and actions that can be taken under inherent jurisdiction are not defined or prescribed and can therefore vary significantly from case to case and from judge to judge.

As Alex Ruck Keene pointed out, inherent jurisdiction is rarely used since it is seen as an expensive and complicated process, without clear indicators of relief that will come from it.

It does, unquestionably, recognise the need to protect people who are vulnerable since they are subject to some form of coercion or control, but appear to have capacity. In these situations, it is legally permissible to get orders directed against the perpetrator so that a safe space can be created for the victim, within which a proper risk assessment can be carried out. It is much more questionable whether the court can take these steps if they go against the wishes of the victim.

Learning points

Delegates examined a case study and shared their reflections on the case, as well as ideas for how they might address their own cases differently in light of what they had heard during the day.

Themes and learning points included:

- **Evidence and documentation are vital**
  Suspicion alone is not sufficient to take a case before the courts. Courts will expect and need to see valid and robust evidence. Complete and accurate documentation is very important. Alex Ruck Keene warned practitioners to be careful of language used in case notes and reports, as any ambiguities could be misconstrued in court. Clarity is essential, with specific examples given to back up any statements or observations.

- **Ensure that adults at risk can talk freely**
  The creation of a safe space is key. A proper assessment cannot be carried out when an individual cannot talk freely due to the presence of a controlling party. Creating opportunities for frank conversations in a safe environment is important. The courts can make orders to allow these safe conversations to take place.
- **Don't be deterred by complexity**
  Because these cases can be very difficult, they can be dropped when they could perhaps be pursued. When a person does not lack capacity, their behaviour can sometimes be put down to lifestyle choices when they are in fact being coerced or controlled. Practitioners should be aware of the range of safeguarding options available to them to assess and take action where appropriate.
- **Focus on empowerment**
  Empowerment is the first principle of safeguarding in the Care Act 2014. Understanding and taking account of what the individual wants must be the priority. Practitioners and the courts have considerable powers to protect people, but this comes with great responsibility.

Comments from participants

"The session was excellently presented and I am very grateful to have access to this level of expertise. It was highly relevant and applicable to my social work role. I found it useful to go over the principles of the Mental Capacity Act and discuss its complexities through the case scenarios, as this is something that becomes quite woolly over time."

"I now have a thorough understanding of the legal arguments and legislation on coercion and control, particularly when it comes to enabling a person to obtain a better quality of life. It helped to have general acknowledgement of the difficulties of working with the Mental Capacity Act."

"Discussions around the case study were extremely helpful, and the networking with people from multiple agencies was also much appreciated."

"The level of expertise provided by Mr Keene will now enable me to assertively challenge capacity assessments by professionals which do not tally with day-to-day experience of an individual, being from the voluntary housing sector."

Resources

39 Essex Chambers resources

Case reports, newsletters and articles

www.39essex.com/resources-andtraining/mental-capacity-law

Case law example of inherent jurisdiction and proposed domestic abuse bill

https://www.39essex.com/cop_cases/southend-on-sea-borough-council-v-meyers/

Social Care Institute for Excellence's Mental Capacity Act Directory

Information for professionals and people who may be subject to the act to help understand it

www.scie.org.uk/mca-directory

Mental Capacity Law and Policy

Aims to promote better, clearer thinking amongst lawyers, policy-makers and professionals as to mental capacity law and practice

www.mclap.org.uk

Mental Health Law Online

Internet resource on mental health and mental capacity law in England and Wales

www.mentalhealthlaw.co.uk

// Self-Neglect and Safeguarding Adults

***Speaker**: Suzy Braye OBE, FAcSS, Emerita Professor of Social Work University of Sussex, and Independent Safeguarding Adults Consultant*

Widely regarded as a leading expert in working with people who self-neglect, **Professor Suzy Braye** drew upon her extensive knowledge in the field to lead this engaging and thought-provoking masterclass. The former Head of Social Work and Social Care at the University of Sussex, Suzy Braye is esteemed for her research into adult safeguarding and self-neglect, recognised for her dedication to the most vulnerable in society.

The session explored research evidence underpinning understandings of self-neglect, with participants urged to challenge their assumptions and embrace a more nuanced, holistic approach. Attendees reviewed powerful testimonies and case studies, reflecting upon the ethical dilemmas and challenges that can arise when working with people who are self-neglecting.

What is self-neglect?

Behaviours considered as self-neglect include the following, taken to such an extent as to endanger health, safety and/or wellbeing and often in the context of refusing services that would mitigate risk of harm:

- **Neglect of self-care** – Poor hygiene and personal care, dirty or unchanged clothing, signs of malnutrition, lack of evidence of food in the home, untreated injuries or skin breakdown, poor dental care, lack of adequate hydration, deteriorating health
- **Neglect of the domestic environment** – Dirty or squalid home circumstances, infestation, hoarding (defined as 'persistent difficulty discarding or parting with possessions, regardless of value' and which affects an estimated 2-5% of the UK adult population)

While self-neglect can be associated with a number of physical and mental health conditions, there is no one overarching explanatory model. It can arise from either an unwillingness or an inability to care for oneself – or both - and indeed apparent unwillingness may mask a more hidden inability. It is best viewed as a complex interplay of physical, mental, social, and environmental factors and therefore needs to be understood in the context of each individual's life experience.

Self-neglect is usually a symptom of other problems, such as:

- Deteriorating physical health
- Onset of depression or other mental health needs
- Trauma response and/or neuropsychological impairment
- Diminished social networks and/or economic resources
- Substance misuse

Suzy Braye stressed the importance of understanding the lived experience of those who suffer from neglect of self-care. This can include a negative self-image, indifference to social appearance or an inability to self-care. When it comes to neglect of a domestic environment, the lived experience could be rooted in a traumatic childhood or earlier life-changing event or loss; hoarded objects often have positive value and bring about a sense of connection or security.

Ethical dilemmas

One of the greatest challenges when working with adults who self-neglect is when they refuse to engage or accept services. Providing support or intervention can be extremely complicated as people are often reluctant to accept support or will engage intermittently. Fulfilling ethical and legal requirements to respect autonomy and self-determination along with the duty to protect from foreseeable harm and promote dignity presents a tricky balancing act. Attendees from fire services and police to social services remarked on the

difficulties of tackling this dilemma in their respective organisations.

Suzy Braye urged participants to challenge their assumptions around autonomy and protection. Is it really autonomy when a person doesn't see how things could be different; doesn't think they're worth anything different; didn't choose to live this way, but adapted gradually to circumstances; is battling mental health, which makes self-motivation difficult; or has an impairment of executive brain function, which compromises the ability to use and weigh relevant information when implementing decisions?

And is it really protection when imposed solutions don't recognise the way a person makes sense of their behaviour; their sense of self is removed along with the risks; they have no control and no ownership of the solution; or their safety comes at the cost of making them miserable?

A more nuanced ethical approach is called for, whereby autonomy does not mean abandonment and protection entails proportionate risk reduction. Querying 'lifestyle choice' through respectful challenge and care-frontational questions can assist someone who self-neglects to see options and make more selfcare-ful choices, in effect to exercise positive autonomy. Equally, protection does not need to involve the denial of wishes and feelings or the removal of all risk. A relational approach to working with the individual, focusing on understanding their life experience and the meaning of their self-neglect, and building trust over time, can result in negotiated rather than imposed solutions.

Mental capacity

As set out within the Mental Capacity Act 2005, capacity is decision-specific and time-specific. A person lacks capacity if they have an impairment or disturbance in the functioning of the mind or brain, as a result of which they are unable to make a specific decision, i.e. are unable to understand, or to retain, or use and weigh relevant information, or to communicate their decision.

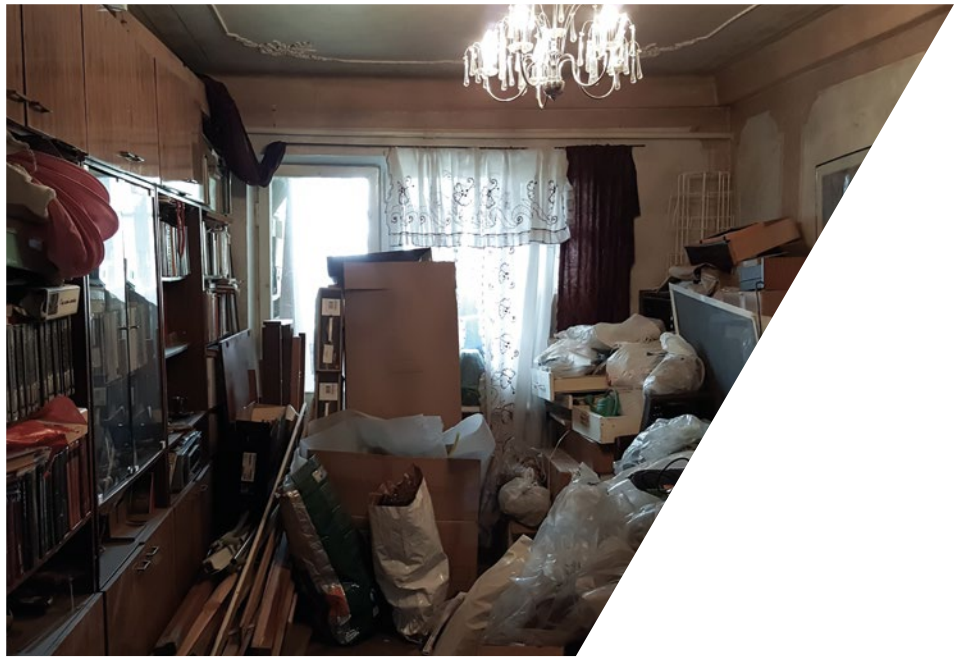
Due to the unique challenges of questioning capacity in cases of self-neglect, an enhanced understanding of mental capacity is required. It is useful to remember that capacity involves not only the ability to understand and reason through a decision in the abstract, but also the ability to do so in practice, in the moment of executing the decision it at the appropriate time.

In complex cases, practitioners must assess both a person's decisional and their executive capacity. The impact

of impaired executive brain function (arising from frontal lobe damage) must be fully understood because this can result in the person having difficulties with initiating, organising and carrying out activities in the moment, thus affecting their executive capacity. They may be able to understand, retain, use and weigh relevant information in abstract discussion, but be unable to do so at the time a decision needs to be implemented. 'Articulate and demonstrate' methods of assessment can be useful here - observing an individual carry out an activity (such as making a drink or a meal, or carrying out self-care tasks) rather than merely talking about their understanding of it. Observation can reveal difficulties that otherwise remain hidden.

Challenges in the organisational context

Organisational pressures, such as time and budget constraints, inflexible charging policies and performance management mechanisms, combined with a reluctance to engage on the part of someone who self-neglects can create 'the perfect storm'. It can be tempting, when someone says they don't want any help, to walk away and move on to the next case. Organisations must create an



organisational environment in which practitioners can work creatively with self-neglect. Doing nothing and/or closing a case before risk has been reduced to an acceptable level is not an option. Actions need to be taken to minimise harm and the chance of repeat occurrences, otherwise the adult at risk is exposed to on-going or increased harm and organisations are at risk of failing in their duty.

Key features of organisational support for effective practice by workers include:

- **Supervision and support** – Recognition of the personal impact of the work; provision of adequate support as well as challenges to decisions where needed; advice from specialists such as legal and medical advisors; efficient training and managerial oversight; legal literacy
- **Time for a 'slow burn' approach** – Workflow that permits repeat visits and longer-term engagement; cumulative picture through tracking of patterns over time
- **Shared risk management and decision-making** – Places and spaces to discuss complex cases, such as panels/forums; escalation where required

Complexities of the legal framework

Prior to the Care Act 2014, self-neglect did not figure in the definition of a 'vulnerable adult', which referred only to risk of abuse or neglect from a third party. The Care Act introduced a broader concept of adults in need of care and support, with self-neglect listed in the statutory guidance as one of the circumstances that constitute abuse and neglect, thereby bringing self-neglect within the remit of adult safeguarding.

Many cases self-neglect, including hoarding, can be responded to using a Section 9 assessment of needs and a single or multi-agency approach using the Care Act's principles of wellbeing and prevention to minimise harm.

Conditions that make it more likely an adult safeguarding enquiry under section 42 is the best response to a concern about self-neglect include, but are not limited to:

- Concern that the person is unable to protect themselves by controlling their own behaviour
- Self-neglect of personal care or health care where there is significant risk associated with
  - Care being refused
  - Wellbeing affected on a daily basis
  - Refusal to engage with necessary services
  - Poor hygiene and inadequate nutrition
  - Lack of mental capacity to manage self-care tasks
- Care of the domestic environment (squalor or hoarding) where there is significant risk associated with
  - Risk of fire
  - Urgent health and safety risks
  - Pending enforcement action creating risk of losing home
  - A vulnerable person living where facilities have been disconnected
  - A refusal for assistance to improve the environment
  - Lack of mental capacity to manage the situation

It is crucial to note that section 11 of the Care Act gives practitioners the legal authority to conduct a needs assessment without the individual's consent where (a) the individual lacks capacity to refuse an assessment and to conduct one would be in their best interests, or (b) where the individual is experiencing or is at risk of abuse and neglect (including self-neglect).

In cases of self-neglect, this is helpful for practitioners to remember as they can undertake an assessment even if this means obtaining information without the person's input.

In all actions taken under the Care Act 2014 to assist and support an individual who is self-neglectful, it is advisable to ensure that mental capacity is assessed in line with the requirements of the Mental Capacity Act 2005. Where capacity in relation to relevant decisions is lacking, there is a duty to ensure that decisions are made in the individual's best interests, again observing the Mental Capacity Act's requirements on best interests decision-making. In complex cases, application to the Court of Protection may need to be considered to assist with determining and implementing best interests decisions.

Legal processes

Where a person has mental capacity in relation to relevant decisions but there is significant level of risk, further legal processes can be considered compel an individual to remove risk, ensure protection or permit service access. There is a very fine balance between the rights of the individual and the rights of others who have been affected by their behaviour, particularly in cases of hoarding. Practitioners must work alongside colleagues in Mental Health Services, Housing, Environmental Health, Fire and Rescue Services, the Police and Legal Services to determine and agree the best legal options to pursue.

Applicable legal options may include:

- Mental Health Act 1983 to secure admission to mental health hospital of an individual with a mental disorder of a nature or degree that warrants such admission, where it is necessary in the interests of their own health or safety or for the protection of others
- Environmental health legislation (Public Health Act 1936, Prevention of Damage by Pests Act 1949, Environmental Protection Act 1990)
- Housing legislation (Housing Acts 1985 and 1988, Building Act 1984, Housing Act 2004)
- Anti-social behaviour legislation (injunctions under the Anti-Social Behaviour, Crime and Policing Act 2014)
- Fire safety provisions (Regulatory Reform (Fire Safety) Order 2005)
- Animal welfare legislation (Animal Welfare Act 2006)
- Inherent jurisdiction: the power of the High Court to make declarations and set in place protective measures where someone (albeit with mental capacity) is believed to be under constraint or subject to coercion or undue influence

It is important to know when you have the power to act and when you have a duty to do so. The first step will always be to try to gain the consent of the person being affected and the acceptance of necessary services to meet their needs.

Interagency working

Suzy Braye highlighted interagency working as a pivotal aspect of best practice when it comes to cases of self-neglect. Silo working, with agencies operating on uncoordinated parallel lines; failures of communication and information-sharing; lack of leadership and case coordination; absence of challenges to poor service standards; absence of safeguarding literacy; absence of legal literacy; or collective omission of 'the mundane and the obvious' all contribute to poor interagency cooperation.

Robust interagency working entails the following:

- **Shared strategic ownership and understandings** – Interagency governance
- **Clarity on roles and responsibilities** - Referral pathways; commissioning priorities; interagency forums for shared risk management
- **Turning strategy into operational reality** – Training, supervision, support; space for relationship-based work; case coordination and leadership

Effective practice is best supported organisationally when strategic responsibility for self-neglect is clearly located within a shared interagency governance arrangement such as the SAB, whose statutory function (Care Act 2014, section 43) is to coordinate and ensure the effectiveness of agencies to meet the objective of helping and protecting adults with care and support needs who are experiencing abuse and neglect. Agencies should share definitions and understandings of self-neglect, with interagency coordination and shared risk-management facilitated by clear referral routes, communication and decision-making systems. Longer-term supportive, relationship-based involvement should be viewed as an ideal pattern of work amongst agencies.

Training and support should be offered to support practitioners so that agencies can constructively engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice.

Knowing, Doing and Being

Participants in the masterclass were provided with a simple, effective framework for working with people who self-neglect, summarised as follows:

- **Know**: the person, their life history; the significance to them of their behaviours
- **Be**: patient, persistent, compassionate, respectful, human
- **Do**: skilfully balance hands-off / hands-on approaches; exercise proportionality; recognise the impact; be practical and value small steps; decide with others when enforced intervention becomes necessary

Learning points

Detailed case studies were reviewed in groups and attendees shared their experiences and ideas for putting what had been discussed into practice. Themes and learning points included:

- **Seek to understand the meaning behind a person's behaviour**

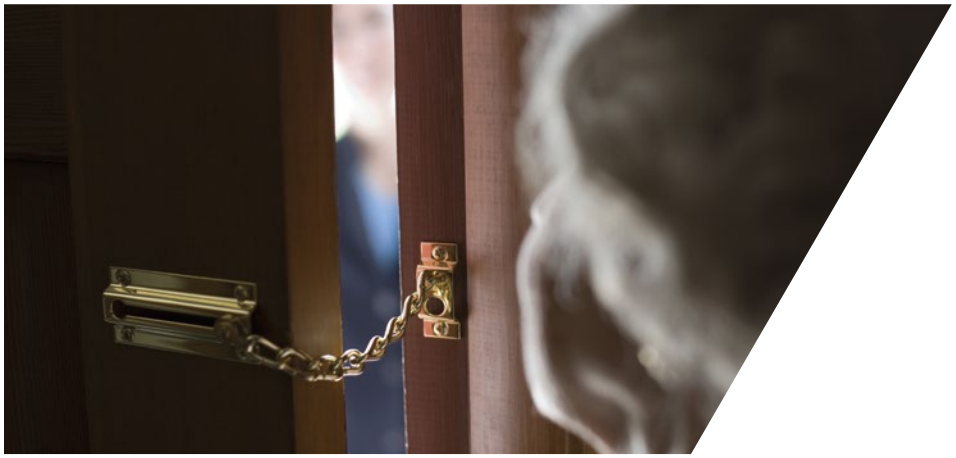
  Building rapport and trust with people who self-neglect is crucial. Participants reflected on the need to empathically understand the meaning and significance of the self-neglect, taking account of the individual's life experience. Working patiently at the pace of the individual is also important, knowing when to make the most of moments of motivation to secure changes. Open communication about risks and options was noted, with practitioners being equipped to ask the difficult questions.

- **Focus on relationship**

  Although it takes time to develop, action situated within relationship-based practice is the optimal approach when dealing with cases of self-neglect. Interventions are best delivered in relationship, where emotional connection and trust have been established. To build these, participants noted the importance of respectful and honest engagement with the individual, and the value of practical input that fits with the individual's perception of their needs.

- **Work with flexibility and persistence**

  Flexibility is needed when thinking about how family members and community resources can contribute to interventions, along with building on relationships and networks that are already in place. Working proactively and persistently to engage and coordinate agencies with specialist expertise was also noted as a priority, contributing towards the fostering of shared goals.



- Good practice indicators for practitioners
  - Understand the history, relationships and life events of a person who self-neglects
  - Focus on family interactions
  - Undertake a robust risk assessment
  - Pay attention to the nuances of mental capacity
  - Undertake proactive responses to service refusal when questioning lifestyle choice
  - Use care-frontational questions
  - Carefully balance autonomy and protection, setting aside assumptions that living conditions are a 'lifestyle choice'
  - Remain involved through persistent care
  - Think beyond the silo and include other organisations
- Good practice indicators for organisations
  - Accessible guidance available for staff
  - Effective staff support and supervision
  - Managerial oversight for significant case decisions
  - Culture of challenge and escalation within the organisation
  - Workflow that permits longer-term engagement
  - Structures that promote interagency working
  - Support to develop legal literacy amongst staff
  - Support for full consideration of legal options

Comments from participants

I found the session to be extremely engaging, with Professor Suzy Braye an excellent speaker. There was a great balance of case study examples, legislation and personal workplace expertise. Service user voices were meaningful, with the case studies on hoarding particularly inspiring."

As a complete beginner in adult safeguarding, I found the masterclass to be very interesting. It was good to learn about best practice in cases of self-neglect, and also to interact with people from other agencies."

I learnt about the need to spend more time with individuals who self-neglect, even if this takes weeks or months. The group exercises also enabled me to gain a better understanding of hoarding and the emotional effects of self-neglect."

I have a better appreciation of thinking more flexibly about capacity assessments as well as how to approach multi-agency working. Having people from multiple professional backgrounds and agencies in attendance was really helpful for case study discussions, such as care providers, occupational therapists, police and fire services."

Resources

Social Care Institute for Excellence

Access research, reports and findings on self-neglect from the work of Professor Suzy Braye, Dr David Orr and Professor Michael Preston-Shoot

https://www.scie.org.uk/self-neglect/policy-practice/evidence-base

https://www.scie.org.uk/publications/reports/report46.asp

Community Care

In-depth information and guides on safeguarding adults and self-neglect

https://www.communitycare.co.uk/adults/

https://adults.ccinform.co.uk/research/research-review-self-neglect/

https://adults.ccinform.co.uk/practice-guidance/guide-to-working-with-adults-where-self-neglect-is-an-issue/

Research in Practice for Adults (RiPfA)

Practice tools to support good practice in self-neglect

https://www.ripfa.org.uk/resources/publications/practice-tools-and-guides/working-with-people-who-selfneglect-practice-tool-updated-2016

https://www.ripfa.org.uk/resources/publications/frontline-resources/working-with-people-who-hoard-frontline-briefing-2017

London Fire Brigade

Resources on fire and hoarding, as well as arranging home visits for risk assessments

https://www.london-fire.gov.uk/safety/carers-and-support-workers/hoarding-disorder/

British Psychological Society

Good practice guidelines on hoarding

https://www1.bps.org.uk/system/files/Public%20files/DCP/a_psychological_perspective_on_hoarding.pdf

National Housing Association

Key considerations for dealing with cases of hoarding

https://www.housing.org.uk/resource-library/browse/hoarding-key-considerations-and-examples-of-best-practice/

// Making Safeguarding Personal

***Speaker**: Jane Lawson, Independent Safeguarding Adults Consultant*

A leading figure in the field of Safeguarding Adults, **Jane Lawson** has decades of experience as a social worker, author/chair of a range of Safeguarding Adults Reviews and Independent Chair for the Safeguarding Adults Boards in Greenwich, Croydon and Bracknell Forest. With her commitment to embedding the principles of Making Safeguarding Personal nationally, she facilitates learning and development across the different agencies involved in adult safeguarding work.

Jane draws on all of her experience in working on the Making Safeguarding Personal agenda and including within the programme (which began in 2009), led by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) and funded by the Department of Health and Social Care (DHSC. She currently works part time on this within the Care and Health Improvement Programme as an advisor.

Emphasising that the interactive session would be more of a workshop than a masterclass, Jane Lawson engaged participants representing multiple agencies in a collaborative process, whereby they could share and learn from one another's experiences. Through group discussions on poignant case studies and short films, the session honed in on the crux of making safeguarding personal at an individual and collective level.

What is Making Safeguarding Personal?

Making Safeguarding Personal (MSP) is not simply about engaging with people and acting in accordance with their wishes. It is about connecting with individuals and building a picture of their unique circumstances in order to understand what motivates them, through multiagency cooperation. This is the starting point for finding a possible way forward.

MSP is also about prevention: empowering people with information so that they can understand risk and protect themselves from future abuse. It is about understanding the range of options for intervening where necessary, including legal options.

Moreover, it is about leadership and accountability of individuals and agencies working to safeguard adults. To make safeguarding personal is to foster a supportive culture in organisations that allows for flexible, creative responses.

A new definition

The intrinsic meaning of Making Safeguarding Personal in strategy and practice is lucidly illustrated in Jane's own personal definition of MSP offered during the session:

Organisations and staff working together to get to the bottom of what is most important for people and communities. They actively reach out, connecting with those most in need. They use their combined capability to achieve outcomes that work for people.

Staff are valued, listened to, supported and developed. They work in partnership to support and empower people, engaging with them to resolve circumstances that are or may become safeguarding issues. There is a focus on wellbeing and safety. People are offered informed choices. Outcomes reflect what people value the most in their lives.

As Jane Lawson reiterated throughout the workshop, this shift in focus from process to people entails a fundamental change of attitude in organisations. It is not merely a question of changing individual practice, but the context in which that practice takes place and can flourish. There is an emphasis on impact rather than ticking boxes, whereby criticism is welcomed and an open environment makes it easy to raise concerns.

Making Safeguarding Personal and the Care Act 2014

Making safeguarding personal goes to the heart of the Care Act. As

outlined within the Care and Support Statutory Guidance issued under the Care Act (chapter 14), MSP is applicable to the whole spectrum of safeguarding activities.

Following the edict of 'no decision about me without me', it emphasises a personalised, simplified approach to adult safeguarding, putting the individual at the centre of the process – their views, wishes and desired outcomes, so that they feel they have choice and control. This is done with the ultimate aim of improving quality of life, wellbeing and safety.

Back to basics

Having been part of the team to develop the MSP approach, Jane Lawson spoke of how strategies must be driven by feedback on safeguarding – what makes it effective and what hinders it – gathered from the full range of agencies and sectors and from staff and people who may need safeguarding support. To make safeguarding personal is to get back to basics, getting to the crux of the values guiding safeguarding policy.

As one participant put it from the London region MSP temperature check in 2016:

"MSP is more about wellbeing and core principles than it is about quantifiable data."

Promoting wellbeing

Promoting wellbeing is pivotal to making safeguarding personal. Although it can be difficult to reconcile, strategies need to always balance safety with wellbeing. The guiding principles informing this include:

- Assume the individual is best placed to judge his or her wellbeing
- Focus on the individual's views, wishes, feelings and beliefs
- Decisions taken holistically, with the individual's participation in decision-making
- Balance between desired outcomes of the individual and the carer
- Protect the individual from abuse and neglect
- Ensure that restrictions are kept to a minimum

Core Safeguarding Principles

The core principles guiding safeguarding are at the heart of MSP, taken from the perspective of the person being safeguarded. Putting them at the centre enables a shift from a process supported by conversations to a series of conversations supported by a process, linking 'I' statements to the Safeguarding Principles, as follows:

1. Empowerment – Support for individuals to make their own decisions: "I am consulted about

the outcomes I want from the safeguarding process and these directly inform the way forward."

2. Prevention – Taking action before harm occurs or risk escalates: "I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help."
3. Proportionality – The least intrusive or restrictive intervention appropriate to the risks presented: "I am confident that the responses to risk will take into account my preferred outcomes or best interests."
4. Protection – Supporting those in need as a result of abuse or neglect: "I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able."
5. Partnership – Working across services and communities to prevent, detect and report neglect and abuse: "I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my situation."
6. Accountability – Enabling service users and leaders to challenge agencies for their responses to those at risk of harm: "I am clear about the roles and responsibilities of all those involved in the solution."

The essential steps

As Jane Lawson emphasised to attendees, the essential steps for developing Making Safeguarding Personal are not new. They are already integral to the business of agencies delivering safeguarding. Following the steps does not require additional work, since they speak to the priorities of existing regulatory frameworks. It makes values and principles explicit, so that they can be applied consistently across all areas of practice.

Participants were urged to use the guidance on good practice of MSP for a range of organisations, including health and social care, advocacy, police, and housing, available on the Local Government Association website.

Leading Making Safeguarding Personal

This refers to the need to define and embed the principles of MSP in one's own practice and at an organisational level, recognising it as a thread that runs through all aspects of service delivery. Does your organisational culture clearly and consistently reflect the values of MSP? For example:

- Open and communicative culture
- Genuine will to hear and learn about what is going well or not so well for staff and for people receiving support
- Culture of dignity and respect that responds to people's feedback and participation
- Lessons are learned where things have gone wrong
- Support for balancing sometimes conflicting principles
- Positive approaches to working with risk

Supporting and developing the workforce

The culture and leadership within organisations and the way staff are treated have an impact on front line practice. Are you empowered and supported to adopt the MSP approach in your practice? Are the following features of the organisation and its practice?

- Organisational culture supportive of challenges to structures, processes or decisions that get in the way of making safeguarding personal
- Clear framework to achieve balance between wellbeing and safety
- Person-centred and outcomes-focused working
- Principles of Mental Capacity Act 2005 integrated in safeguarding practice, with particular focus on best interests decision making
- Mental capacity assessment is an early consideration in safeguarding adults
- Support of advocacy in decision making

Early intervention, prevention and engaging with people

Services need to be influenced by the people who use them, thus support needs to respond to issues that have been identified. Is there a clear focus on meaningful engagement that supports both this influence and in the process of doing so, enhances people's resilience to resolve their own circumstances?

The MSP approach applies in prevention of abuse and neglect as well as to immediate responses to safeguarding concerns. Are people empowered to recognise the potential for abuse or neglect and to raise concerns? Including:

- People empowered to prevent and resolve abuse and neglect in their own lives
- People well informed about quality of care they should expect and supported to raise concerns
- Families/networks engaged and their expertise utilised

- Community engagement, with support co-produced where most needed

Engaging across organisations in Making Safeguarding Personal

Partnership working is vital not only in identifying individuals at risk but also in finding approaches that are acceptable to them, enabling them to work with the staff they are most able to trust. This is especially important where people are resistant to engaging with services.

Do you embrace multi-agency working and engage with a range of partners in order to gain a full understanding of the individual and their context?

In cases of resistance, agencies need to jointly try to understand the complex mix of factors underlying it, and together find a way to support the individual. This involves:

- Clear and shared accountability, with a mutual understanding of what each partner can contribute and who will take the lead in complex situations
- Contribution of all partners valued, including front line staff and volunteers
- Information shared across the partnership

As reflected in the SAR into the death of Steven Hoskin (Cornwall Adult Protection Committee 2007), agencies need to jointly form a full picture of safeguarding cases:

> "Individual agencies did not have access to what other parts of their organisation and other agencies knew. Each held a piece or pieces of a jigsaw puzzle without any sense of the picture they were creating, or indeed the timeframe within which the puzzle had to be completed."

Working with risk

A key focus during the workshop looked into the complexities of working with risk. At the heart of safeguarding lies the tension between the duty to protect someone from risk of harm and the duty to support him or her to have as much independence, choice and control over his or her life as possible.

Although it can be challenging, all those who work in adult safeguarding need to get to grips with this tension, exercising flexibility and tenacity to find solutions that ensure an acceptable balance is struck between managing risk and promoting autonomy.

Working with the aim of improving quality of life, wellbeing and safety is essential. Does an adult at risk have the mental capacity to understand the risks caused by the decisions they are making? Do they understand the impact this has on their wellbeing and safety, as well as the wellbeing and safety of others? Knowledge of and good practice in the context of the Mental Capacity Act is crucial if there is uncertainty around whether an adult fully understands the risks of harm.

Positive risk taking

Jane Lawson stressed that practitioners and agencies need to look at their assumptions and associations around risk. Risk taking is not always harmful; indeed, it is critical to growth. Risk forms a crucial component of a fulfilling, enriching life experience.

A risk-averse culture hinders effective adult safeguarding. Organisations should recognise the positive contribution risk can make in a person's life, with practitioners empowered to work in risk enabling ways. What is the point of making someone safe if it makes them feel miserable?

Supporting and enabling careful consideration of risks forms the cornerstone of positive risk taking, helping to improve an individual's wellbeing while minimising the potential harmful outcomes.

Learning points

Robust and stimulating discussions around case studies took place throughout the workshop, with key themes and learning points including:

- **Work with professional curiosity**

  Many of the cases involved a failure to recognise signs of neglect or abuse. Curiosity and a willingness to engage with adults and their families and/or carers are vital to promoting safety and wellbeing. This entails exploring and understanding what is happening in a certain situation rather than making assumptions or accepting things at face value. Having the ability to go beyond the usual scope of one's role, taking into account different perspectives and considering circumstances holistically.

- **Don't give up**

  In many of the cases where a positive outcome was achieved, tenacity and persistence was practiced on the part of practitioners – be they police constables, nurses or GPs. Too often, there is a lack of meaningful attempts to engage

with an individual and their family or carer, a failure to engage relevant specialists to address risks or a lack of persistence in supporting an individual's understanding of the risks. Not walking away when an individual is at risk of harm or neglect is critical, even when they are resistant to support.

- **Maintain an open mind**

  Maintaining an open mind and a flexible approach, where changing information is taken into account, leads to more effective adult safeguarding. Practitioners need to be open to the unexpected and have flexibility when taking into consideration information that may not support their initial assessment. Working to challenge assumptions by asking questions in an open, respectful manner can be helpful.

- **Understand defensible decision making**

  Defensible decision-making can be a helpful starting point in complex cases, since it focuses on the quality of approach rather than the eventual outcomes. This allows for a shared understanding of risk and agreement on strategies. It was noted that detailed and accurate recording is pivotal in such cases, with assessments and reasons for decisions clearly stated, and examples given to back up any decision taken.

Comments from participants

> I found it a thought-provoking session, with the films we watched being particularly helpful as an accessible way to grasp information and get back to basics when it comes to MSP, wellbeing and adult safeguarding in general."

> Discussions around safeguarding examples where people presenting with capacity were making 'unwise' decisions proved incredibly valuable, showing me where on-going work is needed."

> The case studies and the discussions we had around them enabled me to see the big safeguarding picture, rather than just what we see when our agency intervenes."

> As an organisation that is very person-centred (Solace Women's Aid), we can be too accepting of unwise decisions. The session was an excellent reminder of the need for persistence, challenge and following up."

Resources

Resources to support MSP

The resources describe what 'good' might look like for a range of organisations

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/resources

Making it Real and MSP

Sets out the core ingredients for personalised care

https://www.thinklocalactpersonal.org.uk/_assets/MakingItReal/TLAP-Making-it-Real-report.pdf

Working with risk

A range of resources for those working with risk in the context of adult safeguarding and MSP

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/working-risk

Audio visual resources related to Making Safeguarding Personal

https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal-audio-visual-resources

// Safeguarding Adults Reviews

***Speaker**: Michael Preston-Shoot, Professor Emeritus of Social Work, University of Bedfordshire, and Independent Safeguarding Adults Consultant*

As the former Dean of Health and Social Sciences at the University of Bedfordshire, **Michael Preston-Shoot** has an international reputation for research and publications in the fields of law and ethics in social work education and social work practice. The independent chair of Brent Safeguarding Adults Board and Lewisham Safeguarding Adults Board, he is an expert in adult safeguarding, regularly providing training and consultancy for health and social care practitioners on legal literacy and self-neglect.

Having written, commissioned and researched a number of Serious Case Reviews and Safeguarding Adults Reviews (SARs), Michael Preston-Shoot drew from key findings of reviews to lead a compelling and eye-opening masterclass for participants from multiple agencies across Lambeth.

The session focused on what can be learnt from completed SARs and recommended changes in order to prevent recurrence.

Statutory duty to review serious cases

The Care Act 2014 introduced a statutory duty for Safeguarding Adults Boards (SABs) to review serious cases. A Safeguarding Adults Review must be arranged when an adult dies as a result of abuse or neglect, or experiences serious abuse or neglect, and there is concern about how agencies worked together to safeguard them.

As outlined in Section 44 of the Care Act, SABs have a duty to commission reviews if the above circumstances are met. However, SABs also have discretion to commission SARs based on good practice, or on a case with a tragic outcome that does not necessarily meet the above circumstances. Although it is a discretionary decision in such instances, it is also a statutory decision; hence there can be no Safeguarding Adults Review that is 'non-statutory'.

The purpose of a SAR is to identify lessons to be learnt from the case and apply those lessons to future cases, as well as to improve how agencies work, singly and together, to safeguard adults.

Attendees at the seminar were encouraged to make referrals of cases if they think the criteria are met for a SAR, or equally if they are not sure whether the criteria are met but are nonetheless troubled by some aspect of practice in the case.

SARs under review

The seminar focused on findings from two thematic reviews researched and authored by Michael Preston-Shoot, one of which was co-authored with Suzy Braye, which analysed SARs commissioned and completed by Safeguarding Adults Boards in London and also in the South West of England since implementation of the Care Act in 2015.

Significant learning emerged from these studies, pointing to a serious danger of reinventing the wheel by not capturing and analysing cases based on what is already known. This is particularly evident in cases of self-neglect, which challenge professionals across the safeguarding system.

Nature of the Reviews

Three-quarters of the cases under review involved individuals who had died, while almost half the London sample related to group living situations, raising questions about the quality of care and support provision.

The types of abuse reflected in SARs most frequently related to organisational abuse and self-neglect. Organisational abuse features prominently, referring to cases where staff in care homes and hospitals seriously neglect standards of good quality care, either by design or omission. The prevalence of self-neglect and hoarding further highlights the distinctive complexities and challenges of this aspect of adult safeguarding.

The conspicuous absence of SARs involving domestic abuse was noted. This is most likely explained by the

statutory duty to undertake Domestic Homicide Reviews; nonetheless, these cases offer crucial learning for agencies involved in adult safeguarding. Equally, no reviews involving modern slavery were submitted, possibly suggesting a weakness in the safeguarding system to identify and address this form of abuse.

The demographics reflected a particular emphasis on people over the age of 60, prompting questions around whether SARs are being triggered for cases of younger adults where mortality rates are often high, such as those with learning disabilities or victims of sexual exploitation, or even cases of self-neglect in younger adults.

More cases involved men, potentially pointing to a gender dynamic where serious cases involving women are not being referred as often. Ethnicity was usually unspecified, which is problematic given that other individual characteristics were routinely recorded, and ethnicity can be a significant factor in standards and experiences of care.

Whole system understanding

The masterclass explored key findings from the SARs under review, with recommendations for each area. A holistic understanding of the system is pivotal when examining shortcomings in safeguarding, taking into account the legal and policy context, interagency governance and coordination, organisational features, and direct practice with individuals.

A SAR is rarely triggered by isolated poor practice on the part of practitioners; rather, serious cases stem from a unique and complex pattern of shortcomings and weaknesses that permeate all layers of the system. Each alone would not determine the outcome, but taken together they add up to a fault line.

The financial context is especially significant in affecting all aspects of adult safeguarding. As stressed by Michael Preston-Shoot, professionals across the system – be they in the NHS, police or adult social care – are working under constrained conditions due to austerity measures. Through SARs and other mechanisms, practitioners were urged to make explicit the financial pressures that undermine good practice.

The legal context can also be restrictive, particularly with regards to power of entry, which is not permissible in adult safeguarding in England (although it is in Scotland and Wales). This creates difficulties in cases where access to an individual is impeded – either due to their refusal of services, commonly seen in cases of self-neglect, or due to coercion and control by a family member or partner.

Learning from the SARs

Learning related to core domains of the safeguarding system: direct

practice with the adult, organisational factors, interagency cooperation, and SAB governance.

Deficiencies in how SABs exercise their interagency governance role were highlighted, as pertaining to the content of SARs and management of the review process. Poor agency participation and failures to provide information, failures to use research to underpin analysis and learning, and insufficient action planning for implementation of learning, all affected the quality of SARs and the review process.

Interagency cooperation was mostly hampered by silo working, with agencies working in uncoordinated parallel lines, and an absence of communication and information sharing between agencies.

Organisational shortcomings prominently related to inadequacies of supervision and support, with a focus on case management rather than reflective practice, as well as a lack of managerial oversight, with failures of escalation and responses to escalated cases.

Challenges with understanding and implementing the Mental Capacity Act 2005 were prevalent in many of the SARs; thorough capacity assessments were lacking, as were reviews of capacity in cases where an individual's health and/or environment deteriorated. Direct practice was further hindered by an absence of best interests decision-making and comprehensive risk assessments, along with a lack of persistence in engagement.

Critical learning relating to weaknesses of direct practice, the organisational environment and interagency cooperation was discussed in detail.

Direct practice

- **Mental capacity** – Mental capacity assessments missing, poorly performed or not reviewed; absence of best interests decision-making; absence of repeat assessments for cases of deteriorating health and/or environment.
- **Risk assessment** – Risk assessments absent or inadequate; failure to recognise and act on persistent and escalating risks.
- **Lack of persistence in engagement** – Insufficient engagement, with practitioners giving up too soon when there is resistance to care and support; avoidance of engaging with certain aspects of an individual's situation; erratic contact with an individual; lack of time to build trust.
- **'Lifestyle choice' taken at face value** – Refusal of support too easily accepted, with a lack of respectful questioning about an individual's choices and the inherent risks they carry.
- **Making Safeguarding Personal** – Absence of personalised care; failure to take into consideration an individual's wishes, needs and desired outcomes; prioritisation of autonomy over consideration of risks to others and duty of care.
- **Absence of understanding an individual's history** – Lack of curiosity about the meaning of an individual's behaviour; failure to recognise key features in life histories.
- **Failure to 'think family'** – Absence of attention to complex family dynamics; failure to involve carers.
- **Concerns about service quality**

Organisational environment

- **Absence of supervision and managerial oversight** – Failure to ensure staff competence for work required; absence of effective supervision that promotes reflection; lack of support for staff working with resistant individuals; absence of support with emotional impact of the work.
- **Absence of escalation** – Insufficient procedures for escalation of concerns; inadequate response to escalation.
- **Safeguarding and legal literacy** – Insufficient organisational attention to developing knowledge and confidence in safeguarding; insufficient organisational attention to legal powers and duties.
- **Unhelpful workflow practice**s – Workflow constraining involvement in cases needing attention; barriers to repeat visits and longer-term engagement.
- **Inadequate recording** – Records unclear, incomplete or missing; absence of key information in case records; failure to consult records.
- **Resource challenges** – Financial constraints; overstretched workloads; absence of specialist placements.
- **Agency culture** – Insufficient attention to fostering culture of compassion and accountability; short-term case turnover model of practice.
- **Contract monitoring** – Insufficient contract monitoring; commissioning gaps.
- **Failure to track patterns and concerns** – Failure to recognise safeguarding concerns and cumulative patterns; lack of proactive scrutiny.

Interagency cooperation

- **Silo working** – Agencies working in uncoordinated parallel lines; absence of multiagency forums to establish shared ownership and approach; absence of escalation between agencies.
- **Failures of communication and information sharing** – Crucial information not shared or communications not timely.
- **Lack of coordinated leadership** – Lack of a lead agency and key worker to coordinate collaboration between agencies.
- **Absence of challenge** – Failure to challenge poor service standards.
- **Absence of safeguarding literacy** – Failure to implement safeguarding procedures; inadequate recognition, referral and response to safeguarding referrals.
- **Absence of legal literacy** – Failure of agencies to consider together how legal powers and duties can be exercised through joint strategy.
- **Collective omission of 'the mundane and the obvious'**

Recommendations

The repetitive nature of the findings from SARs under review highlights structural challenges in the financial, legal and policy context that affect all agencies. It further points to a failure to learn from serious cases and tragic outcomes. Perhaps the most important learning for Safeguarding Adults Boards and agencies is to ensure that analyses of findings and recommendations from SARs are used to inform action plans for change.

Recommendations for SABs include the need to implement SAR findings; to review safeguarding policies and procedures in light of the findings; and to consider further work to track impact and outcomes of SARs conducted.

Recommendations to improve direct practice, the organisational environment and interagency cooperation were shared, established through an evidence-based model of good practice.

Direct practice

- Person-centred, relationship-based practice with detailed exploration of the person's wishes, feelings, needs and desired outcomes
- Legal literacy
- Comprehensive assessment and review of risk and capacity
- Balance of autonomy with duty of care
- Full exploration of 'lifestyle choice' when faced with service refusal, with discussion of what might lie behind a person's resistance to engage
- Understanding of the person's history
- Family and/or carer involvement in assessments and care planning where possible
- Recognition of issues around loss and trauma
- Consistent contact so that trust can be built
- Specialist advice availed where needed
- Careful preparation at points of transition, such as hospital discharge and placement commissioning
- Thorough care plans and regular reviews

Organisational environment

- Constructive supervision, training and support for staff
- Development, dissemination and review of safeguarding guidance
- Specialist legal and safeguarding advice availed
- Clarification of management responsibilities
- Clear and thorough case records
- Comprehensive commissioning and contract monitoring of service providers
- Attention to workplace issues, such as staffing levels, organisational culture and thresholds

Inter-organisational environment

- Interagency communication, collaboration and information sharing
- Clarification of roles and responsibilities, with coordinated leadership
- Multiagency meetings for management of complex cases, where information is pooled and shared approach is agreed
- Safeguarding and legal literacy amongst agencies
- Guidance on balancing autonomy with duty of care
- Use of policies and procedures, including escalation of concerns
- Collaboration on hospital admission and discharge procedures
- Clear and thorough recording of assessments, reviews and decision-making
- Senior management oversight

Learning points

Throughout the masterclass, participants engaged in fruitful conversations around the numerous case studies that were presented, all of which contained important lessons for consideration.

- **Develop understanding of Mental Capacity Act**

  Many of the cases involved missed opportunities for capacity assessments and best interest meetings, where assumptions were made about a person having capacity and situations not adequately investigated. Other cases involved mental capacity assessments being poorly performed, or review of capacity not being triggered in cases where an individual's living situation had deteriorated. Professionals across health, social services, welfare and other sectors often fail to complete thorough assessments, thus a better understanding of mental capacity and how to implement it is needed.

- **Seek legal advice**

  Legal literacy and availability of specialist advice is crucial, particularly with regards to questions around capacity and risk. In many of the cases, insufficient legal and/or safeguarding literacy on the part of the practitioner, and a lack of adequate supervision to ensure legal literacy, was a major factor in influencing the outcome of events. There should be no barriers to seeking specialist advice, with participants encouraged to consult lawyers in complex cases.

- **'Think family'**

  Failure to adequately consult and involve family members and/or carers in assessments and care planning was a recurring theme, since important information about the individual's care needs was often missed. They can also play a role in building a picture of the individual's history. Family dynamics need to be better explored as well, particularly the relationship between the carer and the cared-for.

- **Escalate concerns**

  The need to escalate concerns to managers was discussed at length, especially in cases where risk remains high despite risk management measures being implemented. Organisations should ensure sufficient procedures for escalation of concerns, along with efficient managerial oversight of high-risk cases.

Comments from participants

It was a very informative, excellent session. It helped me to better appreciate the fact that all professionals at all levels are valuable and necessary to any adult safeguarding process."

It was very helpful in terms of reflection on my own practice. The presentation was most beneficial, as were the group discussions and use of relevant cases as examples."

I now understand how SARs are conducted, as well as ways of increasing effectiveness of our care, including interagency cooperation. As a newcomer to safeguarding I have found many of the acronyms confusing, so this has increased my knowledge considerably."

The session provided us with a wider overview of the safeguarding system, with collective sharing from different agencies. It offered time to reflect and evaluate what we do."

Resources

Learning from SARs London report

Learning from SARs: A Report for the London Safeguarding Adults Board (2017), by Suzy Braye and Michael Preston-Shoot

http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

Learning from SARs South West report

What Difference does Legislation Make? Adult Safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews (2017), by Michael Preston-Shoot

https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SW-SCRs-SARs-Report-Final-Version-2017.pdf

// Modern Slavery

***Speaker**: Chief Superintendent Paul Griffiths, President, Police Superintendents' Association of England and Wales*

The fifth and final masterclass was led by **Chief Superintendent Paul Griffiths**, an officer with Gwent Police and recently elected President of the Police Superintendents' Association. He is a Senior Investigating Officer, Strategic Firearms Commander, Authorising Officer and a Negotiator Coordinator, having served in both uniform and detective ranks throughout his career.

Paul Griffiths' riveting presentation covered his experience of leading one of the largest modern slavery investigations in the United Kingdom. Operation Imperial, an investigation that began with enquiries into a person who had lost contact with their family, grew to become the biggest police operation into forced labour the UK has ever seen. Through the investigation, Paul and his team went on to identify up to 140 vulnerable adults who were at risk of being victims of forced labour in South Wales.

Paul told moving stories of some of the people encountered through the operation, and how the police developed a 'care-first' approach to working with them. Attendees at the seminar used the stories to draw out their own experiences and insights for shared lessons in professional practice.

Darrell Simester's story

Darrell Simester, a vulnerable adult from Kidderminster in Worcestershire, had suffered epilepsy and struggled through school with learning difficulties. He was well supported by his parents, Jean and Tony. In 2000, when Darrell was 30, he met a family of travellers who invited him on holiday with them to South Wales. Growing tired of minding their children, Darrell ran away from the family and became homeless on the streets. He was soon picked up by another traveller family, who offered him accommodation and food in return for work on their horse farm.

The first family returned to Kidderminster and told Darrell's parents that he had gone missing. The parents reported this to their local police, but because Darrell was an adult, the police recorded him as a 'lost contact' and did not instigate a missing person investigation. Darrell made periodic phone calls to his family over the next eight years, often from withheld numbers and with voices overheard in the background instructing him on what to say. His parents continued to pressure police into locating him, eventually turning to other means in their desperate search for their son.

After 13 years of trying to trace Darrell, Jean and Tony contacted a local newspaper in South Wales, who ran a story in which they made a desperate plea for anyone who recognised Darrell to come forward. The last-ditch

attempt paid off, as they received information that he was working at a farm in Gwent.

They drove to the address and found Darrell working in the yard in a bedraggled state. At first he did not recognise his family. The situation became tense and the police were called, but were unable to do anything, as they could not identify any offence that was being committed. Darrell eventually agreed to go home with his parents and the travellers who ran the farm gave him £40 for his work.

Upon arrival back home, the full extent of Darrell's shocking condition was discovered: a hernia on his groin the size of a football; curvature of the spine and severe weight loss; a fungal infection that had turned the soles of his feet green; and extensive tooth decay.

Darrell gradually began to open up about what had happened to him. He had been made to work over 14 hours a day on the farm, every day, for thirteen years. Once, he ran away after accidentally setting fire to the shed he lived in whilst trying to keep warm. He was quickly found and returned. He had lived in a rat-infested shed for eight years and then moved to a dilapidated caravan. It was so cold that a dog sleeping with him in the caravan died from hypothermia; Darrell had to bury it the next day. He was told that if he tried to escape he would be killed and buried in a pit as well.

Darrell's parents relayed the story to West Mercia police. They started an investigation that was soon transferred to Gwent Police, as the scene of the potential crime.

The impact of Operation Imperial

Operation Imperial became a major police investigation, lasting several years and involving over 300 officers. It radically shifted perceptions of modern slavery and how to tackle it. As well as revealing the extent of the problem, Darrell's case helped to broaden the understanding of forced labour in the UK, the most common form of modern slavery.

The scale of the operation and the shocking nature of Darrell's case attracted international media attention. As a result, the police started receiving a steady stream of information about other locations and individuals. They received intelligence from many varied sources and from other victims, which enabled them to build a picture of how criminals within the travelling community were operating.

Vulnerable people at soup kitchens and homeless centers were often targeted. Criminals would look for weaknesses they could exploit, such as mental health problems or alcohol dependency. They approached individuals with offers of sanctuary – accommodation, food and work. The victims were housed but the promises of pay deferred. Those who were weaker would often not ask for their pay. Those who did, or who tried to leave, were threatened with violence.

Darrell's case also shifted the policing approach to victims of slavery. The police knew that Darrell's evidence would be key to unlocking the case and bringing any successful prosecutions, thus the first priority was Darrell's care. Paul described the approach the police took as a paradigm shift from 'custody to care'.

An international psychosocial expert was brought in to help them understand how to support Darrell's recovery so that reliable evidence could be taken from him. The officer

put with the family was trained in vulnerable adult interviewing and the rapport he built with Darrell over time was a breakthrough. The police worked closely with health, social services, and voluntary and community sector agencies on Darrell's recovery, getting him healthy again and providing emotional support.

The Modern Slavery Act had not yet been passed, so Police relied on a Forced Labour offence in the Coroners Act and the farm owner in Darrell's case was eventually jailed for four and a half years. Since the offence was only introduced in 2010, he could only be convicted for the last three years of Darrell's forced labour. Although considerable police resources were dedicated to Darrell's case, this was the single conviction that was yielded.

The investigation that started with Darrell's case led to a fundamental shift in awareness and understanding of issues around modern slavery, with untold benefits for countless other individuals. The Modern Slavery Act was introduced in 2015 to consolidate and simplify existing slavery and trafficking offences and to increase maximum sentences from 14 years to life.

Multiagency working

Tackling modern slavery, safeguarding adults at risk, and identifying and prosecuting offences requires joint working across a number of agencies.

The National Referral Mechanism (NRM), originally established in 2009 as a framework for identifying and ensuring victims of human trafficking receive appropriate support, saw a considerable growth in referrals through Operation Imperial, including victims of different forms of modern slavery, such as domestic servitude and sexual exploitation. Local authorities, along with a range of other public bodies as well as community and voluntary sector organisations, are able to refer potential victims to be supported through the system.

Local authorities are well placed to identify potential victims and cases of modern slavery. In the South Wales case, Newport City Council's planning department had a wealth of information on the farms that were involved, as several had breached planning regulations. Many of the individuals involved were also known to local Trading Standards. Modern slavery is often driven by financial gain. HMRC can be an important partner in investigations as well as the Gangmasters and Labour Abuse Authority, a public body that protects workers from exploitation.

The voluntary and community sector, particularly charities working with the homeless, are on the frontline in the fight against modern slavery. A decade ago, one homeless shelter in South Wales had unwittingly helped criminals in the traveller community by allowing them regular visits to make offers of work and accommodation to people in the shelter. They now have all the appropriate safeguarding and risk management processes in place, although it is suspected that criminals still operate outside the shelter.

The 'Alpha slave'

Paul Griffiths told the story of another harrowing case involving a victim known as 'Scottish Mike'. Police had been alerted to his situation and eventually found him through information from Trading Standards, who were looking into rogue traders in the traveller community. Physically muscular, he was perceived as a very tough and hard-working individual. Police manufactured an opportunity to meet him and explained he was not in trouble but that they wanted to make sure he was okay. He became emotional and as officers built up a rapport with him, he disclosed that he had been under control for 26 years.

He came from Scotland but moved to Wales after problems with his parents. He had become entrapped by a group of criminals and was controlled through threats and violence. Although he managed to escape back to Scotland, he was soon kidnapped outside a job center by Welsh men who had tracked him down. They bundled him into the boot of a car, drove him back to Wales and beat him. He said that he 'became their property' from then on.

He was paid to lead a team of other forced labourers to complete building work, usually laying driveways. He was constantly threatened that he would come to harm if deadlines were not met. Consequently he used threats on those working with him, as he feared for his own safety. He was what police came to describe as an 'alpha slave'. Over the decades, he was trusted enough to live in rented

accommodation with a woman. She had not understood, at the time, why he was so afraid of the men who would collect him to take him to work, or why he would wince when she tried to show him affection.

Institutionalisation and 'Stockholm Syndrome'

Victims of forced labour often become institutionalised or develop Stockholm syndrome, where people held against their will develop feelings of trust, loyalty or affection for their captors. One of the victims that police rescued, from a farm neighbouring Darrell's, had lived in a dilapidated caravan for eleven years. After being repatriated to his family, it took 18 months of support before he could recognise that he had been a victim.

In another case, police received several phone calls urging them to find a man who had been a victim for 28 years. They found him and offered to take him to safety. However, he refused any help and did not want to talk to the police. Despite extensive efforts, the police could find no grounds to keep him against his will and reluctantly returned him to the traveller family. The family saw him as a risk and wanted nothing more to do with him, sending him to a homeless shelter. The man still refuses to speak to police about his experience, which he says would be a betrayal of his family, and as a result no prosecutions have been possible in his case.

One of the most significant challenges for the police is that they have no powers to take vulnerable adults who are potential victims of slavery to safety, if they do not want to be helped. There was some discussion during the masterclass around use of the Mental Health Act and whether lack of capacity could be a route to bring potential victims to safety while their cases are investigated.

Similarities with domestic abuse cases where a victim does not want to bring charges against the perpetrator were explored. Paul explained that 'victimless' prosecutions (where the victim does not support the prosecution) are possible for any crime, although the CPS is understandably reluctant to bring such prosecutions.

Conversely, some individuals who appear to be victims are not. The police were concerned about a Polish man working on a farm after receiving a tipoff. When they approached him, he claimed that he was happy with his working conditions and earned more money than he could in Poland. He assured them that he could – and did – leave when he wanted. His version turned out to be correct and he left with £1,000 pounds that he had saved working on the farm.

Identifying signs of modern slavery

Attendees discussed the relevance of Operation Imperial to their own work. The different types of industry that could be environments for modern slavery were explored, such as car washes, nail bars, the sex industry and domestic servitude. The need for all agencies to be aware and alert to signs of potential slavery was emphasised.

Paul highlighted some of the things to look out for in potential slavery situations:

- Is the potential victim vulnerable – 'unable to protect him or herself against significant harm or exploitation'?
- What makes them vulnerable?
- Do they have an addiction or are they misusing substances?
- Does the situation they are in make them vulnerable?
- If there is a victim, there must be an offender, so what is their relationship?
- What does the perpetrator have to gain? It is usually a financial motive, but not always. How do they exert control?

Attendees agreed that it is vital to be curious and question relationships, if anything is of concern. It is better to make a mistake than walk away.

Learning points

- **Think 'outside the box'**

  Thinking outside the box and utilising professional curiosity are crucial to identify potential victims of modern slavery. If things don't feel right then find out more, don't just walk away. In the cases of forced labour on the South Wales farms, many agencies had opportunities to find out more or to join the dots, but none of them did until Darrell's family made the breakthrough of finding him.

- **Work closely with other agencies**

  There is a wide range of agencies that are likely to have information relevant to potential cases of modern slavery. These could include the police, health services, fire brigade, local charities and voluntary services, HMRC, housing, trading standards and planning departments. For example, members of the fire brigade could monitor for signs of modern slavery when carrying out safety inspections. Information

that may seem insignificant in isolation may be far more valuable when combined with information held by other agencies. Joint working, building relationships and establishing mechanisms and processes for sharing concerns and intelligence are vital.

- **Safety first and build rapport**

  If you suspect that an individual may be at risk of harm, the first priority must be to help them to a place of safety. Addressing any physical and mental health needs takes precedence before trying to find out about their ordeal, particularly as they are likely to need support in order to understand that they have been victimised. As in any case work, building rapport with individuals is key, particularly with people who may feel conflicted about their loyalties, afraid of the consequences of talking about their experiences, or who are not yet able to understand or accept that they have been victims of exploitation.

Comments from participants

> It opened my eyes to how widespread this issue is. More awareness makes it possible to recognise the signs of modern slavery in my own practice."

> A very insightful session, and interesting to know how we can support people who are at risk of exploitation."

> Paul's wealth of knowledge and the astonishing case studies he presented were very informative. It was helpful to hear about how the police were able to recognise patterns and implement lessons learned in how they deal with tackling modern slavery.'

> I gained an understanding of how victims of forced labour may not see the need for help but with the right help they can be safeguarded. It was also beneficial to learn about the multitude of agencies that can be used to assist in such cases."

Resources

Unseen

Charity supporting survivors of trafficking and slavery and equipping frontline staff and businesses to identify victims and take appropriate action

www.unseenuk.org

Anti-Slavery International

Human rights organisation dedicated to eliminate all forms of modern slavery in the UK and around the world.

https://www.antislavery.org

Modern slavery helpline

24/7 specialist support and guidance for potential victims, statutory agencies, frontline professionals, businesses and members of the public

08000 121 700

With thanks to…

Councillor Edward Davie, Lambeth council's Cabinet Member for Health and Adult Social Care

Cllr Davie is responsible for health and adult social care and works together with colleagues to ensure safe, efficient and effective services. His strategic focus is to reduce health inequalities so that more residents enjoy longer, healthier lives. He is the elected member representative of the Safeguarding Adults Board.

Janna Kay, Quality and Safeguarding Adults Manager

Janna works closely with the Safeguarding Adults Board Chair to ensure the Board maintains a focus on achieving its strategic objectives. Janna leads on safeguarding in Adult Social Care. She helps front line social work teams in the often challenging work of protecting vulnerable people from harm. She organises learning forums for staff and is often called upon to advise on some of most complex cases. Janna co-ordinated the Masterclass events.

Contact: Safeguardingadults@lambeth.gov.uk

Caryn Thandi Petersen

Caryn is a features writer and editor, specialising in areas of mental health and wellbeing, human rights, inequality, lifestyle and the arts. She has a wealth of experience in developing communications materials for organisations across the public and private sectors, including briefing papers, reports and booklets for specialist projects as well as content for websites and brochures.

Contact: Caryn.thandi@gmail.co.uk

Fiona Connolly, Lambeth council's Strategic Director for Adults and Health

Fiona Connolly is responsible for the council's support services for adults, carers and information about public health. Her teams are responsible for delivering council services, often in partnership with the NHS and other bodies, to a wide range of Lambeth residents. Fiona is a member of the Safeguarding Adults Board and supported the production of these masterclasses.

Ceri Gordon, Adult Safeguarding Support Officer

Ceri is responsible for co-ordinating the work of the Lambeth Safeguarding Adults Board and all its sub-groups. As such, she plays an essential role in ensuring the board and its partners work together to ensure effective local safeguarding arrangements are in place. Ceri was pivotal in organising the Masterclass events.

Contact: LSABAdmin@lambeth.gov.uk

How to raise an adult safeguarding concern in Lambeth

If you think an adult is at risk of being neglected or abused, or someone is neglecting or abusing you, please contact Lambeth Adult Social Care.

The quickest and most secure way to raise concerns is using the online form, which can be found at lambethsab.org.uk

Alternatively, you can contact the Initial Contact Service by phone on **020 7926 5555**

In an emergency you should always call the Police on **999**.

If it is not an emergency but you suspect criminal abuse is involved, you can call Police on **101**