South West London
Academic, Health and Social Care
System

Adult Safeguarding

Masterclass series

THE ROYAL BOROUGH OF
KINGSTON
UPON THAMES

Contents

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 up as legal advice.

Foreword

This report summarises a series of seminars held between March and July 2017 on five central themes in adult safeguarding. The series was commissioned by the former SW London Academic, Health and Social Care System and supported by the Royal Borough of Kingston upon Thames. We would particularly like to thank Dawn Secker and her team for all their hard work in making sure the Masterclasses were such a success.

The Masterclasses offered a rich learning opportunity for professionals from more than 30 different organisations covering a broad range of disciplines to come together and learn from each other's experience in different aspects of providing care and support for vulnerable adults and their families and carers.

Each session was led by an expert in the field who offered some thoughts and information on the topic and then facilitated discussion among the professional audience.

The seminars particularly underlined the critical importance of working across professional and organisational boundaries – learning from each other's expertise, recognising each other's contribution and finding new ways of collaborating in order to deliver the most effective services.

This report is a way of capturing and sharing with you some of the lessons which came out of the discussions and we hope you find it useful and informative.

Kathy Tyler
Director, SW London AHSC System

Introduction

By Siân Walker, Independent Chair, Kingston Safeguarding Adults Board

Safeguarding adults is about empowering and protecting vulnerable people with care and support needs who are unable to protect themselves, so that they can live in safety, free from harm, abuse or neglect.

The Care Act 2014 sets out clearly how local authorities and the wider health and social care system as well as the police and other public services should protect adults at risk of abuse or neglect. Multi-agency working is at the heart of effective safeguarding and Safeguarding Adults Boards bring together senior strategic leaders from all these organisations in each local authority area to ensure effective partnerships to deliver this.

The Care Act is part of a much wider legal framework that practitioners must operate within to support and empower vulnerable people with care needs. Professional development is vital for good practice and one of the roles of the Adult Safeguarding Board is to ensure that staff receive appropriate training. Good professional development is about much more than training in policies and procedures, it is about sharing experiences, learning together, exploring new approaches and developing professional networks.

The series of safeguarding masterclasses that ran in Kingston between April and July 2017 were so valuable because they provided expert knowledge from highly experienced speakers, coupled with the sharing of experiences and insights from the broad range of practitioners that attended. We know we learn best by constantly sharing ideas and expertise, so that we can work together more effectively.

The masterclasses covered a wide range of important issues, from self neglect to modern slavery, but a number of common themes emerged across the sessions including:

- the need to understand and be able to apply the most appropriate legal frameworks in each situation;
- the importance of robust and documented evidence to inform and defend decisions; and
- the importance of truly understanding the needs and wishes of individuals and ensuring that we focus on empowering them to realise personalised outcomes.

This report summarises the learning and discussion covered in each session. Each article includes a set of practical learning points from the masterclass and list of further resources where applicable. While no write-up can do justice to the quality and depth of discussion from the sessions, it is intended as an aide memoir for those who were able to attend and to capture and convey some of the insights for others.

The breadth of issues covered was matched by the breadth of experience that attendees brought to the sessions. Participants came not only from adult social services, but also NHS hospital and mental health trusts, clinical commissioning groups, nursing and care homes, housing associations, the police and fire service.

One of the most positive aspects of the series was seeing participants sharing experiences, networking and forming relationships that will last beyond the masterclasses. It epitomised the spirit of multi-agency working and collaboration which is central to effective safeguarding.

I would like to thank the masterclass presenters for leading such informed and engaging sessions and the participants for sharing their experiences, their questions and their insights. I would also like to thank the South West London Academic, Health and Social Care System (now part of the South London Health Innovation Network) for commissioning the Masterclass series and this report and the Royal Borough of Kingston-upon-Thames Council for devising and organising the masterclass series.

Siân has over 40 years experience in social work, both with children and adults. She was Director of Health & Social Care for the City of Cardiff and an Assistant Director at Wiltshire prior to that. 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 Kingston, Lambeth and Devon and was recently appointed a Care Commissioner for the States of Jersey

Coercion and control with ‘capable’ adults

By Alex Ruck Keene, Barrister, 39 Essex Chambers, Honorary Research Lecturer at the University of Manchester, Wellcome Trust Research Fellow, Dickson Poon School of Law, Kings College London

The first in the series of masterclasses was led by Alex Ruck Keene, a barrister, writer and educator widely regarded as a leading expert on the Mental Capacity Act 2005.

The session explored the methods available for professionals to address coercive or controlling behaviour in the context of vulnerable adults. 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.

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 to vulnerable adults.

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, 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 vulnerable adults 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 through the masterclass.

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.

Criminal offences

There are several criminal offences that can be brought against people who are controlling or coercing vulnerable adults.

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.

It only applies in situations where people are family members or are in or 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.

The act defines controlling behaviour 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 assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten.

A successful prosecution would need to prove that the behaviour has had a ‘serious effect’ on the victim. This could include serious alarm or distress, fear of violence or an adverse effect on day-to-day activities.

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 2016, there have been relatively few prosecutions under Section 76. However, it is a tool that could, and potentially should, be used more often.

Modern Slavery Act 2015

The Modern Slavery Act 2015 defines an offence of ‘holding in servitude’. People who have been brought into the country, perhaps for an arranged marriage, or to work in the hospitality or care sectors, can be very vulnerable, particularly if they do not speak English. This law may be applicable in these circumstances.

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.

Looking forward

While prosecuting offences is retrospective, other routes are available to practitioners to inquire and intervene proactively when they or others, such as GPs or church leaders, are concerned about a vulnerable adult.

Domestic violence protection notices

A DVPN (domestic violence protection notice) is only applicable in very 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.

The issue of ‘capacity’

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 themselves.

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 vulnerable and 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 perfectly 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.

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 the 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 the 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. There have been cases where the court has imposed urgent actions that have impacted on individuals for months, based on genuine concerns, which would have quickly been dispelled had the necessary evidence been gathered and reviewed straight away. These have resulted in significant damages against the authorities involved.

After an application has been accepted, the court can then make orders to properly assess capacity. The court has the power to require a third party to allow access to the individual, including for the purposes of enabling a full capacity assessment to be carried out. It is not true that the Court of Protection will only accept a psychiatrist’s report as proof of incapacity, although judges will naturally find such a report a persuasive piece of evidence when they come to make their decisions.

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.

The Court of Protection is not adversarial; there are no winners and losers. Judges will welcome practitioners who recognise that these cases are difficult and acknowledge that the third party may well bring some positives to the relationship with the individual as well as the behaviour that causes concern. It is possible for practitioners to misunderstand perpetrators’ behaviour and assume a harmful intent to actions that are meant to be benevolent. Presenting heavily one-sided evidence, or sticking doggedly to the case in the face of changing evidence will not be looked upon well by the judge.

Where the court decides that the individual does not have capacity to make the relevant decisions, the court can make those decisions on the individual’s behalf, including requiring a third party to leave the individual’s home or ordering the removal of the individual to alternative accommodation.

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 limited from doing so by another rule, law or authority. It was used as the means for the High Court to intervene to protect mentally incapacitated adults before the Mental Capacity Act 2015.

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.

It does, unquestionably, allow orders to be made against third parties requiring them to allow access to the individual for all proper social work purposes. It is much more questionable whether the court can go further and make orders directed against the individual themselves. It is fundamentally problematic for the court to order people to do things if they do not want to do them. If the court should have the power to do this, there should be no need for the Mental Capacity Act. It must be remembered that ‘empowerment’ is the first principle of safeguarding in the Care Act 2014.

Learning points

Delegates examined a case study of London Borough of Redbridge v GC [2014] EWCOP 485 (see the judgment at: http://www.bailii.org/ew/cases/EWHC/COP/2014/485.html). They then shared their reflections on the case, and their 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.

- **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.

- **Ensure that vulnerable adults can talk freely**

  One of the factors in the case study was that the individual had very few opportunities to talk freely, without the controlling party being present or listening at the door. Creating opportunities for frank conversations in a safe environment is important for a proper assessment and to empower the individual. The courts can make orders to allow these safe conversations to take place.

- **The value of multi-agency working**

  The case study revealed, with hindsight, that various agencies missed several opportunities to intervene much sooner in the case. Often, while no agency has sufficient evidence or clear red flags on their own, they may collectively have the necessary information and evidence to take action.

  Multi-agency risk assessments and effective joint working across social services, with police, housing, health and other agencies is highly valuable for understanding the full picture, identifying opportunities to intervene and collating robust and documented evidence.

- **There is no single framework for protecting vulnerable adults**

  The discussions on the day highlighted the lack of a single legal framework for protecting vulnerable adults. In Scotland the Adult Support and Protection Act 2007 is applicable to all vulnerable adults. Without a similar framework in England and Wales it is more difficult to protect adults who are judged to be ‘capable’ from third party control or coercion from tenants, lodgers, friends or ‘hangers on’ who impose themselves into the vulnerable person’s life.

  This issue and the possibility of a law similar to Scotland’s is currently being considered by the Law Commission. A representative was present at the masterclass to hear about the experiences and perspectives of the attendees.

- **Focus on empowerment**

  Empowerment is the first principle of safeguarding. What is the point of keeping people safe if they are made miserable in the process? That is a form of abuse in itself. In the case study it was felt that too little emphasis had been placed on understanding what the individual at the heart of the case actually wanted. There was little doubt that others were controlling many aspects of her life, but they did appear to be taking care of her physical needs. She may have wanted the people to continue living with her in her house, rather than living alone, so long as the controlling aspects of their behaviour were modified.

  Understanding and taking account of what the individual wants must be the priority. Practitioners and the courts have considerable powers to protect people, but with that comes great responsibility.

Resources

39 Essex Chambers resources

Case reports, newsletters and articles

www.39essex.com/resources-and-training/mental-capacity-law

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 or implement it.

www.scie.org.uk/mca-directory

Coercive Control

Website for social workers and other health and social care practitioners to develop knowledge and skills in working with situations of coercive control.

www.coercivecontrol.ripfa.org.uk

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 (previously called Wiki Mental Health)

www.mentalhealthlaw.co.uk.

Court of Protection Handbook

Accompanies the publication Court of Protection Handbook: a user’s guide.

www.courtofprotectionhandbook.com

E-mail Alex Ruck Keene

alex.ruckkeene@39essex.com

Working with people who self-neglect

By Jean Hanson, Managing Director of Social Care Consultancy Ltd, Associate of Skills for Care, specialising in safeguarding adults

This masterclass was led by Jean Hanson, an experienced practitioner, consultant and trainer with expertise in working with people who self neglect. The session explored practical and evidence-based approaches for working with people who self-neglect within the strategic framework provided by safeguarding adults partnership boards. Attendees reviewed a case study and shared experiences and ideas shared for putting what had been discussed into practice.

What is self-neglect?

Behaviours considered as 'self-neglect' include:

- **Lack of self care -** of personal hygiene, nutrition, hydration, etc.
- **Lack of care for one's environment -** hoarding, squalor, or 'filthy or verminous' premises (the environmental health definition of 'filthy' is bodily fluids, faeces and foodstuff fluids, and 'verminous' refers to rats, mice and cockroaches).
- **Refusal of services which reduce harm –** medical, domiciliary care, befriending, etc.

Using the right language around self-neglect is important to ensure practitioners are maintaining a positive regard for the individuals involved. It is better to speak of 'people who self-neglect' rather than 'self-neglecters' or 'hoarders', and practitioners should 'work with them' rather than do things 'to' or 'for' them.

The position of self-neglect within safeguarding policies and procedures is somewhat complicated because safeguarding usually relates to protecting people from third parties.

Self-neglect was included within safeguarding in the Care and Support Statutory Guidance in April 2015 because policy-makers wanted to provide practitioners with a framework and multi-agency approach for reducing harm in self-neglect cases, which were often long-running and protracted.

However, in March 2016, the guidance was revised to clarify that "Section 42 is aimed at those suffering abuse or neglect from a third party. It is not ordinarily applied to those failing to care for themselves." Nonetheless, there are two sections of the Care Act 2014 that practitioners can use to intervene in support of people who self-neglect: Section 1, the legal duty to promote an individuals wellbeing; and Section 9, the duty to assess an individual's needs for care and support.

The role of the Mental Capacity Act in self-neglect was discussed and it was noted that mental capacity can often be given as a reason for not talking action. However, even if people have mental capacity, that does not mean that interventions should not be made. Mental capacity is never accepted as a justification for a lack of action in case reviews.

> It is correct that the first principle of the act is a presumption of mental capacity, and the third principle is that individuals have the right make what might be seen as unwise or unsafe decision. However, the third principle goes on to state that the consequences of those decisions should be explored with the individual, and the second principle is that individuals have a right to be properly supported to make decisions. It should be remembered that a person's capacity to decide about their safety and welfare can be temporarily reduced by their risky behaviours (e.g. lack of hydration, nutrition, sleep or social contact) or by depression, agoraphobia, low self-esteem or post traumatic stress.

Strategic role of "Safeguarding Adults" boards

The care and support statutory guidance is clear that safeguarding adults boards (SABs) should have the overview of working with people who self-neglect. Self-neglect situations have the potential for death or serious harm and for risks of litigation and community censure. The multi-agency SABs are the appropriate forum for strategic discussions on dealing with what are often complex and challenging situations for practitioners and managers, as well as communities more broadly.

The SAB's duties include ensuring that robust data is collected, for example on the numbers of self-neglect cases and their outcomes. They should develop cross-agency prevention strategies, providing challenge and ensuring cooperation between member agencies. SABs should also conduct and learn from reviews, hold peer reviews and self-audits and ensure adequate training and guidance for practitioners.

Practitioners should support SABs by maintaining comprehensive records, and this is essential for all high-risk cases. All the evidence and facts must be documented, including the adult at risk's desired outcomes, priorities, choices and feelings.

Risk assessments, decisions and instructions should be detailed, including who made them. Actions, contingency plans and any formal or statutory issues should be recorded with comments from the safeguarding adults manager - it is important to evidence that practitioners are not acting unguided. Records should document the options discussed, what was tried, what didn't work, and what succeeded. In these kinds of cases small steps and minor victories may be all that can be achieved, so it is important they are noted.

Making it personal

Attendees reflected on the need for practitioners to balance their duty of care with the need to respect and support an individual to be autonomous, have choices and take risks.

Self-neglect cases can be particularly difficult because individuals may not want or think that they need help. Practitioners should therefore take the 'making safeguarding personal' approach. This involves working with the individual to encourage or facilitate them to think about what changes they would like to make. It will involve negotiation and compromise and it is important to recognise that it will take time.

Support should be provided in a respectful way, but with challenge where it is appropriate, for example around fire-safety (see below). It is important to remember that practitioners are unlikely to 'cure' people of their self-neglecting behaviours but should focus on reducing potential harm.

Conversations may be about how individuals structure their day, new tasks or activities they could try, or helping them

to identify appropriate places to store goods so they can use cleared areas (such as beds) for their original purpose. People may need simple support to manage their thoughts, to understand that they do not need to be anxious about discarding objects, and that they can choose which thoughts to follow.

Practitioners should work with people's strengths and build resilience, helping to develop their decision-making ability, rather than focus on their weaknesses. Practitioners should position themselves as supporting the individual to achieve what they want, rather than saving them from the situation they are in.

Like anyone else, people who self-neglect dislike feeling judged, for example through words, body language and facial expressions. In Jean's experience, they appreciate straight-talking, but only from people with whom have built a rapport. They want practitioners to seek to understand their behaviour and why they do it. They appreciate practical, non-judgemental help and want to be asked what they want to change and how they want to change it. They like being given information, new ideas and being kept informed.

The impact of trauma

Many people who self-neglect share common personality traits. They often take pride in, or feel a need for, self-sufficiency. It is common to have a strong instinct for preserving places or possessions and a need to maintain identity and control. Often they will have had a history of experiencing traumatic events, such as bereavements, abuse, relationship breakdowns or having had children taken into care.

> In post-traumatic situations, what may be viewed as problematic behaviour might actually be solution-focused behaviour and evidence shows that practical interventions tend to be more successful than therapeutic ones.

Common after-effects of trauma include a tendency to isolate oneself, difficulty in trusting others, and not keeping to a healthy routine. When working with people who have experienced trauma, practice should be safe, respectful, reliable, acknowledging not denying, collaborative, empowering and promoting of their choices and control (Harris and Fallot, 2001). Making people feel safe can involve empowering them to feel in control of the situation, for example by allowing them to set the terms of any visits - perhaps setting a time limit - or letting them know that they can bring the meeting to a close at any time they like.

Underpinning evidence and research

Throughout the session, frequent references were made to the work of Professor Suzy Braye and Dr David Orr from the University of Sussex who are widely regarded as international experts in working with people who self-neglect.

All their work is available on the Social Care Institute for Excellence website at www.scie.org.uk. They have summarised their findings as:

- **Know** the person, their life history, the significance to them of their behaviours.
- **Be:** show respect, empathy, honesty, reliability, care, true presence.
- **Do:** skilfully balance hands-off / hands-on approaches; watch out for small agreement and movement; be practical and value small steps; decide with others when enforced intervention becomes necessary.

Another useful framework for practitioner to consider is Professor Hazel Kemshall's 2010 work on 'defensible decisions'. She has identified that a safeguarding action or decision can be deemed 'defensible' if an objective group of professionals would consider that:

- All reasonable **steps** have been taken **proactively**, and in a **timely** way
- Reliable risk **assessment** methods have been used
- **Information** has been triangulated (i.e. compared across multiple sources and types of information) and evaluated
- **Decisions** are made jointly, and involve the subject
- All risks and decisions are **recorded, communicated to others** and **evaluated**
- Policies and **procedures** have been followed
- A **professional, investigative** approach was adopted.

Ensuring that these steps are followed is important, not only to mitigate the risk of litigation or censure but because they are good practice and will enable practitioners to offer the best support for the individuals they work with.

Hoarding and the risk of fire

The increased risk of fires caused by hoarding behaviour was discussed. One of the attendees was a borough commander from the fire service. He explained that house fires are mostly caused by smoking, cooking and heating but that circumstances are significantly changed in cases of people who hoard. Often rooms are not used for the purpose they were intended, for example the individual may sleep in a living area. Multiple plugs might be used because some sockets are not accessible, portable electric or gas heaters might be used because radiators are obstructed. All of these factors increase the risk of a fire.

If a fire does occur, entrance and exit is often difficult for fire crews and exits may be obstructed making it difficult for individuals to escape. Hoarded objects may make it difficult for fire crews to reach the seat of the fire. Therefore, if the property is empty and life is not at risk, they will not enter and will only attack the fire from outside, increasing the chances of significantly greater fire damage to the property and its contents.

The fire service will undertake home visits to conduct risk assessments, provide advice and fit smoke detectors. They can also carry out joint visits with other practitioners. It was noted that such visits can often be very constructive in encouraging individuals to adjust harmful behaviours. Home visits can be arranged by calling into any fire station or through the London Fire Brigade website at www.london-fire.gov.uk/HomeFireSafetyVisit.asp.

An online training tool has been developed with the support of the London Fire Brigade for professionals who come into contact with vulnerable people. It aims to help practitioners to understand and identify fire risks and the preventative measures that can be taken to minimise them in order to reduce fire-related deaths and injuries among vulnerable people. It is free, can be completed in just 60 minutes, and is available at www.tsa-voice.org.uk/e-learning.

Learning points

A case study was reviewed in groups and Jean and attendees shared their experiences and ideas for putting what had been discussed into practice. Themes and learning points included:

- **Case conceptualisation – think before you act!**

  Practitioners should ensure they have considered all the information available and have challenged any assumptions before deciding on a course of action. It is important to ensure that risks assessments have been carried out, mental health issues considered, other agencies consulted and, crucially, the wishes of the individual explored and recorded. Decisions should not be taken alone but in discussion with managers and other agencies. In the case study examined, there was a lack of professional curiosity from various agencies about what was really going on and professionals had made a series of assumptions.

- **Think flexibly and focus on harm reduction**

  The focus of any action should be on reducing harm, rather than eradicating the self-neglectful behaviour. Evidence shows that practical interventions tend to be more successful than psychological ones and small victories should be celebrated. Often the solutions may lie outside the usual services, for example they could involve providing advice to family members, or bringing in befriending or dog-walking volunteers, so it is important to think flexibly. Building on any strengths that have been identified can be very effective, for example trusted relationships, or occasions when the individual has shown awareness of their situation or sought some form of help.

- **Develop a plan with the individual, and keep it updated**

  Developing an action or risk management plan with the individual ensures that they feel engaged in it and are far more likely to follow it, particularly if it is referred back to and regularly updated. The process of maintaining it ensures that they are receiving relevant and timely information and advice. It was suggested that encouraging the individual to write the plan in their own hand, where appropriate, can be effective. Taking photographs can also be useful in self-neglect cases so that individuals can be reassured about what was where before agreeing to action to move objects.

- **Crises can be valuable catalysts for moving situations forward**

  Sometimes crises cannot be foreseen or avoided. When they do occur they can provide valuable opportunities for encouraging change. Examples could include spells of hospitalisation, serious or terminal illness, pet welfare or the identification of significant health risks or fire hazards. Crises often act as a catalyst to bring agencies together. Where crises involve children, their protection under the Children Act becomes the primary priority, although that does not mean that the adult does not also continue to be a priority.

- **Practitioners need to be reflective and self aware**

  The main tool that practitioners have at their disposal is themselves. It is therefore essential that practitioners are reflective and self-aware. This involves an appreciation of how different environments, personalities and issues affect them; how assertive, flexible and sensitive their approaches are and whether they are able to build trust; an understanding of their own feelings and how they impact on their practice; and their attitudes to taking and living with risk. In working with people who self-neglect it is important that practitioners know their own thresholds for expressing disgust and judgemental reflexes.

- **Maintain 'positive regard' however difficult**

  Providing the best care relies on maintaining a positive regard for the individual concerned. A positive regard is not just what a practitioner says or does in the presence of the subject or other professionals; it is also what they say and do in private and with trusted colleagues. While it is important for practitioners to be able to reflect on their feelings in their work, it would not be appropriate, for instance, for a practitioner to return to the office from a visit and say "What a disgusting man!" If they were demonstrating positive regard, they might say, "What a disgusting house! How can we help that man?" Practitioners need to remain respectful, while also challenging where appropriate and this is often an issue of team culture.

- **Early closure or annual reviews are usually insufficient**

  Self-neglect cases carry significant risks, both for the individual and the local authority. Where people are deemed to have capacity for their choices, or where cases seem intractable, it can be easy not to take action. It is important to recognise that these cases are difficult and time consuming and require empathy, rapport and multi-agency working. SABs have a vital role in supporting practitioners to manage these cases effectively and practitioners themselves should not underestimate the power their interventions can have to be catalysts for significant and positive change.

Working with families and carers

By Dr Ruth Allen, Chief Executive of the British Association of Social Workers

Before becoming chief executive of the British Association of Social Workers, Dr Ruth Allen was director of social work at South West London and St Georges' Mental Health NHS Trust where she led the development of the carers' strategy for South West London. She has researched the long-term mental health impact of domestic violence and provides organisational consultancy and professional development support in the fields of social work and mental health.

Ruth led this highly discursive, interactive masterclass on working with families and carers in safeguarding cases. The session began with attendees identifying some of the challenges and issues they wanted to explore. These included confidentiality and information sharing with wider family and carers; families supporting older adults and children as carers; difficult conversations and not 'taking sides'; and working with other agencies where families have multiple needs and varying eligibility criteria.

Who's involved?

'Family and carers' can encompass a very broad range of people. They could be adults, children, or children on the cusp of adulthood. They could be spouses or partners, siblings or dependents. There is no such thing as an archetypal family. Some people would consider their friend networks, including neighbours and other acquaintances, as 'family'. Many people with mental health issues can be dislocated from their natural family and rely on other networks. However, just like a family, the individuals within these networks can exert both positive and negative influences.

Different family members and carers can also play a wide range of roles in the situation. They can be key helpers and partners in finding solutions, or a block on making progress. They may be the perpetrators or colluding in abuse or they may be considered 'victims' themselves, either because they are co-recipients of abuse, or because they are harmed by seeing or knowing that that their loved one has experienced abuse. Alternatively, the person with the care and support needs could be abusing family or carers.

Practitioners need to be mindful that family members and carers can vary between having a positive and negative impact depending on situation. Individuals will have mixed feelings about someone who is being abusive to them if they are a loved one or if they are also caring for them.

Legal literacy

Practitioners must understand the legal frameworks available to them. Legal literacy is defined as "the ability to connect relevant legal rules with the professional priorities and objectives of ethical practice" (Braye and Preston-Shoot, 2016). It is a mixture of:

- Law - doing things right, including following local policies and procedures
- Ethics - doing the right things
- Rights - thinking derived from human rights and equality.

However, in working with families, practitioners need to be prepared to encounter situations where there is a clash

of competing rights between different family members. Ultimately, in safeguarding, practitioners need to make decisions that are defensible and that feel right to the person at the heart of the issue, in line with the principles of making safeguarding personal. Both of these considerations are explored in more detail below.

The key areas of law and guidance are:

- The Care Act 2014
- The Mental Capacity Act 2005
- The Mental Health Act 1983
- The Human Rights Act 1998
- UN Convention on the Rights of Persons with Disabilities

Practitioners must be familiar with the definitions of abuse and situations that require a safeguarding response, including those categories in more recent legislation such as modern slavery and self-neglect (both the subject of other masterclasses in this series).

Objectivity and making safeguarding personal

Kemshall's 2003 criteria for defensible decision-making was explored in the masterclass on working with people who self neglect page 10. One of the criteria that is particularly important when working with families and carers is that practitioners ensure they are collecting objective information.

Guidance for working with carers from Research in Practice for Adults (2016) states that "Social workers need to be able to use critical analysis of the legal rules to work out how best to apply them to situations involving carers. They need to apply professional judgement and the principles of defensible decision making, and be able to evidence their reasoning and thought process – 'show their working' to apply the law in practice."

Carers and families often feel marginalised from the safeguarding process, so the sooner practitioners can explain their thinking and decisions, the better. Practitioners need to feel accountable to families and carers as well as the individual. Making safeguarding personal in the context of families involves recognising the human nature and culture of the family; seeking to understand how things feel to everyone involved; identifying their rights, wants and needs; and exploring what a good outcome would look like from all points of view.

Domestic abuse

Situations of domestic abuse require particular consideration. Family or carers can be both the perpetrators or co-recipients - either directly or vicariously - of abuse. The safeguarding process only applies to people who have care and support needs (whether or not the local authority is meeting any of those needs); are experiencing or at risk of domestic abuse; and, as result of those care and support needs, are unable to protect themselves from that abuse or risk of abuse.

Domestic abuse is picked up through a wide variety of channels, including the police and health services. Local safeguarding boards and community safety partnerships need to consider the interface between domestic violence and adult safeguarding, covering situations where adults with care and support needs are being abused by intimate partners or close family members.

Practitioners need to be aware of the support that is available in situations of potential domestic abuse, including advocates and others who might be better placed to have initial conversations. Social workers are charged with being investigators, but that does not mean they cannot call on the support of others who might be better received in the first instance or able to ask different questions.

Assessments and interventions

The Care Act 2014 states that the duty of a local authority to promote an individual's wellbeing applies to carers as well as to adults who need care and support. Principles related to carers and safeguarding include involving carers in safeguarding enquiries about the person they care for and considering whether joint assessments might be appropriate.

When assessing an adult, practitioners must involve any carer that the adult has. There is a duty to assess a carer where they may have needs for support, either currently or in the future. An assessment of a carer

should look at their ability and willingness to care; the impact on their needs, including employment and participation in education, training and recreation; the outcomes that they wish to achieve; and how support could contribute to achieving those outcomes. There is a duty to address the carer's needs for support where they meet the eligibility criteria.

The Care Act 2014 guidance states that "An assessment should not just be seen as a gateway to care and support, but should be a critical intervention in it's own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to accept support when they require it." Carers often report experiencing assessments as a 'tick-box' exercise at the end of which they may or may not receive some support or resources. However, assessment should be used as an opportunity to build relationships and understanding.

There may be other specific short-term interventions that a family might benefit from. In some cases, that may be all that is required, rather than long term services. These could include relationship-based interventions, systemic or psycho-educational interventions, or family group conferencing. These interventions might form part of the assessment.

Attendees discussed the importance of developing specific skills in working with families. Only one attendee at the masterclass had received such training and there was agreement that having more people within teams able to carry out a variety of approaches for family assessments and interventions would be very beneficial.

Information sharing

Issues around sharing information with families and carers can be challenging and were discussed in depth. It was noted that understanding what is happening and why is very important for families and carers

The Social Care Institute for Excellence guidance states "It is good practice, unless there are clear reasons for not doing so, to work with the carers, family and friends of an individual to help them to get the care and support they need. Sharing information with these people should always be with the consent of the individual. If the person lacks the mental capacity to make decisions about sharing information with key people, then the Mental Capacity Act should be followed to ensure each decision to share information is in the person's best interests. Decisions and reasoning should always be recorded."

> Attendees felt that the culture within an organisation and team can have a significant impact on how practitioners approach the sharing of information. Ideally, an organisation will presume that all information can be shared unless there is a reason not to and it will be unacceptable to claim information is confidential without exploring what aspects could be shared.

Practitioners also have a role in helping individuals to think through some of the implications if they say that they do not want information shared with other family members. The approach to sharing information with family and carers often gets set early in the process. However, it should be revisited regularly as relationships develop and situations change.

Learning points

- **Hypothesise and bring professional curiosity to make it personal**

  It is crucial to understand the individual in the context of the family dynamic. Making safeguarding personal involves recognising the culture of the family and what a good outcome would look like from all points of view. Practitioners should take the time to build an objective view and avoid jumping to conclusions, even when things are moving quickly. As a view forms, it can be treated as a hypothesis to be continually tested, rather than assumed as fact.

- **Think creatively about interventions and assessments**

  Practitioners should make the most of assessments as an opportunity to build rapport, develop relationships and understanding, and to test their hypotheses about the family dynamic. This includes assessments for carers and family members. The Care Act guidance states that an assessment should be a critical intervention in its own right which can help people to understand the situation.

  A variety of interventions, such as psycho-social approaches and group conferencing can be useful. In addition, involving people from other agencies, voluntary and community sector organisations, or advocates, can introduce a different perspective and help to build engagement and understanding.

- **Build networks and work across agencies**

  Colleagues in other agencies, and in other organisations such as the voluntary and community sector, are a valuable resource. In addition to formal joint working, which should be supported through local safeguarding boards and safety partnerships, colleagues in other organisations can bring a fresh perspective. As noted above, there may be occasions where other people can bring a different insight to the family dynamic, are better placed to have initial conversations, or could help to engage individuals who have become isolated.

- **Develop and draw upon the professional skills of the team**

  Given the important role of family and carers in so many cases, practitioners will benefit from specific training on working with families. In addition, skills in relationship-based interventions, systemic and psycho-educational interventions and family group conferencing are very valuable and having people with these skills in the team mean they can be called upon to provide support when appropriate.

- **Take a positive view of sharing information, and keep it under review**

  Carers and families often feel marginalised from the safeguarding process. Practitioners should seek to develop a proactive view of sharing information, and aim to share unless there is a good reason not to. It is important to help individuals think through the implications of what they choose to have shared. If an individual does not want information shared, that decision should be revisited at appropriate intervals as relationships and the situation develop.

Community deprivation of liberty

By Steven Richards, Mental Capacity Act adviser, trainer and writer

Steven Richards has worked in the field of mental health for over 20 years, both for the NHS and voluntary sector. He is a specialist adviser on the Mental Capacity Act with the Care Quality Commission. Steven has been an inpatient advocate for Mind and has represented directly before the Court of Protection. He is a director of Edge training and consultancy: www.edgetraining.org.uk.

Steven led this masterclass, which examined the law and procedures surrounding the deprivation of liberty for adults in community settings. The Mental Capacity Act established clearly defined procedures and safeguards that institutions, such as hospitals and care homes, must follow when they put in place care plans that deprive an incapacitated individual of their liberty. However, there are many instances where care plans put in place in other settings, and even in people's own homes, amount to a deprivation of liberty. In these cases, a Community Deprivation of Liberty (CDoL) order must be authorised by the Court of Protection.

Consent and restraint

Steven reminded attendees that consent is the starting point for all interactions between individuals and practitioners. Whatever action a practitioner is taking, they must have legal authority to do it and in most cases that authority comes from consent. In its legal definition, consent must be both informed and freely given (not coerced). Informed means that the individual has been given and understood information on the nature of the intervention, its purpose and potential consequences.

If there is any doubt, an assessment of capacity must be undertaken. As was explored in previous masterclasses, an assessment of capacity is not a blanket assessment; capacity can only be assessed in relation to an individual's capacity to make a specific decision at a specific time. Where a person lacks capacity, actions can only be taken in their best interests and there is a statutory checklist of factors to consider which includes the wishes of the individual and consultation with family or carers.

In some cases, an individual's bests interests will involve preventing them from doing something in order to prevent them coming to harm. The legal definition of restraint in the Mental Capacity Act is 'the use or threat of force to make a person do something they resist or the restriction of liberty of movement, whether or not the person resists.'

There are four criteria in the act that must be met for an adult to be restrained:

- they must lack capacity;
- it must be in their best interests;
- it must be to prevent harm to the person lacking capacity; and
- the restraint imposed must be proportionate.

Where a person is restrained outside of a formal institutional setting through restrictions in a care plan, the restrictions may reach a threshold where they are also deprived of their liberty and this must be made lawful through a CDoL order.

Threshold for community deprivation of liberty

A landmark Supreme Court ruling in 2014 established the threshold for what counts as a deprivation of liberty. The cases of *P v Cheshire West and Chester Council* and *P&Q v Surrey County Council* overturned previous judgements that had taken into account whether the person was objecting to their confinement and how frequently they went out of their care setting. The new ruling deemed that these matters were not relevant. The ruling in the three cases reviewed by the Supreme Court not only set a lower threshold for deprivation of liberty but also confirmed that it applied to domestic settings.

One of the cases was that of MIG, an 18 year old with severe learning disabilities and hearing, visual and speech impediments. The court found that she was incapable of independent living and largely dependent on others. She lived in a domestic dwelling with a foster mother she regarded as 'mummy' who provided intensive support with most aspects of daily living. There were no locked doors, but if she tried to leave alone she would have been stopped. She had not tried to leave and was settled and content. None of her relatives opposed the placement. There was no medication, no physical restraint and no restrictions on visitors. MIG had a good social life and went to college daily, but had to be escorted as it was not safe for her to cross the road alone. The court found she was subject to *'continuous supervision and control and not free to leave'* and therefore deprived of her liberty.

The Law Society's guidance on identifying a deprivation of liberty states that 'where the person or body responsible for the individual has a plan in place which means that they need always broadly to know where the individual is and what they are doing at any one time' then that would suggest the individual is under continuous or complete supervision or control. The use of assistive technology to track individuals (who lack capacity) or alert staff if they leave a premises could lead to a deprivation of liberty. Even though the technology does not restrict the individual, its purpose is to alert staff so that they can take restrictive action.

Even in instances where individuals are allowed out on unescorted leave, they could be considered deprived of their liberty if they are only able to leave with the permission of staff, if staff decide the duration and conditions of the unescorted leave, or if staff can stop the leave at any time.

'Freedom to leave' is defined as the freedom to discharge oneself and reside somewhere else on a long term basis. The Law Society guidance states that a person is not free to leave if they are only able to do so with permission and, if they do seek to leave and not return, then steps will be taken to locate them and bring about their return if they do not do so of their own accord.

Whether liberty is deprived or not is unrelated the quality of care of plans in place. The Supreme Court stressed in its 2014 ruling that "we should not confuse the question of the quality of the arrangements that have been made with the question of whether these arrangements constitute a deprivation of liberty."

Applications for community deprivation of liberty orders

Article 5 of the European Convention on Human Rights (which is separate from the EU and will not be affected by Brexit) is the right to liberty. The European Court of Human Rights has found that liberty is deprived and must be authorised in law when there are three elements in place:

- **Objective element:** confinement in place for a non-negotiable period of time
- **Subjective element:** the individual has not consented
- **State element:** a state body, such as an NHS trust or local authority, is involved.

Where these three elements are in place, there are different legal frameworks to authorise the deprivation of liberty depending on the circumstances:

- 18+ in a care home or hospital = Deprivation of Liberty Safeguards (DoLS)
- 18+ not in a care home or hospital = Court of Protection (CDoL)
- 16-17 in a placement anywhere = Court of Protection (CDoL)
- Any age in a hospital registered to use the Metal Health Act for the treatment of mental disorder = Mental Health Act
- <16 not in a mental health unit = Children Act or Family Court

Applications for CDoL authorisations must be made to the Court of Protection which has agreed a streamlined process, sometimes called the Re: X Process, to deal with the rising number of applications.

Applications are made on the mandatory COP DOL10 form. There is a cost of around £900 when the form is submitted. If the form is returned for any reason and needs to be resubmitted the charge is incurred again. Any staff can complete the form – it does not need to be a lawyer or best interests assessor – but they should be professionals. The form does require evidence of a medical diagnosis of 'unsound mind'.

The form requires the assessment of capacity, diagnosis of unsound mind, best interests assessment and the care or support plan to be attached. It asks for details of the level of supervision and the use of restraint or sedation and assistive technology. It requires details of the risks of harm if liberty is not deprived and what less restrictive options have been tried. The form also asks if the person has a tenancy (and if so, who has authority to sign the tenancy), whether there are any restrictions on contact with others, and for the findings of consultation with the individual and 'anyone interested in their welfare'.

CCGs should apply for those individuals that they are funding. Where a number of individuals are subject to the same restrictions, separate applications must be made, but a copy of 'generic information' may be attached to each application.

The information on the form is assessed by a judge, so it is important to think in terms of the evidence. All opinions (conclusions) given by professionals should be founded on and refer to the evidence that led them to reach the opinion. The issues the judge will be considering include whether there is any conflict with existing advance decisions or arrangements; whether the arrangements amount to a deprivation of liberty; whether the arrangements are in the individual's best interests; and if the deprivation of liberty is a proportionate response to the risk and seriousness of potential harm to the individual.

A CDoL order can be made on the basis of the submitted papers alone without the need for a hearing but the court is likely to decide on an oral hearing if there is anything that it wishes to examine in more detail or if any of the parties requests a hearing. Issues that would not be appropriate for the streamlined process and would require a full hearing include any challenge about the individual's lack of capacity or best interests; a failure to consult with the individual or other relevant people; any objection by the individual to the care plan or placement; and any potential conflict with a relevant advance decision or lasting power of attorney or deputy.

Authorisations can be made relatively quickly in straightforward cases. Authorisations are almost always made for one year, with a report-based review by a judge annually. Authorisations will establish the review point, the right of appeal and identify the individual's representative.

However, the need for a representative to be identified can be problematic and is leading to many applications being 'stayed' by the court with no authorisation given while a representative is identified.

If a reauthorisation is not secured by the review date, the deprivation of liberty will become unlawful. Courts will not chase renewals, so teams need to keep on top of this. There is some cross over with the 'regular' reviews required under the Care Act, and local authorities will want to ensure they are not duplicating effort where it is avoidable.

Discussion points

Queries were raised about what would constitute an appropriate risk assessment to provide evidence that the restrictions in place through the care plan are proportionate. Attendees discussed how it is possible to provide evidence that an individual would come to harm if they have so far been protected from harm. Steven highlighted that evidence provided has to be personal to the individual; it can't be based on 'what we do for everyone else'. It was suggested that the individual could be exposed to a situation and observed, for example they could try going out on their own but with someone following them at a close distance.

As noted above, the language used in an application for a CDoL is important. Professionals often speak of 'supporting' an individual. For example, they might say they have put in place a plan that supports an individual to leave the house with arrangements for them to be escorted. However, a judge would consider this a restriction as well as support.

Steven alerted attendees to be aware of any potential breach of Article 8 of the European Convention on Human Rights: the right to a private and family life. This might occur in relation to an individual who lacks capacity if a professional limits contact with their family, refuses a family request for discharge to return home, or removes the individual from their family because of concerns the family are abusive. In these cases, legal advice should be sought urgently as this would require a separate Court of Protection welfare application.

Learning points

- **Remember how low the threshold is**

  It is important to remember how low the Supreme Court ruling sets the threshold for deprivation of liberty. Even if the individual is in their own home, they and their family are content, and there are no locked doors, they may be deprived of their liberty. What matters is whether they are subject to continuous supervision and control (which may be through the use of technology) and whether they are free to decide to leave and not return.

- **Be very detailed and explicit about the care plan**

  When considering whether a care plan amounts to a deprivation of liberty, and when submitting an application for a CDoL, the care plan needs to be detailed and explicit. Be mindful to consider that plans that 'support' an individual to do an activity might also be imposing constraints and restrictions on how they do those activities.

- **Get the CDoL application right first time**

  A CDoL application is costly. It is also long and detailed. But it is clear what information needs to be supplied and it can be completed by a non-professional. Scrutiny before it is submitted is important because if it is returned and needs to be resubmitted for any reason the costs are incurred again. Remember that the information will be reviewed by a judge who will expect to see the evidence for any stated opinions about care needs and risks, for example.

- **Ensure processes for reauthorisation requests and to avoid duplication**

  CDoLs are usually issued for review after one year. However, the court will not request this so teams need to ensure that they have processes in place to prompt the submission of reports requesting reauthorisation at the right time. There are cross overs with other processes, such as the 'regular' reviews required by the Care Act, so local authorities will want to align processes to avoid duplication wherever possible.

Resources

Law Society's guidance

Practical and authoritative guide to identifying a deprivation of liberty, commissioned by the Department of Health

www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Case law

Sign up for the newsletter, download the acts, codes of practice and case law

www.mentalhealthlaw.co.uk

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 or implement it.

www.scie.org.uk/mca-directory

BooksWise

Free downloads of assessment of capacity form, best interests form, rights leaflet for people under DoLS (or representatives), DoLS screening tool, MHA or DoLS chart

www.bookswise.org.uk

BooksWise app

A mini guide to the MCA for iphone, iPad, and Android phones and tablets

Search in your app store for 'mental capacity act' from BooksWise Publications

39 Essex Chambers resources

Barristers chambers specializing in MCA and DoLS, with useful resources on community DoL.

www.39essex.com/resources-and-training/mental-capacity-law

Modern slavery

By Paul Griffiths, Vice President, Police Superintendents' Association of England and Wales

Darrell's story

Paul's talk began with the story of Darrell Simester, a vulnerable adult from Kidderminster who was born in 1970. Darrell had suffered epilepsy, had learning difficulties and had struggled through school. He was well supported by his parents. In 2000, when Darrell was 30, he met a family of travellers who invited him on holiday with them to South Wales.

It transpired that the family had taken Darrell to mind their children while they went out in the evenings. He was tired of this and ran away from them, becoming homeless on the streets. He was soon picked up by another traveller family who offered him accommodation and food in return for work and he joined them 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 'lost contact' and did not instigate a missing person investigation. Darrell made periodic phone calls to his family over the next eight years and whilst he insisted he was ok, his parents did not believe him and continued to pressure the Police into locating him. Over the following thirteen years his parents continued trying to trace Darrell. Eventually, following campaigns through both traditional and social media, they were informed he was 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 the work he had done that week and told him he could take the three horses he had earned over the thirteen years he had worked on the farm.

Darrell had lost 3.5 stone in weight, had not cleaned his teeth for thirteen years and had a large testicular tumour. He gradually began to tell his parents what had happened to him. He had worked over 14 hours a day on the farm, every day, for thirteen years and left only twice. 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 had then been moved in to a dilapidated caravan. One night, it was so cold, that the dog he shared the caravan died from hypothermia and 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 which was soon transferred to Gwent Police, as the scene of the potential crime.

The fifth and final masterclass was led by Detective Chief Superintendent Paul Griffiths, an officer with Gwent Police and currently Vice President of the Police Superintendents' Association of England and Wales.

Paul's powerful presentation covered his experience leading Operation Imperial, an investigation that began with enquiries into a person who had lost contact with their family. He and his team went on to identify up to 140 potentially vulnerable people who were at risk of being victims of forced labour in South Wales.

After Paul told moving stories of some the people encountered through the investigation, and how the Police developed a 'care-first' approach to working with them, Paul and the attendees used the stories to draw out their own experiences and insights and the shared lessons for professional practice.

The impact of Operation Imperial

Operation Imperial become 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 scale of the problem, Darrell's case helped to broaden the understanding of the issues, beyond a previous focus on trafficking into prostitution and domestic servitude.

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 the criminals within the travelling community were operating.

The criminals would actively seek out vulnerable people at soup kitchens and homeless centres. They looked for weaknesses that they could exploit, such as metal health problems or alcohol dependency. They approach individuals with offers of sanctuary – accommodation, food and work.

The victims are housed but the promises of pay are often deferred until they are drawn into the environment. Those who are weaker will often not ask for their pay. Those who do, or who try to leave, are 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, but the first priority was Darrell's care. Paul described the approach the police took as a paradigm shift 'from custody to care'.

They brought in an international psychosocial expert to help them understand the path from supporting Darrell's recovery to being able to take reliable evidence 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, voluntary and community sector agencies on Darrell's recovery, getting him healthy again, addressing his tumour and teeth problems and providing emotional support.

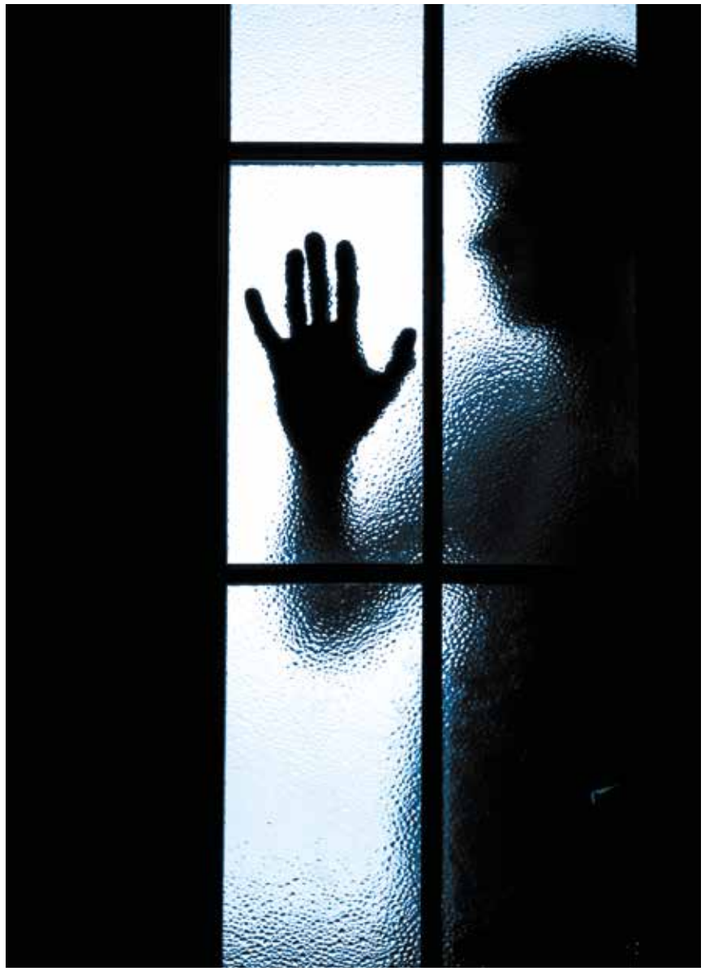
The Modern Slavery Act had not yet been passed and they relied on a Forced Labour offence in the Coroners Act. Eventually the farm owner was jailed for four and a half years for forced labour. He could only be convicted of Darrell's forced labour for the last three years of his slavery because the offence was only introduced in 2010.

While considerable police resources were dedicated to Darrell's case, it yielded just one single conviction of four and a half years. It was recognised that the investigation that started with Darrell had 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.

Multi-agency working

Tackling modern slavery, safeguarding vulnerable people and identifying and prosecuting offences requires joint working across a number of agencies.

Close working between police forces is obviously very important. The National Referral Mechanism (NRM), originally established in 2009 as a framework for identifying and ensuring victims of human



trafficking receive appropriate support, saw referrals grow, including all victims of modern slavery. Local authorities, along with a range of other public bodies and 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 with, 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 any investigations and the Gangmasters Licencing Authority is involved in protecting 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 the 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, but it is suspected that the criminals still operate outside the shelter.

The ‘Alpha slave’

Police had been alerted to a potential victim known as ‘Scottish Mike’. They 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 got emotional and as officers built up a good 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 and became entrapped. He was controlled through threats and violence. He escaped and went back to Scotland where he signed on. Soon after, he was kidnapped by four Welsh men outside the job centre, bundled into the boot of a car, driven back to Wales and beaten. He said that ‘he became their property’ from then on.

He was paid to lead a team of other slaves to complete building work, usually laying driveways. He was threatened that if deadlines were not met and he would come to harm. As a result he used threats to 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’

Often the victims become institutionalised or develop Stockholm Syndrome, where people held initially against their will develop feelings of trust, loyalty or affection for their captors. The second victim that the police rescued, from a farm neighbouring Darrell’s, had lived in a dilapidated caravan for eleven years, He was repatriated to his family and 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 him food, contact with his family, and to take him to safety. He accepted food but did not want any further help and did not want to talk to the police. Despite extensive efforts, the police could find no grounds to keep him against him will and reluctantly returned him to the traveller family. The family saw him as a risk and wanted nothing more to do with him and sent him to a homeless shelter. The man still refuses to speak to the 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.

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

Discussion

Paul was asked whether interventions from social services might jeopardise police investigations or evidence gathering in modern slavery cases. He was very clear that the first priority has to be ensuring that vulnerable individuals are safe. He explained that in kidnap cases, ensuring the safety of the victim always takes precedence over evidence gathering. Slavery cases, he said, are kidnaps in ‘slow time’.

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 around the 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) can be brought for any crime although the CPS is understandably reluctant to bring such prosecutions.

Attendees discussed the relevance of Paul’s story to their own work. It was recognised that while there were a few horse farms in Kingston, there were many other types of industry that could be environments for modern slavery, such as car washes, the sex industry and domestic servitude. The need for all agencies to be aware and alert to signs of potential slavery was highlighted. One attendee from the fire brigade said that while they monitor for vulnerable adults when they carry out fire safety inspections, potential slavery is not something they would naturally consider.

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.

The cultural aspects of the South Wales case were discussed in depth. Paul was precise with his language to say that he was dealing with criminal individuals within the traveller community. However, he did reflect that while much useful intelligence came from individuals within the traveller community, many others seemed to turn a blind eye to the use of forced labour. Many in the community felt it was normal for a family to have a ‘dosser’ who would work for accommodation and food and some in the community said that they were ‘doing the dossers a service’ by keeping them away from drugs and alcohol.

Paul said that it was important not to shy away from tackling potential crimes, for fear of appearing racially insensitive. In Gwent, the police have done a lot of work to develop relationships with the travelling community, both to develop mutual understanding between the police and the community and also to establish that having a ‘dosser’ is unacceptable and forced labour is a crime.

The cultural aspects of the victims was also discussed. Paul said that he believed criminals were increasingly turning to foreign nationals for slave labour because they are much harder for the police to trace and they are more reluctant to give evidence. In addition they may also come from cultures where there is less trust in the police, or they may expect the police to see them as illegal immigrants, rather than as vulnerable individuals who need support. They may also have families under duress back at home.

Learning points

- **Be curious**

  Professional curiosity is 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 case of the criminals and their victims in 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 slavery. These could include the police, health services, fire brigade, local charities and voluntary services, HMRC, housing, trading standards and planning departments. Information that may seem insignificant on its own, can often 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. They are likely to need support to understand that they have been a victim and to address any physical and mental health needs, before it is appropriate to begin trying to find out more about their experience. 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 the victims of exploitation.

- **Legal literacy around mental health issues is important**

  Attendees felt that there continues to be some confusion and uncertainly across the various agencies about the powers that are available under current metal health and mental capacity legislation to protect vulnerable adults. All people working with vulnerable adults should have a high level of legal understanding around the relevant legislation.

- **Don’t shy away from cultural issues**

  There are a number of recent examples where cultural factors have meant that vulnerable people have not been protected and potential crimes have not been investigated. While it is important to be respectful of cultural sensitivities, they are never a reason not to take action to protect vulnerable individuals, investigate potential crimes, or to educate communities about what is acceptable and what is illegal.

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

Modern slavery resource centre

Resources for frontline professionals

www.unseenuk.org/learn-more/frontline-professionals

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

Thanks to everyone who attended, led and facilitated these courses. We hope you gained valuable insight and learnt how to better enable effective implementation of safeguarding adults.

Contact Details
Health Innovation Network

Kathy Tyler,
Programme Director
Capacity Building
kathy.tyler@nhs.net
07795 956414

Josh Brewster,
Project Manager
Capacity Building
josh.brewster@nhs.net
020 7188 7188 ext 57042

https://healthinnovationnetwork.com/projects/south-west-london-system/
twitter:@HINSouthLondon

Postal Address
Health Innovation Network,
Minerva House,
5 Montague Close,
London SE1 9BB

Royal Borough of Kingston upon Thames

Dawn Secker,
Service Manager and Principal Social Worker
Royal Borough of Kingston upon Thames
dawn.secker@kingston.gov.uk
0208 547 6102

Postal Address
Royal Borough of Kingston upon Thames
Guildhall 1
High Street
Kingston
Surrey KT1 1EU

With thanks to Dan Wood,
dan@danwoodcomms.co.uk

South West London
Academic, Health and Social Care
System

THE ROYAL BOROUGH OF
KINGSTON
UPON THAMES