Editorial

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Welcome to this second issue of the year. As usual, we initially present some information from recent news sources that link to the world of safeguarding and public interest in this topic.

To start this issue, although we have been advised that the end of austerity in the UK is in sight, its impact lives on and is seen in many aspects of society. Where would we be without crisis management and Brexit? Some might imagine that things would be better without these aspects...

It was encouraging that during January, Ofsted proposed to overhaul its inspection framework[1]. It will emphasise the quality of young people's education and address the "off-rolling" – that is the exclusion – of less able pupils to bump up the examination league tables. And, this has been followed by some suggestions and a government consultation proposing that there should be a national register of children who are home-schooled. The apparent intention of such an initiative would be to assist local councils to take action when standards of such educational provision appear to be poor, or if children are identified as at risk in the home setting[2].

We learned about the wisdom of Citizens' Assemblies last year when Fintan O'Toole[3] set out the ways in which an experiment in "deliberative democracy" addressed the Republic's seemingly intractable divisions concerning abortion. It involved 100 "ordinary"/demographically representative people giving up five weekends to hear from experts in medicine, law and ethics, to women who had been affected by Ireland's restrictive laws and to lobbying groups. It gave participants the means to have difficult discussions. "If democracy can create the context for that humane exchange to happen over and over again, it can withstand everything its enemies throw at it". Although O'Toole laments that Westminster's Conservative Party did not favour the approach over a referendum, we wonder what would it take for such an assembly to consider the distribution of funding for public services?

The succession of horrifying murders arising from knife crime persists. From the pitiless murder of 14-year-old Jaden Moodie during January to those of Jodie Cheney and Yousef Ghaleb in March – both 17 years old. Rising knife crime has coincided with cuts to the UK's youth services. In 2018, in the West Midlands alone, there were 690 child victims of knife crime[4].

The limited impact of scandals is being played out in the wake of London's Grenfell Tower tragedy. The hunger for change is being muted by the owners of buildings wrapped in combustible cladding who are desperate of offload the bills for replacing the cladding onto leaseholders. There are 437 buildings in England with "Grenfell-style cladding systems". It turns out that during 2015, the government was warned of the dangers of flames passing through concealed cavities – but the advice was kept confidential until early February[5]. Although the government has paid £400m for cladding removal from social or residential buildings which are 18 metre or higher[6], those in privately owned buildings tend to be in dangerous properties which are believed to be un-mortgageable. "Social Housing in England after Grenfell" is a milestone document by Shelter's appointed social housing commission. It makes the case for a strengthened regulator with the powers to inspect private and social landlords; the outlawing of no-fault eviction with limited routes of redress. It concludes that building high-quality housing in mixed communities is in the national interest. If this is a catalyst, we might claim that Grenfell halted a dysfunctional housing market.

The harsh context in which Universal Credit is being "rolled out" was exposed by four single mothers during January. Their legal victory confirmed that the DWP has been incorrectly

interpreting the universal credit regulations. The women argued that they were struggling financially because of enormous variations in the automated assessments of their monthly payments[7]. The flagship programme is six years behind schedule. During February, Steven Smith was denied benefits and deemed "fit for work". He is 64, six stone, had chronic pulmonary disease, osteoarthritis, an enlarged prostate and uses a colostomy bag and can barely walk[8]. Although two doctors confirmed that he was very physically compromised, he "failed" a DWP work capability assessment during 2017. It is remarkable that he required professional assistance to have the decision overturned. During February, the Work and Pensions secretary admitted that Universal Credit had contributed to an increase in food bank use. During March, the Work and Pensions Secretary announced that she wanted to alter the course of the government's welfare policy to a more compassionate direction[9]. Not surprisingly we wait to see what form that might possibly take.

The Lawn Tennis Association received "repeated warnings" about Coach Daniel Sanders and inappropriate behaviour over a five-year period and yet Sanders remained as Head Coach at Wrexham Tennis Centre until he was arrested and charged during 2017. He was recently sentenced to six years for the sexual abuse of a child he was coaching. Sports Resolutions reviewed events[10]. It determined that the LTA did not prioritise safeguarding and that its responses to allegations were inadequate. Safeguarding in sport is an important and increasingly prominent issue.

The Femicide Report for 2017, published by Women's Aid and the Counting Dead Women Project, makes for grim, but interesting reading as it catalogues the deaths of 139 women in the UK who were killed during that year by a man - or where the principal perpetrator (either charged or convicted) was a man known to the woman. One snippet of information from the report is that of those women who were older than 60 years at the time of their deaths, most of them were killed by a male member of the family - either spouse, son or grandson; indeed, 7 per cent of the women were killed by sons (Long et al., 2018).

Australia's "Deaths Inside" project has collated a definitive, searchable database cataloguing the deaths in custody of 147 Aboriginal and Torres Strait Islander people from 2008 to 2018. There have been more than 407 deaths since 1991 - the publication date of the Royal Commission into Aboriginal deaths in custody[11]. Since there was no national register, every police and corrective services department was contacted for information and coronial findings were collated and checked. The difference in treatment between Indigenous and non-Indigenous people was stark. The former died from preventable conditions and were less likely to receive the medical care they required.

The "misguided" programme of dispatching children to former British colonies from the 1920s-1970s for a "better life" failed on so many levels. The children typically faced lives of servitude, hard labour, separation from their siblings and some endured physical and sexual assaults. Those who were sent by a church, state, voluntary or other organisations, unaccompanied by an adult family member or sent to live with a member of their birth family are eligible for payments of £20k[12].

Towards the end of March, the Secretary State for Health (and Social Care) announced that the much-delayed Green Paper on Social Care would be issued at the beginning of April. Given the extent of other issues pre-occupying parliament at this time, it seemed likely that there might be a further delay. This is particularly since we were previously assured that the Green Paper would be issued in January, together with the NHS Plan and nothing appeared at that time. Meanwhile the social care system continues to creak (if not come apart) at the seams, and safeguarding is as affected as other parts of this evermore deteriorating system.

Fr Martin Shipperlee, the Abbot of Ealing Abbey in London resigned during February[13]. His departure followed his appearance before the Independent Inquiry into Child Sexual Abuse when he answered questions about his handling of allegations of sexual assaults by monks and teachers. Two Senior Monks - Andrew Soper and David Pearce have been jailed for a series of offences against pupils. The former fled from police bail during 2011. During 2017, he was convicted of 19 charges of assault against 10 pupils ranging from sadistic beatings to anal rape and was sentenced to 18 years in prison. David Pearce had pleaded guilty during 2009 to sexual attacks on five boys, four of whom were under 14 years. His crimes spanned 36 years.

The Catholic Church remains mired in an "abuse crisis[14]" as its "conspiracy of silence" is under increasing scrutiny. Ex-Cardinal Theodore McCarrisk of Washington, DC was defrocked during February although his sexual assaults were apparently common knowledge in the church. An explanation has been offered by the abbot primate of the English Benedictine Congregation: training hinged on doctrine with insufficient attention paid to self-understanding and human development. In addition, "There was catastrophic moral failure and weak leadership [...] [which can involve] naiveté: a willingness of a bishop to believe a paedophile priest when he admits an offence, says it will never happen again and begs forgiveness". In Australia, Cardinal George Pell remains a Cardinal irrespective of his conviction for sexually abusing two boys at St Patrick's Cathedral in Melbourne. The church awaits the outcome of Cardinal Pell's appeal. This abuse crisis is not over yet...

The first paper in this issue is by Jim Rogers and Lucy Bright from the University of Lincoln and considers issues relating to professional assessments of mental capacity within the framework of the Mental Capacity Act (MCA) 2005. The paper presents findings from a research project which explored the approaches used by different groups of assessors of the mental capacity assessments which are conducted as part of Deprivation of Liberty Safeguards (DOLS) processes. The study consisted of use of vignettes and interview(s) with different groups of assessors about the factors that are likely to have an influence on the assessment process. Most of the participants did not refer to the two-stage test of capacity, although this is required, nor did they discuss the "causative nexus" which mandates assessors to clarify that it is the recognised diagnostic element which results in the inability of the person to meet the functional aspects of the two-stage test.

Most assessors did not refer to the required two-stage test of capacity or the "causative nexus" which requires that assessors must make clear that it is the identified "diagnostic" element which is leading to the inability to meet the "functional" requirements of the capacity test. These results are relevant to all people in health and social care sectors who undertake the assessments of mental capacity. The findings will also be helpful to all of those involved in training in relation to the MCA. Since the DOLS regulations are being reformed, there are implications that are pertinent to policy makers in the UK and in other countries which have similar legislative frameworks relating to capacity.

The second paper is a viewpoint piece by Ian Cummins of Salford University, which considers the concept of vulnerability, particularly in relation to the work of the American Philosopher Martha Fineman. In essence, the element of Fineman's work that Cummins draws on relates to her calls for a radical rethinking and re-conceptualisation of societal notions such as autonomy and vulnerability. Cummins argues that this type of re-framing could result in a move away from the managerialism and process-driven approaches that currently appear to be predominant within social work practice. This is an interesting and thought-provoking paper, and although it is directed at modern-day social work, could well apply and have implications for other areas of practice within human services and clinical professions.

Our third paper is also a conceptual paper, this time relating to the abuse of individuals who live in care settings. It is provided by Independent Consultant Steve Moore, whose work will be familiar to readers of this journal. The paper considers some of the existing theories and research on why adults may be abused - or be at risk of abuse and suggests the addition of some recent work from social psychologists that may be relevant to this area. By using such theories in considering explanations for behaviour(s) in different circumstances, the paper offers the chance to think through how these particular theories might be used to both explain how abuse develops and what might be done to counter such situations, particularly those that occur in care homes.

The following paper by Denise Shanahan of Cardiff and Vale University Health Board (and Cardiff University) is a practice-related article, which is based on a conceptual analysis of poor care, following one specific theoretical perspective, Rogers' evolutionary cycle. The aim of the paper is very much to explore the concept of poor care, with a particular focus on the care of older people in health-related settings. From the findings of the conceptual analysis that was undertaken, poor care is recognised in the context of the previous circumstances of individuals, their use of services (especially in relation to healthcare) and their interaction(s) with healthcare staff. It would appear from this analysis that

interpersonal characteristics and dynamics, together with organisational constraints are also relevant in such considerations. The need for further work relating to both thresholds for reporting and to improve recognition of situations of poor care is highlighted in the paper.

Our fifth paper is by Ana Gil from the National Health Institute, Lisbon, Portugal, and also concerns the care of older people, as it reports on a research study which investigated systems relating to quality procedures and complaints in nursing home care. In Portugal, an inspection-only approach is used in relation to quality systems, and the study examined complaints and the monitoring systems in place that effectively control the quality of care provided in nursing homes. Through the analysis, the study explored how mistreatment of older people is identified and dealt with by the national social security services (regulators). One particular focus was on the indicators which are used to assess how poor quality care and mistreatment is perceived and defined, the factors which affect the mistreatment of older people in nursing home settings and what sanctions are used to prevent and intervene in situations of mistreatment. Also, an analysis of more than 3,500 complaints made to the inspection services, a qualitative component was also used, through the use of focus groups with inspectors from the national service. The findings from both strands of the study are discussed in terms of the identification of abuse and violence within nursing home settings and the implications of the findings for the regulation and control of care quality - and the effectiveness (or not) of such measures.

The final paper in this issue is provided by Julie McGarry and colleagues from the University of Nottingham and King's College, London. This paper has a different focus that of exploring the primary care response to domestic violence and abuse (DVA) through considering the operationalisation of a national initiative that has been rolled out within primary care settings. The Identification and Referral to Improve Safety (IRIS) initiative was developed for use within primary care to support the women survivors of DVA. Whilst the initiative has been evaluated at national level, much less is known about its implementation and likely impact at the local level. This relatively small-scale qualitative study was, therefore, designed to examine the effectiveness of the use of IRIS within one locality in the UK, and interestingly did so with both providers of the service and the (women) users of the service. This was achieved through the use of interviews with professionals from primary care teams and a focus group/interview with women who had used the IRIS system within one primary care locality. Both elements of the study identified the issues relating to safety (and provision of a safe place for victims/survivors) as key and establishment of a whole team approach was also seen as crucial for success in implementing the initiative.

The final item in this issue is a book review, written by Independent Safeguarding Consultant, Pete Morgan, which considers an edited volume relating to safeguarding practice under the Care Act, written by Adi Cooper and Emily White. This book contains a number of contributions from professionals in practice and provides ideas and suggestions about improving practice, something which all of us in safeguarding strive to achieve.

We hope that this issue of the journal provides ideas and suggestions for readers to reflect on about the wide-ranging field that is adult safeguarding. As we have said on previous occasions, we are always interested in hearing from potential contributors and willing to discuss ideas for possible papers relating to research, policy and/or practice in this broad topic area. If you have suggestions or ideas, and wish to discuss these further, do make contact with one of us and we will be pleased to provide advice and offer support on this. Our contact details appear on the inside cover of the journal and are also available on the journal website.

Notes

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