Editorial

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Welcome to this first issue of the new volume and Happy New Year to all our readers (even if belated!). To start with, we provide some information and recent stories that relate to safeguarding, which have appeared in different types of media in recent weeks. In fact all of the items cited appeared within a period of one week in December (which may, of course, be noteworthy in itself!)

In a break from our normal pattern of providing brief snippets of such items, to begin, we provide some more detailed information about a recent court case that was concluded towards the end of the year. In early December, a serial rapist, Joseph McCann, was found guilty (and sentenced to 33 life sentences) following incidents that occurred after he had been released early from serving a prison sentence due to errors that had occurred by the Probation Service[1]. It is worth considering these events and failures in some detail as there are similarities with some of the issues that are found at times in Safeguarding Adult Reviews in relation to lack of communication and information sharing between agencies. During a previous period in prison from 2008 (for violent burglary), as the judge had considered him to be dangerous, he had been given a sentence of Imprisonment for Public Protection, which meant that after a minimum term of two and a half years he could only be released when the Parole Board decided that it was safe to do so. Although such sentences were intended to protect the public from violent and dangerous offenders, they were cancelled as part of reforms introduced by government that took place in 2012. Applications for release made to the Parole Board in 2010, 2012 and 2014 were all rejected; however, at the time of a fourth application in 2016, the Parole Board accepted a view that McCann's behaviour had improved sufficiently that he could be released, subject to quite stringent conditions relating to regular contact with a probation officer, staying in approved premises (probation or bail hostel), accepting a night-time curfew, regular drug testing and informing authorities of any new relationship that he had.

Within months of his release in March 2017, he was arrested and charged with burglary and remanded to custody. Unfortunately, the correct procedures were not followed – as he was on licence from prison when arrested, he should have been recalled to prison and the Parole Board would have been informed of this by the Probation Service, but this did not happen. The consequence of this failure was that the Parole Board then had no control over the decisions made about his future release from prison. In January 2018, McCann was sentenced to three years in prison for burglary (including vehicle theft). The judge at that hearing indicated that the recall process should have been applied and the Parole Board notified and further stated that the sentence given would run concurrently with his existing sentence (re-applied as a result of his recall, if this happened retrospectively), and with no reduction in the sentence applied due to time spent in prison on remand whilst awaiting the court hearing.

However, the recall process was not applied, the Parole Board was not informed and time served whilst on remand was counted as part of his sentence. The effect of this meant that McCann was treated the same as any other offender who had been given a fixed-term or determinate sentence. He was therefore released in February 2019, at the halfway point in his sentence, after spending 18 months in prison.

Within two months, he had begun re-offending, carrying out a series of sex attacks on women and children in England over a period of two weeks, before being arrested. His victims were aged from 11 to 71 years and included three women who were abducted from the street at knifepoint and repeatedly raped. Following a court hearing which he repeatedly refused to

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attend, McCann was found guilty of 37 different offences and given 33 life sentences. The judge has called for an independent, systematic investigation of the failures in the system, which resulted in the victims not being adequately protected[2]. It appears that the main questions about the failure to notify the Parole Board focus on the National Probation Service, in particular the office which dealt with McCann on his release and which held responsibility for his case. In conjunction with this, the chief executive of HM Prisons and Probation Service apologised for the failings for his early release and has said that "strong and immediate" action was taken in relation to those involved.

Evidently it will be interesting to see what transpires in the independent review of the case that is held (and indeed to see how long it takes for that to happen). It will also be of some interest to see if there was – or has been – any involvement of safeguarding services – related to either adults or children who were affected; as well as the older woman of 71 years, two 14 years old, a 13 year old and an 11 year old were all assaulted by McCann during his two week spell of offending. What is also of note is the acknowledgement of the judge, during sentencing, that the victims would probably "never fully recover". And in an impact statement made by one 25 year old woman to the court, she talked about the sequence of harrowing and painful events that happened and the deep trauma that she has experienced as a result. What has made this more difficult for this young woman is that she has had to pay to access the therapy that she needs to assist her; as there was an 8–12 month waiting list for equivalent NHS services and treatment, she therefore took a decision not to wait for this period of time and to access treatment on a private basis. Her impact statement also referred to the current levels of under-resourcing for NHS services, in particular those for survivors of violence and abuse[3]. This may be (at least in part) due to many years of austerity and cuts to services by successive governments, which readers are aware has been a theme within a number of our editorials.

Also in December, a report of likely cuts and restrictions to the advocacy system used in courts (and known as McKenzie Friends) was announced. Concern has apparently been increasing about the possible misuse of such schemes and of people being charged for such services by advocates for court hearings, which is stated as having resulted from the previous withdrawal of legal aid provisions to assist in representing individuals attending courts. Such advocates may not have received any legal training and the Bar Council, Law Society and a number of politicians are reported to be concerned about the provision of incorrect and potentially even dangerous advice given to defendants[4].

As we approached the end of the year, and as part of a focus on the NHS in a rather fraught election campaign, a number of reports highlighted studies concerning the number of deaths of patients in the hospital sector – attributing these to staff shortages and other resource issues. One such report, following a study by doctors, reported that over 5,500 patients had died since 2016 following delays in admission to hospital wards from accident and emergency departments and that long delays in finding beds has resulted in an increasing number of patient deaths[5]. This was attributed to current levels of under-funding of the health service (by the Patients Association which commented on the report). Another report published just days after the first one and produced by the National Reporting & Learning System reported on patient safety issues within the health system that occurred in the last year (as part of an annual reporting system of such events). Such issues include problems with medication, staffing, infection control and the type of care given[6]. In the period between November 2018 and October 2019, over 4m patient safety incidents were recorded by the agency. Broadly, these are defined as situations in which incidents that were unexpected, or unintended could have, or did, lead to harm of individual patients receiving NHS care. Other safety incidents concerned issues related to consent, paperwork and facilities. The publication also noted reports about some cases of patient abuse by staff or a third party – although these were not identified as safeguarding incidents (nor any reference made to responses from safeguarding systems) in the report. In addition, of the total number of incidents, more than 4,600 patient deaths were reported due to safety incidents that occurred in either hospital, mental health or ambulance service trusts. Of these incidents, 530 deaths were specifically linked to mental health trusts, whilst 73 related to ambulance trusts. Such figures are surely worthy of further investigation and analysis.

This issue contains four papers and a book review. All of these papers report on issues that are very much part of safeguarding, even if they are not necessarily of central concern to the overall topic as it is often conceptualised. All four papers provide interesting information and food for thought in their respective areas, and also illustrate the need for further work in these issues (as found elsewhere across the broad terrain that is safeguarding).

The first paper, by Ian Cummins from Salford University, is a viewpoint paper that reviews a research report issued earlier this year in relation to the role of the appropriate adult within the criminal justice system. These schemes have been developed for those adults who may be involved in offending behaviour but need representation at key points of the process, for example when being interviewed in police stations. The work undertaken and the resulting report, issued by the National Appropriate Adult Network, established that there are still notable (and significant) gaps in the provision of relevant AA schemes across both England and Wales and makes for very interesting reading. Implications of these findings are also explored within the paper.

The second paper in this issue is by Sarah Shorrock and colleagues from the University of Central Lancashire and Pubic Health Wales and reports on research undertaken that explored professional/practitioner perspectives of a Multi-agency Safeguarding Hub (MASH) initiatives that have been set up in a number of different areas in England (although this study focused on a MASH in one local authority area). One of the aspects that the researchers were keen to explore was examining the factors that either enable or act as barriers to working in partnership through a MASH/multi-agency approach. In order to achieve this, semi-structured interviews were undertaken with a range of practitioners from one MASH location; the findings were analysed through the use of a thematic analysis in relation to interview transcripts. These practitioner interviews found that establishing a multi-agency approach to safeguarding is complex and consists of many different facets. For example, whilst information sharing and trust between agencies were reported as being improved, there were a number of potential barriers to successful partnership working. These included the absence of a common governance structure, lack of a unified management system, no formalisation of practices and procedures across the different agencies involved and a lack of shared resources. These latter factors were viewed as constraining the extent to which the MASH structure and process could be considered a multi-agency approach to safeguarding (at least in that particular setting). Implications for practice and for further research are drawn out from this interesting piece of work.

Our third paper, by Michael Preston-Shoot (University of Bedfordshire), is a paper that is more practice oriented and also considers aspects of the broader safeguarding process, with a view to improving practice in a specific area of the topic. This is achieved through an exploration of how Safeguarding Adults Boards (SABs) might demonstrate the impact of their role and work in relation to their statutorily required responsibilities in a more effective and timely way than currently appears to be the case. Drawing on definitions of impact that have been developed in relation to healthcare, social work education and university research, the paper examines the potential relevance of such definitions to assist in data capture concerning both the outcomes and impact of SAB activity. It also explores frameworks that have been developed to capture data and to implement initiatives and strategies to change practice and service development, relating this to safeguarding within adult services. One of the key propositions of the paper is that in order to instigate and manage such changes, there is a need to ensure that there is sufficient clarity about the desired outcomes that are to be achieved – and that these are embedded in changes at both practice and procedural levels. It further argues that the current financial, legal and policy contexts in which SABs are located leads to some significant challenges to establishing and maintaining change that has real impact – although it also acknowledges that there are usually also opportunities which can be drawn on to achieve such changes. This is an interesting paper that is likely to be of use to those working directly with SABs in strategic and managerial positions.

The final full paper in this issue concerns the mistreatment of older people in care homes, by Independent Researcher Steve Moore. It deals quite specifically with the area of under-reporting of abuse and abusive situations that occur within such care settings. This is achieved through consideration of the findings from two research projects that were undertaken in England between 2015 and 2019 . A survey that was completed anonymously was used with newly appointed staff in 11 recently opened care homes in order to obtain both quantitative and

qualitative data about the reporting of abuse within the care homes in which these staff had previously worked. Almost 400 surveys were completed and returned, of which 285 indicated that respondents had witnessed abuse occurring on at least one occasion. Of these responses, a significant number of survey responses also reported awareness of abuse that had not been reported either within the care home(s) in which they had worked, or externally to appropriate authorities. A number of such respondents stated that where abuse had been reported in care homes no subsequent action had been taken, or that external authorities/organisations had not always been involved in responses to abuse. In addition, some respondents depicted strategies that had apparently been used in order to deter reports of abuse to external agencies and to suppress its occurrence from either the statutory regulator and/or service commissioners. The findings from the studies presents evidence of continued under-reporting and even possible concealment of abuse by staff working in private sector care homes. The paper concludes with a discussion of the implications of the findings for future practice and initiatives in this area.

The final contribution in this issue is a book review by Ann Anka (University of East Anglia), who provides a review of the book *Safeguarding in Social Work practice – a Lifespan Approach*. This is a potentially useful volume, as it takes a lifespan perspective on issues relating to safeguarding, which is much needed when considering the broader sphere of family violence.

We hope that this issue of the journal will provide items and ideas for readers concerning the broad subject area that comprises adult safeguarding. As regular readers of the journal know, we are always interested in hearing from potential contributors and to discuss ideas for possible papers relating to research, policy and/or practice in this increasingly broad topic area (as has been seen in this issue). If you have suggestions or ideas for papers, please do get in touch with one of us as editors, and we will be pleased to provide advice and offer support about this. Our contact details appear on the inside cover of the journal and are also available on the journal website.

Notes

1. www.bbc.co.uk/news/uk-england-london-50684470 (accessed 6 December 2019).
2. www.bbc.co.uk/news/uk-england-beds-bucks-herts-50676721 (accessed 7 December 2019).
3. www.theguardian.com/uk-news/2019/dec/09/survivor-of-attack-by-joseph-mccann-tells-of-long-wait-for-therapy (accessed 9 December 2019).
4. www.telegraph.co.uk/news/2019/12/08/mckenzie-friends-must-banned-courts-overrun-untrained-advocates/ (accessed 9 December 2019).
5. www.theguardian.com/society/2019/dec/10/thousands-of-patients-die-waiting-for-beds-in-hospitals-study (accessed 10 December 2019).
6. www.theguardian.com/society/2019/dec/08/deaths-of-4600-nhs-patients-linked-to-safety-incidents-says-labour (accessed 8 December 2019).