Teeswide Safeguarding Adult Board

# Molly

## A Safeguarding Adults [Rapid] Review (SA[R]R)

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## 1. INTRODUCTION

1.1. Molly was a 25-year-old female of White British origin who was found deceased at a property of a person not well known to her. At the time writing this overview report, the cause of death remains under investigation by the coroner. Molly had been known to multiple services in the years prior to her death. Molly was open to safeguarding for two years and was discussed within the Team Around the Individual (TATI)[1] process for over a year. The referral for a Safeguarding Adults Review indicated concerns regarding Molly related to sexual exploitation from multiple perpetrators, sexual violence, historical abuse, self-harm, domestic abuse, self-neglect, homelessness, and drug use.

## 2. PROCESS AND SCOPE AND REVIEWER FOR THE SAR

2.1. The Terms of Reference, scope and methodology for the SA[R] can be found in Appendix 1. The review set out to cover a three-month period prior to the death of Molly, being the time that risk was escalating. TSAB commissioned an independent reviewer to chair and author this SAR[2].

## 3. FAMILY INVOLVEMENT IN THE REVIEW

3.1. A key part of undertaking a SAR is to ensure that families are integral to the review process. Families can provide their views and insights that professionals may not have. A more complete picture of the person is often available from families who often provide a unique perspective. TSAB wrote to Molly's mother to inform her of the review. The author met with Molly's mother; her views and thoughts are included throughout this report where they are relevant to learning.

## 4. BRIEF BACKGROUND PRIOR TO SCOPING PERIOD

4.1. This section identifies a very brief synopsis of the background of Molly. The intention is to set the context for the review period. The section includes some of Molly's child and young adult life experiences, her family situation, and brief details of some of the professional services that had previously worked with her. Some of the services have already been subject to systemic change, in particular how children's services work with those who are sexually exploited.

4.2. Molly was a white British female who had lived with her mother and then mother and stepfather for most of her childhood. Molly was the middle child with one older and one younger brother. At the age of 15 Molly was identified as being at risk of child sexual exploitation and had been using drugs. Molly was known to Children's Social Care who assessed her needs resulting in social care involvement for over a year. A referral to Barnardo's for specialist work was made to support Molly to understand the various issues that were affecting her and at the time she was seen as putting herself at risk (terminology and victim blaming language and thoughts are no longer used as best practice). Ultimately substance misuse was reported to have stopped and it was assessed that mother and stepfather were

[1] https://www.tsab.org.uk/wp-content/uploads/2021/04/TATI-Guidance.pdf

[2] Karen Rees is an Independent Safeguarding Consultant with a nursing background. Karen worked in safeguarding roles in the NHS for a number of years. Karen is completely independent of TSAB and its partner agencies.

able to provide a protective environment. Further referrals were made when concerns were noted but these were not opened for further assessment.

4.3. Molly had also been known to Child and Adolescent Mental Health services following an overdose.

4.4. At 17 Molly became pregnant with the father being a male that she was in a relationship with. Molly continued to use substances and her relationship was known to be abusive. This resulted in the unborn baby being subject to safeguarding plans and then placed with Molly's mother following birth. The child remains with Molly's mother to date under a special guardianship order. There were no restrictions on Molly having contact with her child. Molly at 17 was still a child under the Children Act but was not afforded protection under the Act as would happen now. Molly's daughter continues to have contact with her father with Molly's mother describing him as a good dad but a bad boyfriend.

4.5. Molly had been known to be a victim from various Child Sexual Exploitation operations undertaken by the police at the time to disrupt perpetrators and ensure that she was taken home if found when missing.

4.6. As Molly reached 18 and eligible for Adult Services, she no was no longer able to receive the protection of the Children Act and Child Sexual Exploitation operations. She was largely now deemed as an adult with mental capacity to make her own decisions and was reported on occasions to be engaged in sex work.

4.7. Molly's substance misuse continued to escalate with her moving to more opiate-based drugs. Her ability to maintain treatment in drug treatment services was severely affected by her increasing chaotic lifestyle, abusive relationships, and apparent sexual exploitation.

4.8. Molly had numerous contacts with Adult Mental Health services due to intentional and accidental overdoses. Molly was recognised as having Post Traumatic Stress disorder following a period of time being assessed but was not able to engage in further therapy and counselling that was offered.

4.9. Molly's mother described her as a child who had not been very 'streetwise' as she had always preferred her children to play in the back garden of the house where she could keep them safe, rather than out at the front of the house. Molly's mother stated that Molly was a very loving and giving girl who believed that everyone she met was her friend. As she got older and it was apparent that exploitation was continuing, Molly never understood that she was being exploited or the risks that she was placing herself at. Molly's mother tried all types of support but felt that she was going round in circles and that nothing she said could convince Molly that these people were not her friends.

4.10. Molly's mother stated that Molly always liked to be well dressed and wore makeup to make the best of her appearance.

4.11. Molly had the support of numerous agencies who all worked hard together to offer whatever advice and support that was available. Molly had first been referred to Adult Safeguarding services when she was 23 as there were concerns regarding her mental health, a suicide attempt and domestic abuse. At the time she was known to substance misuse services and mental health services. The safeguarding

case was closed five months later as risk appeared to be managed. A further concern was raised the following month and the case was reopened and remained open to safeguarding until Molly's death. In addition to this, Molly's case was heard at the TATI meetings from 17 months prior to her death.

4.12. It was not disclosed until Molly was 23 that she had been the victim of child sexual abuse from the age of nine years and that continued until she was an older teenager. At this point it became clearer to professionals how this significant trauma had impacted on her life from the age that concerns were first raised about her overdoses, missing from home and involvement with adult males.

4.13. Any other information available to the review is contained within the review period and is therefore included below.

## 5. ISSUES FACING MOLLY DURING THE REVIEW PERIOD

5.1. This section is intended to briefly describe the issues facing Molly during the three-month period of the review as presented in the reports and additional information gathered from agencies who worked with her. As identified above, many of these issues commenced within Molly's childhood, but all of these escalated significantly within the scoping period. It is not intended to take an in depth view here as that will happen in section six analysing in more detail the interactions and multiagency working regarding these issues.

### Trauma

5.2. All Molly's identified risk factors emerged as a result of the trauma that she had experienced as a child. Having been the victim of child sexual abuse, her ability to understand 'normal' relationships was misconstrued. There is a plethora of research related to the links between child sexual abuse and later sexual revictimization and exploitation[3]. Research suggests that the trauma of abuse creates a complex set of psychological responses that are difficult for observers to understand. As a result, a victim may present with low self-esteem and self-worth, self-harm, high risk sexual behaviours, inability to self-regulate emotions or understand positive relationships. This can lead to a higher tolerance of coercion, force and intimidation that are not associated with positive relationships.

5.3. Molly was described by those that worked with her as very childlike and lacking in maturity; the author would suggest that this too was because of the trauma that had affected her childhood. All these impacts were issues for Molly.

5.4. The evidence of the impact of this trauma commenced in childhood and albeit there were some more settled periods, there was a spiralling and escalation that Molly was unable to engage with help for as the psychological effects of trauma had an impact.

### Substance misuse

[3] Lalor, K. & McElvaney, R. (2010) Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behaviour, and Prevention/Treatment Programs. Trauma, Violence, & Abuse, 11(4) 159-177

5.5. The research evidence collated in the study referenced above points to the fact that there is a higher rate of substance misuse in those that have experienced Child Sexual Abuse. The reasons for this are multi-facetted and are linked to trauma responses. For Molly, she started misusing substances at a very young age and this continued to escalate. Within the timeframe of the review, Molly's substance misuse had escalated to the injecting of heroin. It was known by those working with her that Molly had stated that she was not able to inject herself and so this was done by others; there were reports from police that Molly stated that perpetrators had taught her to inject herself. Substance misuse in the last couple of years of Molly's life was very much linked to the exploitative and abusive nature of the relationships with perpetrators. Having turned to substances in her teenage years, perpetrators would offer her drugs in exchange for sex. As time progressed it became clear to those working with Molly, that perpetrators also provided drugs in order to perpetrate and traffic[4] Molly for sex. Molly told workers that those injecting her with heroin had started to do it when she was asleep, and this created a fear in her. There was work undertaken with relating to the risks that this posed. As stated previously her ability to engage with drugs services was limited by her chaotic lifestyle brought about by those that perpetrated abuse against her.

5.6. Molly's mother told the author that in the last couple of weeks before she died, Molly's appearance changed dramatically. She described her as like a skeleton, dishevelled and unkempt, something that was not like Molly previously This was at a time where professionals had been struggling to find her and Molly's mother had been to many places to try and find her. Molly's mother believed that this was the time that the substance misuse was at its highest and that it was because of this that Molly stopped caring for herself.

### Sexual Exploitation

5.7. In the first instance it is important to understand what the term Adult Sexual Exploitation[5] means. Following on from this it is important to note that Molly had been sexually exploited within her teenage years and this was an extension of that. Molly did not recognise all of her relationships as exploitative and felt that some of the perpetrators were her boyfriends.

[4] **Trafficking** can happen across international borders, or within one country. It can involve movement between cities, towns, rural locations, or even from one street to the next.https://www.stopthetraffik.org/smuggling-trafficking-knowing-differences/

[5] **Adult Sexual exploitation**
Adult Sexual Exploitation (ASE) is a form of sexual abuse that involves someone taking advantage of an adult, sexually, for their own benefit through threats, bribes, and violence.
Perpetrators usually hold power over their victims, due to age, gender, sexual identity, physical strength or status.
Adults can be sexually exploited in many ways. Examples include:

- rape
- sexual assault
- being tricked or manipulated into having sex or performing a sexual act
- being trafficked into, out of, or around the UK for the purpose of sexual exploitation (i.e. prostitution)
- being forced to take part in or watch pornography
- being victim to revenge porn (when a previously taken video or photograph, which was taken with or without consent, is shared online)

Anybody can be a victim of sexual exploitation. While it mainly affects women, men can also be victims.
At one end of the scale adult sexual exploitation can describe a one-off situation between two adults, while at the other end it may include instances of organised crimes where a number of adults are trafficked and sexually exploited.
https://www.devonsafeguardingadultspartnership.org.uk/exploitation/sexual-exploitation/

5.8. There was occasional mention in reports for this review regarding Molly being engaged in sex work. The author would suggest, as would those who worked closely with Molly, that at no time was Molly engaged in 'sex work'. Those working in the sex industry indicate that there is a difference between those who choose that as a career and that there is choice and control over the decisions that a sex worker makes. It is not without its risks but is far removed from anything experienced by Molly. In exchange for sex, Molly felt that she was offered care in terms of food and a roof over her head at times. This is often described as 'survival sex'

5.9. As time progressed the risks escalated as those perpetrating harm were involved and known to be part of organised crime gangs and as the abuse increased so did the substance misuse. More importantly Molly spent more time in the accommodation of those perpetrators, increasing the risk to workers who had risk assessed that it was not safe to enter those proprieties. The perpetrators were very powerful in terms of being able to manipulate Molly and knew the systems well and how to continue to perpetrate their crimes whilst evading arrest and prosecution. The frustration this had on professionals and the reasons why this continued will be discussed in section 6.

### Domestic Abuse

5.10. Molly was a victim of domestic abuse within some of her relationships. Molly was discussed at Multi Agency Risk Assessment Conference (MARAC) on a few of occasions recognising Molly as a high-risk victim of domestic abuse with different partners. One of her partners was also discussed at Multi-Agency Tasking and Co-Ordination (MATAC) which aims to target perpetrators of domestic abuse to disrupt serial offenders and/or work to address their behaviour. Much of this abuse is intertwined with the issues identified above.

5.11. There were difficulties in assessing which of those abusing Molly fitted into the true definition of domestic abuse perpetrators as many were not intimate partners but were exploiting her. This will be discussed in more detail later in this report.

### Suitable Accommodation

5.12. Molly was never without somewhere to stay with agencies supporting her accommodation options at various points. Molly did become technically homeless on occasions and had a range of addresses, these varied from private rented, hostels, hotels and supported accommodation in order to meet her given needs at the time. Molly was evicted from most properties due to her or those visiting her, causing damage or breaking rules of tenancy e.g. use of drugs or having males who were not allowed into the accommodation or being abusive to staff. Molly was often the victim of 'cuckooing'[6]. It was clear to those working with Molly that the provision of effective and safe accommodation was not available, and perpetrators were able to access her with her often staying with those who were perpetrating crimes against her.

[6] **Cuckooing** is a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing, storing firearms, and other criminal activity. The crime is named for the Cuckoo's practice of taking over other birds' nest for its young. https://www.programmechallenger.co.uk/practitioner/resources/cuckooing/

### The Criminal Justice system

5.13. Molly struggled to disclose enough details about what was happening to her due to a mistrust of the system and fear of more violent action from perpetrators if she disclosed offences. This made use of the criminal justice system difficult once Molly had reached 18 years. This led to police, social care and housing support allocated workers to offer intense support towards disclosure. Of the disclosures that Molly did make and the interviews that were given to the Police using best practice Achieving Best Evidence interviewing techniques, none led to effective prosecutions. One disclosure in particular resulted in the evidence being presented to the Crown Prosecution Service who then did not progress with the case as other evidence undermined Molly's.

## 6. ANALYSIS AND LEARNING - Strengths of Multi Agency working

6.1. The analysis section takes a strengths-based approach identifying what went well and then building a picture of areas where learning has been identified, as well as further steps that should be taken to achieve stronger systems. Systems and services that worked with Molly have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that have been changed already due to early learning from this review. These, as well as where agencies have identified their own learning will be noted throughout this report.

6.2. The professionals who worked with Molly both before and during the scoping period displayed a huge amount of compassion and empathy and worked with her very well. Many individuals and services went over and above basic service levels to try and ensure that there was a network of support around her. They also worked with her mother and knew her well. The excellent nature of the collaborative working across all agencies is evidenced throughout the chronologies, reports and responses within the practitioner workshop. There was no stone left unturned in trying to explore every avenue of support. There is much to learn from this practice. Molly's mother also recognised this and stated that she felt that professionals had done what they could but that the door was shut and the men (and women) who were controlling her, supplying drugs and abusing her were never brought to justice.

6.3. Despite the immense efforts of those involved there were some key system blocks and barriers to prevention and protection that will be explored further to try and understand why these have occurred and what the Safeguarding Adult Board should consider for the future.

6.4. Both the strengths as well as blocks and barriers are explored below in terms of the key lines of enquiry in the terms of reference for this review.

### The Safeguarding system

6.5. During the review period Molly was open to safeguarding. Meetings were being undertaken as much as fortnightly as information changed so quickly. There were robust multi agency plans in place with good attendance and information sharing throughout. Meetings were not only formulated in crisis but in order for agencies to work alongside each other and Molly to prevent risk escalating. During the review it was clear that all risks were known to all of those that were working directly with Molly. The review discussed whether it was usual to have a safeguarding case open for so long. It was identified that in

very complex cases where risks are escalating regularly, that it is not unusual for cases to remain open to safeguarding processes. This was in line with safeguarding policies and procedures and recognised as strong practice. It was noted that, in particular, the most concerning cohort are those vulnerable women like Molly.

6.6. There was further strong practice in that Molly had attended the safeguarding meetings. This is in line with the expectations of the Care Act and Making Safeguarding Personal. The Making Safeguarding Personal (MSP) initiative began as far back as 2009 by the Local Government Association and Association of Directors of Adult Social Services[7] to ensure outcome focussed, person centred responses to adult safeguarding, rather than it being a process that happened to people without knowledge. This has since become enshrined in the Care Act (2014) and requires that the adult and /or their representative is part of the safeguarding process. Unfortunately, due to the Covid pandemic restrictions, when safeguarding meetings became virtual, Molly was no longer able to attend her meetings as she did not have the technology or the space to do this and was not comfortable with this way of engaging in meetings. Molly would feedback to the support worker and social worker; it is noted that the social worker would always keep Molly updated on the outcomes of meetings. As time has progressed, it would be usual now for a key worker to be with a person to dial in to the meeting showing that practice has now strengthened in this area. Molly was always given copies of her support/safeguarding plan with explanations by the social worker and support worker.

6.7. There was one notable concern regarding attendance at safeguarding meetings that had been identified. The attendance of the police had been problematic. Whilst in some safeguarding cases the absence of police may not have such an impact, it was the criminal justice processes and general policing of Adult Sexual Exploitation that Molly was a victim of that was of particular need within the safeguarding meetings. Other professionals would have benefitted from hearing some of the rationale regarding apparent limitations of police and CPS decisions. It is also the case that any action requested of the police would be delayed as it would require follow up outside of the meeting. This issue however was subject to escalation by senior managers and, as a result, there has been improved attendance by police at safeguarding meetings. This evidences how use of the escalation can be effective.

6.8. When it had been discerned that the risk was escalating and that safeguarding plans alone were not providing any improved outcomes for Molly, a referral was made to TATI. When Molly had been referred to the process it was very new, Molly being the first person discussed. The review workshop discussed TATI and its effectiveness as a process. It was identified that the purpose of TATI was to involve managers at a more senior level from statutory and other agencies. By doing this there is an ability to share more ideas for innovative practice, ensure all legal routes for protection have been considered and also, by involving more senior managers, to mobilise more resources where required.

6.9. It was from these meetings that it was identified that with so many practitioners involved, that it would be beneficial for Molly to have a few key people that she would have contact with and that they would become the key coordination roles. Those key people became the allocated Police officer (this has been identified as good practice within the police report for this review, to identify an investigation officer who was able to work long term with Molly and build a relationship with her), the social worker and her

[7] Lawson, J. Sue Lewis, S & Williams, C. (2014) Making Safeguarding Personal 2013/14 Summary of findings London, LGA

support worker from housing support services. It was also from TATI meetings that requests were made to continue to support Molly in some services above what would be usual or where cases would have been closed following period of intervention. It was clear that TATI minutes and notes were circulated to those working directly with Molly and evidenced a good system of information sharing and joint risk management.

6.10. The review workshop also discussed if there were any areas where practice needed strengthening; a couple of areas were identified. It was agreed that, although when TATI commenced as a process it was well attended by senior managers, as time has gone on attendance became more of an issue with meetings being delegated down the management structure. Whilst for some meetings this may be relevant and appropriate, the author would suggest that when the requirement is that senior managers may need to mobilise resources and take other senior management decisions, then it may not be appropriate. Delegation downwards will only work if there is a follow up with the senior manager that had been deputised in order to progress and agree actions. This can be problematic if that manager does not or cannot agree to specified actions.

6.11. There is guidance for professionals and documentation in respect of the TATI process. There does not appear to be a protocol that all statutory agencies have signed up to. Additional operating procedures for the process may help strengthen and prevent further issues of a system that is proving to be supportive to professionals who are working within safeguarding arena with more complex cases. It is also noted that TATI structures and procedures across the four local authority areas that make up the TSAB are different. As there are some organisations that cover all areas of the TSAB, that there should be progression to undertake to have one process that is the same across all areas.

6.12. The commencement of the TATI process came from a previous SAR and as such, is a very positive process that has seen many improvements in the safeguarding system for complex cases. As the process has evolved, each area has taken on a different view of how best to implement it; it is now suggested that this is therefore reviewed.

6.13. Both systems worked well together in this case. The managers and professionals attending them shared ideas and information as well as keeping each other updated with current outstanding assessments or appointments, e.g. substance misuse services would update the meetings on the engagement and prescribing that was current for Molly, housing and accommodation issues and changes were also regularly discussed as well as current threats from specific males. These are just a few of the benefits of these multi agency meetings. Plans were made to ensure that appointments did not coincide with each other. Leaning in this section comes from strong practice as well as the gaps that were identified.

6.14. The issue as to whether Molly would have benefitted from transitional safeguarding arrangements will be discussed in the next section as these circumstances sit with Adult Sexual Exploitation.

**Learning from strong practice**

- Regular safeguarding meetings keep all professionals up to date with risk, roles of others, and agreed actions and impacts.
- The interface between safeguarding enquiry meetings and TATI meetings ensures senior managers are involved in risk management in complex cases.
- Applying a Making Safeguarding Personal Approach keeps a person engaged with the meetings that are related to their own safety and wellbeing. Sharing plans ensures that the person has a record of concerns and actions of agencies and themselves.
- Invoking the escalation policy for safeguarding can have positive outcomes in the resolution of disagreements and concerns regarding way an agency is responding to safeguarding duties.
- Constant review of changes made due to Covid restrictions limits gaps in services beyond which is unavoidable

**Points for strengthening practice**

- Protocols that all are signed up to regarding procedures (TATI) ensures and understanding of the agreements and commitments of statutory organisations.
- Terms of Reference, operating procedures for processes offer in depth guidance to all regarding the process pathway, intended outcomes etc.
- There is a benefit from having the same process across all of the TSAB area.

### Adult Sexual Exploitation

6.15. The reasons for the open safeguarding case and the TATI meetings were because of the risks posed to Molly by the abuse and exploitation perpetrated against her by many adult males. It is important to note that it was good practice to identify that the criteria and threshold for safeguarding Section 42 was met and continued to be met before and throughout the period under review. The three-point test decision was made based on the fact that Molly had needs for care and support because of her mental health and substance misuse.

6.16. It could be argued in some circumstances that these would not necessarily be seen as care and support needs for the local authority. In an article related to transitional safeguarding in a professional journal[8] one safeguarding adult services manager stated that the Care Act interpretation of care and support needs should be applied with flexibility for those who have been sexually exploited as teenagers where that abuse continues into adulthood. If consideration is only given to care and support needs as being ones where personal care, managing within the home and within the community is required then even if children have received social care support, it does not necessarily mean that at 18, those same people will have access to adult social care. Although Molly was not immediately subject to adult safeguarding proceedings and did not transition directly, once a referral was made, she was deemed in need of care and support and meeting the threshold for Section 42 enquiry and later TATI. This was good practice. Despite the excellent work of the safeguarding system and so much information known to many, if not

[8] Carter, C. (2020) 'Exploitation does not stop at 18': chief social workers highlight gap in support for young adult victims. Community Care March 24, 2020 https://www.communitycare.co.uk/2020/03/24/exploitation-stop-18-chief-social-workers-highlight-gap-support-young-adult-victims/

all of the services working with Molly, this did not transfer into the action that was undertaken and generally is undertaken when the victim is under 18.

6.17. It is of note that there has been more work done on transitional safeguarding in the area and this is proving positive. Molly, at the time of transition to adult services, was not open to children's services so this would not have benefitted her. It is clear that if more had been known about what Molly's daily life was like at 17 and a half to 18 then she may well have remained open to children's social care and then have benefitted from transitional safeguarding arrangements if her case was being considered now.

6.18. It is in this consideration that brings most of the learning for this review. The blocks and barriers to protecting Molly from adult sexual exploitation are multi-faceted.

6.19. There is a well-established Child Sexual Exploitation Strategy with robust systems and processes in place for senior managers to meet together and another for those professionals working directly with those at risk. There is no overarching Adult Sexual Exploitation equivocal strategy, and it is individual processes and procedures that are relied on for protection. This means that there is no one policy that is signed up to by all. In the adult arena, ASE is linked in with modern slavery and trafficking. This is indeed what ASE can be classed as but there are nuances related to the nature of sexual exploitation that make it unique in the impact that it has.

6.20. There is a meeting of senior managers identified as VEMT (Vulnerable, Exploited, Missing, Trafficked) in the locality. The Terms of Reference for that process states:

*"The VEMT group has been established to provide strategic direction across Tees for professionals working with children, young people and adults who may be at risk of, or vulnerable to, exploitation or who by way of going missing may be at risk".*

6.21. The rest of the document indicates the engagement and reporting mechanisms that involve the safeguarding adult board. In fact, this is very misleading. In reality the process is only used for children and young people and not for adults who are at risk. In principle this means that is looks as though there is a process for adults, this is not the case and should be rectified to either include adults or provide clarity that it is not related to adults at risk.

6.22. There is also a group of professionals that meet who are working with those directly with those who are sexually exploited. This is known as the VEMT Practitioners Group (VPG), and its Terms of Reference are very clear and indicate that this is a process and group only used for children who are vulnerable of missing, exploited, and trafficked.

6.23. The author would suggest that there is a requirement for an overarching strategy/operation such as that of Operation Sanctuary in a neighbouring locality, to understand the scale and nature of the problem and the needs of those specifically affected by ASE. There is work underway regarding the wider Modern Slavery and Trafficking arena, but as noted previously, more clarity regarding how ASE fits into that is required for this group of victims.

6.24. During the review process there was discussion regarding progress since the joint safeguarding adult and children review related to Operation Sanctuary. It was discerned that it was not clear what had happened regarding the national recommendations that were made; this should be followed up as a result of this review. There has been an appetite to move the focus more towards adult victims as well as child victims within the VEMT process, but progress is slow. The discussion turned to whether TATI was the process for adult victims. It was identified that TATI is a safeguarding process and concentrates on the victims' safeguarding needs under s42 Care Act, rather than work that is required to disrupt and deter perpetrators.

6.25. All of the research and work that is undertaken in this area of work in both children and adults who are trafficked and exploited identifies pursuing and disrupting perpetrators as one of the major elements for reducing the impact and risk of ASE. In the case of Molly this was very limited. The reasons for this appeared to be because Molly did not trust the criminal justice system to protect her as it had not in the past. Because of the lifestyle that Molly was being forced to live, she was often associated with crime, substance misuse and sex working. In recognising this mistrust, an individual officer was allocated to build up the trust and to work with her towards robust disclosure of sex and violence perpetrated against her. This worked and led to Molly naming offenders and offering an interview to give evidence. This was all excellent work and was a real hope for those that were working with her. Unfortunately, when the case was presented to the crown prosecution service, it was dismissed as it was stated that Molly's evidence would not be credible due to other evidence undermining her statement. This had a devastating impact on Molly and those that worked with her. Molly was offered a Victim's Right to Review but declined this as her belief was that it would not change the outcome. These issues also gave more power to perpetrators who knew that, even with evidence, it would be doubtful that cases would come to court, or even if they did, that being found guilty would be highly unlikely. It was noted that on one occasion the 'service' of Molly were offered to a male worker by a perpetrator who had Molly's phone. This situation meant that Molly had no avenues left. Her substance misuse escalated, and the perpetrators had so much control that it became impossible for workers to visit her due to the risk posed by perpetrators who were known organised crime perpetrators. At that point visits had to take place outside of the property.

6.26. Negative cultures and blaming language can have a negative impact on victims making disclosures. There was some evidence of this in this case in describing Molly as a working prostitute. Apologies for these attitudes were made by the organisation concerned to other professionals at the workshop for this review and ongoing work is underway within the organisation to address negative views and language.

6.27. It is of note that despite the number of referrals made to police regarding further crimes and a multitude of intelligence related to known perpetrators these did not lead to consolidated action by police. These issues were escalated by Adult Social Care Managers, and this was strong practice. It could be argued, however that the escalation process can continue upward in the ranks of hierarchy in organisations until strategic decisions can be made. Use can also be made of the Office of the Police and Crime Commissioner if necessary. This should not be seen as a direct criticism of the police but of how issues of concern should be challenged by other agencies as part of the multi-agency safeguarding duty. A multi-agency strategy makes this much easier to do.

6.28. Much of the reason for the change in abilities to protect under the Care Act when a person transitions from the Children Act is that Mental Capacity to consent to being safeguarded comes into effect. There is still limited understanding as to what can and cannot be done legally with regarding to getting a full picture of the mental capacity of someone who does have a disturbance of the mind or brain (PTSD and depression in Molly's case) and appears, on the face of it, to either be presumed to have capacity or is assessed as having have capacity for the decisions being made. This issue will be addressed in a further section on legal literacy. It can therefore be seen that, in order to progress work with regard to ASE that the peruse and disrupt elements need to be embedded in strategy and supported by decision makers that include the Crown Prosecution Service and others.

**Learning from strong practice**

- Recognition of a person who is an adult being sexually exploited ensures appropriate risk management plans, multiagency working and use of safeguarding systems
- Recognition that a person is being exploited despite apparently having consented is important.
- Understanding of the use that substance misuse has in the ongoing exploitation of person allows for deeper understanding of the coercion and control in ASE.

**Points for strengthening practice**

- Child Sexual Exploitation has more focus than Adult Sexual Exploitation despite many adult victims were victims as children.
- Protocols that state that they include adults but in reality, do not, are misleading and unhelpful.
- When a specific issue is included in an overarching strategy that covers other linked areas, each areas must have its own underpinning strategy to ensure that each element receives full attention and resourcing.
- Ensuring all intelligence to a specific victim can be linked across all force areas is imperative to ensure safety and robust information sharing.
- In ensuring robust working ASE, perpetrator pursuit and disruption must be a key priority in any strategy.
- Understanding the national perspective from other reviews can inform learning locally.

### Trauma Informed Care

6.29. It is known that in response to the harms and traumas experienced in a person's past and the ongoing traumas for Molly, professionals need to offer Trauma Informed Care (TIC)[9]. The main purpose of TIC is to increase professionals' awareness of how trauma can negatively impact on a person so that practices that might be inadvertently adding to trauma can be avoided. In using TIC, the sensitivity of professionals enables the person to see them as trustworthy and feel safe to disclose abusive experiences. Additionally, practices which give a person back choice, and some controls are viewed to be particularly valuable.

[9] Asmussen, Dr K. et al. (2020) **Adverse childhood experiences What we know, what we don't know, and what should happen next**. Early Intervention Foundation February 2020.
https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

6.30. The work undertaken by many services including housing support care worker, social worker, substance misuse services showed excellent TIC. The agreement that there would be a handful of workers that would be key contacts, the allowance for the housing support worker to continue to be allocated longer than would be usual, ensuring appointments were coordinated and at times and places that were appropriate to Molly and professionals offered last minute appointments and moved things in their diaries to accommodate seeing her were all examples of this. Other services were also noted to be able to offer extended service beyond the time that would be usual.

6.31. One of the major impacts on being able to offer TIC is the ability for professionals to build relationships with those who have been impacted by trauma. The ability for those workers to work long term with Molly, meant that she was able to build rapport and trust with those workers.

6.32. Substance misuse services told the review that they were able to work more flexibly and in a more trauma informed way when Molly was in their children's service, but that this became more difficult once she transitioned to adult services. This is a noted issue, and more posts are being put in place to enable more trauma informed working. When Molly had been seen by Adult Mental Health Services prior to the timeframe of this review, she had identified that she was impacted by trauma but stated that she did not want counselling to address those but did want to work on her low mood and self-esteem. Molly was not able to meet the expectations of attending appointments and was therefore discharged in line with the policy. Some statutory services find it more difficult to be able to offer more trauma informed care due to the way they are commissioned.

6.33. Where services have stated that the 'person has not engaged' It is suggested within this review that recording should evidence what has been done to encourage and support engagement for those affected by trauma rather than 'did not attend, discharged in line with policy' Mental health services had previously worked extremely hard to engage with Molly and during the timeframe of the review had assessed her when she had been in crisis. Molly stated that she was not sure how mental health services could help her. Whilst there is a Did Not Attend policy within mental health services there is also a non-engagement policy; this will be reviewed by mental health services to ensure that any relevant learning from this review is included.

6.34. It is also the case that, for many services, being able to work successfully on issues to improve outcomes for a person, that person needs to have some form of stability. Because of the accommodation issues identified above, as well as her ongoing substance misuse, it was not possible to ensure safety and stability for Molly away from those that were controlling her life. It should be stated, however that if the right accommodation had been available and that the perpetrators were managed, then Molly would have been more likely to engage with substance misuse services as she had in the past. This meant that Molly was not able to work on building resilience, another key component of recovering from trauma.

6.35. There were considerations given to sourcing the right accommodation away from the area for Molly so that she may be away from the perpetrators. This was dismissed on discussion as it was recognised that this would add to Molly's trauma by moving her away from those that she had strong professional relationships with and her family, thus losing all of her support networks. It would also have been highly likely that Molly's need for drugs and 'care' would have either drawn her into abusive circles in other

areas or back to those that she knew could supply her. Molly would have needed to be stronger before this could have been an option.

6.36. It is important that commissioners and providers consider how best to meet the needs of those who have suffered significant trauma. For this, services need to be able to offer trauma focussed practice. Commissioners should also consider along with provider organisations the need for the offer of therapies other than talking therapies. Some who have suffered trauma are not able to talk about their experiences, nor engage in more traditional therapies. During the research that the author undertook for this review, Equine Assisted Psychotherapy came up on several searches regarding treating and supporting children and adolescents who have experienced trauma[10]. Music, art therapy as well as nature type therapies have evaluated very well. Whilst these are more costly, if they are beneficial, then ultimately, they are cost effective. Molly's mother told the author that Molly needed these types of therapies much earlier and needed to learn practical skills and have structure in her day.

6.37. The Local Authority Adult Social Care have noted that there is more flexibility within practice standards as attitudes have changed. This lends itself to TIC and that this has been welcomed by social workers who have long wanted to have the ability to work and build relationships with those who are eligible for support under the Care Act. The Safeguarding Adult Board have recently identified Trauma Informed Practice is important in safeguarding adults work and invested in providing training and resources to agencies. Work on this area will continue.

**Learning from strong practice**

- Building of good relationships benefits victims of trauma.
- Good relationships with victims can lead to disclosures and ability to start to address trauma.
- Good TIC will support victims to engage with services.
- Services that are able to be flexible offer better options to victims of trauma.

**Points for strengthening practice**

- Trauma Informed Care requires commissioners and providers to consider how best to resource services to be flexible.
- Offering a variety of therapies that includes non-talking therapies can benefit those who are victims of traumatic pasts.
- All organisations need to have a strong understanding of impact of trauma if they are to offer evidence-based services and protection.

### Legal Literacy

6.38. Whether there is or is not a strategy for Adult Sexual Exploitation, the use of legislation in this complex area requires professionals to have some understanding of its appropriate application. In terms of the Care Act Legislation under Section 42, (Safeguarding) it has already been identified that the legislation was understood and applied very well. There are some reasons why the legislation was applied more easily than in some other circumstances due to Molly consenting to the need for protection. The Care Act is legislation and policy that is well known to professionals and generally only becomes more

[10] Craig , EA . et al (2020) **Communicating Resilience among Adolescents with Adverse Childhood Experiences (ACEs) through Equine Assisted Psychotherapy (EAP). Western Journal of Communication** Volume 84, 2020 - Issue 4 Pages 400-418 | Published online: 17 Apr 2020

problematic and complex if a person is not able to engage with the process.

6.39. Alongside this, however, there is the application of the Mental Capacity Act. Where a person has a disturbance of the mind and brain and is unable to make decisions for themselves then a best interest decision can be made to ensure the best interests of the person are met. In cases of this nature, assessing mental capacity is often more complex. On the surface it appeared that Molly did have capacity to make her own decisions and this understanding was evidenced in records. However, there were several issues that impacted on the mental capacity of Molly. Firstly, Molly was known to misuse substances and this drug use escalated as time progressed. When a person is under the influence of substances, they do not have capacity to make most decisions and in particular decisions regarding their own safety. Secondly, in the abuse and exploitation that she was experiencing, Molly was being coerced and controlled by perpetrators and feared what may happen to her if she did not comply with what was requested of her by her abusers. In both situations, a person may appear to have capacity or may have fluctuating capacity. This brings debates as to whether, in cases of ASE, sex is ever consensual and whether the person has agency and control over their decisions or whether those decisions are only being made due to the influence of drugs or control from others.

6.40. This is where careful consideration and advice needs to be taken. Being able to carry out things that a person has said they could/would and had agreed to not only provides evidence that the person has made and understood the decision required but also that they have the executive functioning to be able to put decisions into practice. Where there is something that can affect that executive functioning it can be suggested that there is no display of being able to demonstrate decision making in the way that the Mental Capacity Act intends. Some of the constraints in this case were related to the fact that Molly was often able make decisions but also explain her decision making, however given the above regarding executive capacity there could have been more challenge between agencies of this understanding.

6.41. As concerns were rising, there were questions to the local authority legal team regarding the application for an inherent jurisdiction[11]. The issue of whether to apply for this option was discussed within the TATI meetings and explored with the legal team. The decision at the time was that this was not a viable option as the outcome would be that the court would have only been able to impose safe accommodation with appropriate support provision, something that was not available locally, therefore it was felt the court would not have options to impose this. There were also some concerns regarding a deprivation of Molly's liberty and as such may be in breach of her human rights. This is a specialist area, but the author would offer the following observations:

- Based on the nature and purpose of an inherent jurisdiction, Molly fitted into this approach to protection.
- Inherent jurisdictions have been used successfully in Child Sexual Exploitation

[11] The courts have explained that **"[T]he inherent jurisdiction** can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent." (A description given originally by Munby J in Re SA (Vulnerable Adult with capacity: Marriage) [2005] EWHC 2942 (Fam) at paragraph 77, then endorsed in Re DL).
https://1f2ca7mxjow42e65q49871m1-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/Mental-Capacity-Guidance-Note-Inherent-Jurisdiction-October-2019.pdf

- The inherent jurisdiction can be against the perpetrators and give powers in that way
- The perpetrators were breaching the human rights of Molly everyday
- The criminal routes to dealing with the perpetrators had not been successful
- It cannot be predicted what view a court may take and there is a requirement for more caselaw in this area.

6.42. Following discussions at the workshops, the local authority has reflected in their agency report that there could have been more frequent legal advice sought which could have provided more evidence, (especially as risk was rising) and more challenge of the advice that an inherent jurisdiction was not viable. As a result, the local authority is now presenting a case of a similar nature as a 'test case' in order to protect the person concerned but also to provide learning and caselaw.

6.43. Housing legislation was limited in protecting Molly. It is clear that each time there was a threat of homelessness, then accommodation was found very quickly due to the excellent work between the housing department and other agencies. In that way the Homelessness Reduction Act ensured that her needs were met, and that alternative accommodation was sought. The issue was that the legislation does not go as far as to say how much the needs of the person must affect the type of accommodation.

6.44. Whilst Molly always had a roof over her head, most of these properties had no way of protecting Molly from visitors who posed a risk to her. As mentioned before, Molly was subject to cuckooing from some of the accommodation she lived in. Perpetrators, where they could not have direct access to her easily, would ensure that she broke the rules and that she would then be evicted and she would then be in new accommodation, and the cycle would happen over again. Most of the accommodation providers did not have the specific skills needed to afford protection to Molly. The local authority has a list of 11 properties that Molly was allocated over a three-year period. During discussion at the workshops this was clearly frustrating for professionals who stated that there was no suitable accommodation where Molly could be safe from those who were abusing her. Under the provisions of the new Domestic Abuse Act 2021, there is currently a process of procuring safe and secure accommodation contracts with skilled providers and other providers' contracts, who are not adhering to the requirements of contracts, are being ended by the local authority.

6.45. The criminal justice legislation and system has been mentioned previously throughout this report, the blocks and barriers of its effectiveness has been discussed. In terms of legal literacy, other professionals felt frustrated that crimes were clearly being perpetrated but no action was being taken. This led professionals to question, during the review, why this had been the case. Professionals stated that they shared concerns with the police constantly regarding the crimes and issues that they were aware of that were facing Molly, as and when they became aware of them. It appears that these intelligence reports go into a central intelligence hub where they are reviewed and tasked to the most appropriate department or team for action. As a result, they are not always seen in the greater context of what is known by those working with a person. Following receipt of intelligence, officers would investigate and often visit or make contact with Molly, but this could often mean these were officers not known to Molly, If Molly did not wish to expand or verify details within the intelligence it is likely the intelligence would be closed and held on Molly's file.

6.46. Whilst the difference between intelligence and direct reports of crime is noted, it could be suggested that some intelligence may hold more weight than others. In cases of this nature, intelligence is as important, if not more important than direct evidence. This is especially so as Molly would tell other workers what had happened to her, but she would not admit these things to the police for the fear of backlash from perpetrators. The police are looking into new pathways and alerts into these issues but also it is important that other professionals understand where the information they report is stored and that they should highlight that there may be other intelligence when some information that they are aware of is not being highlighted in meetings. It is clear that all intelligence received is recorded and visible to all officers, however there can be different information shared at different meetings based on what the officer attending believes is appropriate and relevant to that meeting. The police have made several recommendations within their own agency repot and have already taken action to address the issues that this case has highlighted.

6.47. Use of the Domestic Abuse and Crimes Act was largely understood and some of its application has been identified in a previous section. Molly was discussed at MARAC on a few occasions. The difficulties experienced by professionals at using this legislation to keep Molly safe was again due to the skill of the perpetrators in the control that they had over Molly. Although Molly believed that many of her abusers had or were at times her partners, in reality this was not the case. The sexual exploitation that Molly suffered was intertwined with violence and coercive and controlling behaviour and as a result needed to be managed in one place. It was clear that, generally, the information shared at any MARAC meeting was known and shared at TATI meetings, however it did mean that Molly was being discussed in yet another forum; whilst this is necessary as the purposes are different, some professionals stated that they did not know all of the information shared within some meetings and that different intelligence was shared, on occasion, in different meetings. This again adds to the complexity of ensuring all knowable information is known by all.

6.48. The Domestic Violence Disclosure Scheme (Clare's Law)[12] was also used with Molly, to try and support her to understand the risk that she was under from those that were abusive to her who she believed were her partners. For Molly, these men were often offering her food, shelter and protection from others and were also ensuring that she had a supply of the drugs that she was addicted to; on occasions therefore, she believed that they were caring for her. By using Clare's Law, the crimes appropriate to her risk that had been previously committed, were disclosed to her. Generally, this is always good practice as it ensures that victims can be forewarned and able to plan their own safety with the support of agencies. Making these disclosures though, must be done with the right network of safety and support in place and must be done in a location that is safe. Molly had one Clare's Law disclosure made outside of the house of the perpetrator that the disclosure was about. Molly was not prepared to accept the information. In Molly's case, her mother told the author that whilst most that would see this information, she would imagine, would ask for support, Molly appeared to take no notice and did not believe that it affected her. Whilst Clare's Law disclosures also help the victim, they also help those in the immediate professionals' and family network who are in a protection role to understand and plan for risk management. The Home Office non-statutory guidance (that will soon be replaced with

[12] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

statutory guidance following the enactment of the Domestic Abuse Act 2021) states that the safety of the person the disclosure is made to must be planned and made at a safe time and location. The police have an operating procedure that details the process that is undertaken for Clare's Law disclosures. The incident above is described by police as not usual practice and is evidenced by the many safe disclosures that are made throughout the force area.

6.49. From the domestic abuse perpetrator perspective there were difficulties in discerning which relationships fitted the criteria of domestic abuse as opposed to sexual exploitation by known/unknown offenders and criminal gangs. The review identified that there were probably only two earlier relationships that fitted the domestic abuse definition and criteria. That meant that management of perpetrators through the MATAC programme was only used with one of Molly's abusive partners.

**Learning from strong practice**

- When a system is well understood and legislation applied regularly in an effective multi agency arena, there are benefits to those who use services. (Care Act Section 42 in this case)

**Points for strengthening practice**

- Understanding of Executive Capacity and testing this against inherent jurisdiction of the High Court may offer greater safety to victims who appear to have capacity but are being coerced and controlled.
- Early and continued legal advice is supportive to professionals and legal advisors and may better safeguard those who are being exploited.
- Escalation and Challenge between agencies and services (including legal services) continue to be important elements in safeguarding those at risk of harm.
- Provision of appropriate and safe accommodation for those who require additional support may help those who are unable to be in control of their own tenancies.

### Complex Cases: Support and supervision

6.50. All the professionals involved with Molly, were affected in one way or another by working with her. Molly was a very likeable person and those working with her were desperate to support her to improve outcomes for her. Many of the professionals were frustrated and some became emotional that they were not able to find a way to end the abuse that she was suffering from. Professionals were honest in the workshop in that they stated that they knew that Molly was likely to come to serious harm or death from the result of the lifestyle that she was living, through no fault of her own.

6.51. Some professionals stated that they did have access to supervision, and some had access to externally facilitated counselling services. Of those that had the offer of supervision, some stated that this was clinical or management supervision and that whilst this was beneficial, they would have valued the ability to independent counselling and support services being offered as routine when working with distressing complex cases.

6.52. Organisations need to be aware of vicarious trauma[13] and ensure that there are strategies in place to manage it; unrecognised, this can lead to mental ill health and burn out. It was noted that there is ongoing work within the local authority in the recognition of vicarious trauma. Health organisations have well embedded safeguarding supervision, with the NHS Hospitals NHS Foundation Trust identifying to the safeguarding team, any staff who have been involved with traumatic events. Likewise the specialist primary care practice has 1:1 face to face safeguarding supervision with the safeguarding lead (relating to children and adults) as well as quarterly Action Learning Sets for all staff with a psychologist and Staff Wellbeing and Support access to Psychologist for 1:1 support.

6.53. Once professionals were informed of Molly's death, the distress was very evident and there were multi agency debriefing sessions and organisations ensured that their own practitioners had access to the services they needed. It may be that there are opportunities for those engaged with complex distressing cases to receive independently facilitated multi agency supervision outside of the professional meetings that they attend. This would enable any trauma in professionals to be recognised earlier. It is important to note that some of the professionals involved felt that they had a great deal of support from each other, again this is very strong practice.

**Learning from strong practice**

- Peer support is a very effective way of checking out how other close colleagues (single and multi-agency) are feeling.
- Bringing all professionals together following a tragic event can help to identify those that need further support whilst recognising the trauma that all working with an individual will feel.

**Points for strengthening practice**

- Recognition of the impact on practitioners of working with complex and distressing cases could result in bringing together those professionals in multi-agency, independently facilitated support/supervision.
- Organisations who are aware of and manage vicarious trauma are beneficial to staff and may offer earlier supportive interventions.

## 7. SUMMARY AND CONCLUSION

7.1. In summarising the learning from this review, it is useful to use a model for a whole system approach used in other adult safeguarding research literature[16] (see figure 1). This model shows how each domain interlinks with the next around Molly.

[13] **Vicarious trauma** is a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health and social care professionals. https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

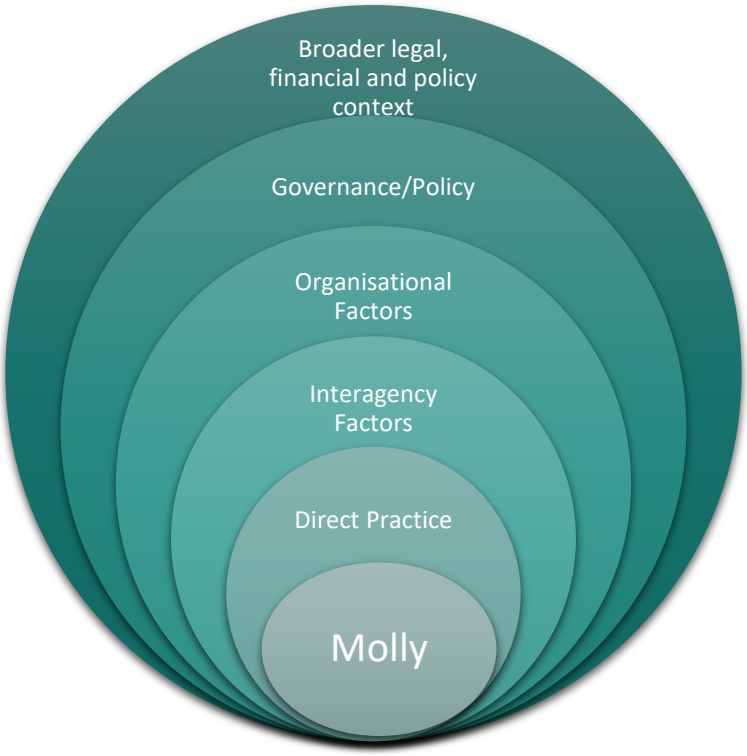


Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

7.2. This review has recognised some very strong practice throughout, from many of the organisations and services involved. Learning from this strong practice is as important as learning from the elements that need further strengthening; both are identified within this report.

7.3. Starting at the centre of the above model is Molly, who had experienced trauma as a child as a victim of child sexual abuse and exploitation. Molly continued to be a victim of the abuse against her that escalated within the timeframe of the review.

7.4. The direct practice around her saw largely strong practice with professionals who were engaged with Molly and worked closely together around her using trauma informed approaches. There were a few professionals who were not able to see Molly as a victim, but this was very limited and not the norm in this case. It is important to note that even one negative response though, can have significant implications for the person concerned.

7.5. Molly's mother also tried to do as much as she could to protect her, searching the houses where she knew she might be to try and make sure she was safe and take her back to her accommodation; Molly never stayed and repeatedly went back to her friends; Molly's mother told the author that she was unable to take her home as it was not safe for Molly's daughter.

7.6. Despite all the strong practice there were blocks and barriers to protecting Molly. At the interagency and organisational levels, there were again some very positive interagency relationships in this case.

Organisational factors were where the frustrations for professionals were initiated from. By not storing or sharing all of the intelligence where it was needed, not all the information was known in all forums and those that had made intelligence reports felt that they had been ignored. It was also at this level that Adult Mental Health services were not able to offer an effective service due to the constraints and policies on the commissioned resources and not being in a position to be able to build a relationship in order to offer care from a trauma informed perspective. There were, however, some frustrations that the criminal justice processes were not able to afford protection and some of this frustration was aimed at the police. It is important to note that the allocated officer did not cause frustration and was part of the core group of workers that were working well with Molly.

7.7. At the governance and policy level we see that there are some robust safeguarding procedures that were being worked with well, evidencing strong practice. This was particularly the case with the enhanced role that TATI provided. There were, however, other strategies, policy and guidance not in place to support the safeguarding work. Whether Adult Sexual Exploitation sits within or under a trafficking and modern slavery strategy, there is still a need to identify clear guidance and the nuances in strategy regarding Adult Sexual Exploitation. The pursue and disrupt element against the known perpetrators was largely not undertaken and where it was, it was ineffective. The lack of suitable and safe accommodation locally also sits within this level.

7.8. At the highest level, there is a lack of national guidance that specifically looks at Adult Sexual Exploitation as a discreet issue or at the transition to adulthood whilst being sexually exploited as a child. There is also limited case law to provide evidence of how the High Court may view inherent jurisdictions in this area of work whether it be for the victim or the perpetrators.

7.9. As a result of using this model it is easier to see where recommendations need to be directed. The direct practice and interagency factors largely worked well, it was those issues more distant to Molly that did not provide her with the appropriate care and protection that she needed to make the necessary changes to her life. Those systems ultimately let her down and she died.

## 8. RECOMMENDATIONS

The recommendations are built around the noted areas that require consideration of stronger practice.

### 1. The Safeguarding system

1.1. TSAB should identify relevant professionals across the TSAB area to explore the TATI process. Areas that need to be addressed are-

- One process for TSAB area
- Where TATI links into other systems (localised where necessary).
- Providing full TOR/Guidance/ and operating protocol with strategic sign up across TSAB area.
- Consideration of a ‘rebranding’ that recognises the complex case and risk management that TATI seeks to address.
- Ensuring legal representation/ advice/information sharing with legal, is included regularly and sought by those agencies involved who have access to such advice.

- Independently facilitated multi agency supervision for the professionals working with complex cases that are discussed within this forum.

## 2. Adult Sexual Exploitation

2.1. TSAB should seek regular updates from work underway on the Cleveland wide ASE strategy and ensure that the following are included:.

2.2. TSAB must identify where recommendations from other ASE SARs remain relevant and assess the need to adopt and/or amend these to benefit those at risk/victims in the TSAB area.

2.3. TSAB should request that the Crown Prosecution Service and Police investigators work to improve the victim's journey through the criminal justice system to create better outcomes for victims of ASE.

2.4. The local Crown Prosecution Service should identify how the current national review will be implemented locally and provide updates to TSAB.

2.5. TSAB should write to the Victim's Commissioner regarding this SAR highlighting learning regarding evidence that may undermine a vulnerable witness's evidence. Reviewing how coerced victim's evidence is viewed should be considered in the proposed new 'Victim's Law' currently under consultation.

2.6. TSAB should seek to understand what work is underway nationally to address ASE.

2.7. TSAB should develop ASE Guidance that is separate to sexual abuse guidance, identifying the differences and approaches that are beneficial to victims.

2.8. TSAB should address the issue of VEMT excluding adults given that many of the children discussed up until their 18th birthday continue to be victims and are subject to abuse from the same perpetrators.

## 3. Trauma informed Care

3.1. TSAB should write to mental health commissioners in the CCG for NHS Mental Health Services and the provider organisation seeking to request that consideration is given to alternative practical therapies being commissioned as well as more traditional talking therapies for those impacted by trauma who are unable to engage in the latter.

3.2. TSAB should continue the work that has started to embed the understanding of Trauma Informed Care.

## 4. Legal Literacy

4.1. TSAB should remind professionals via appropriate means, about the complexity of executive capacity and using expert/legal advice where a person is being coercively controlled and/or using large amounts of substances and there is grave concern regarding the decisions they are making that would question executive functioning.

4.2. TSAB should be updated periodically on the progress of provision of improved and safe accommodation in light of the duty within the Domestic Abuse Act.

4.3. TSAB should write to Local Authority Housing to request where support may be available to restrict non-commissioned housing providers who increase the risk to vulnerable people by

their practices and behaviours.

## 5. General Learning Briefing:

5.1. TSAB should consider various methods of sharing the learning from this review e.g. podcast, video, as well as the traditional learning briefing. This should include the celebration of the good practice that this review has highlighted.

5.2. A case study should be developed to support individual and team reflection and for use in single and multi-agency training.

**Appendix One:**

Terms of Reference and Project Plan (Redacted)

## 1. Introduction

A Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

**Condition 1 is met if—**

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

**Condition 2 is met if—**

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;

- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

## 2. Case Summary known from referral and scoping

Molly was a 25-year-old woman of White British origin who was found deceased at a property of a person not well known to her. The cause of death remains under investigation at the time of drafting these Terms of Reference. Molly had been known to multiple services in the years prior to her death. Molly was open to safeguarding for two years and was discussed within the Team Around the Individual (TATI) process for one year. Concerns regarding Molly related to sexual exploitation from multiple perpetrators, sexual violence, historical abuse, self-harm, domestic abuse, self-neglect, homelessness, and drug use.

## 3. Decision to hold a Safeguarding Adults Review

The Safeguarding Adults Review Sub-Group of the Safeguarding Adults Board met to consider the case for review. Following the collation of chronologies, the case was further considered. It was agreed by all members present that a formal Safeguarding Adults Review should be undertaken and made a recommendation to the TSAB Independent Chair. The Independent Chair endorsed this decision.

## 4. Scope

The review will cover the period from 1st April 2021 until the date of death. The date of 1st April is specifically related to a time whereby risk was escalating due to increasing influence by organised crime individuals and gangs. It covers a time where there was intense work being undertaken by many professionals. Information will also be sought from agencies regarding background information, key events and interventions at any point prior to the scoping period.

## 5. Methodology

The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

TSAB elected to use a rapid review methodology that engages frontline practitioners and their line managers. Chronologies collated during the scoping phase along with documents used for decision making were reviewed by the author to ensure that areas for enquiries already identified were relevant. Agencies are asked to review their own involvement and provide a brief report of their learning and recommendations. A reflective workshop will be undertaken using an appreciative enquiry approach undertaken using virtual meeting technology or face to face if Covid restrictions allow. The workshop will focus on understanding the strengths in the current systems and working towards identifying any areas for further improvement.

## 6. Key Lines of Enquiry to be addressed

The following case themes that will be addressed and are not in any order of priority or importance.

### 6.1. The Safeguarding System

6.1.1. How strong is the safeguarding system in cases that remain open to safeguarding for a lengthy period?
6.1.2. How does TATI support the safeguarding system?
6.1.3. How does the safeguarding system inform care planning and interventions?
6.1.4. How do we ensure that the safeguarding system is outcome and goal focussed and how do we measure its success?

### 6.2. Sexual Exploitation

6.2.1. What does the culture locally tell the review about agency views of those who are trafficked and exploited for sex for the gain of others?
6.2.2. What is undertaken locally to break up and disrupt those who seek out the vulnerable to sexually exploit them?

### 6.3. Trauma Informed Care/Approaches

6.3.1. What supports professionals to understand Trauma
6.3.2. What is Trauma Informed Care?

6.3.3. What options are available to professionals to deliver Trauma informed Care in the following areas:

- Transition to adult services
- Provision of suitable housing and placements
- Engagement with those affected by Trauma

6.3.4. What are the barriers to delivering Trauma Informed Care

### 6.4. Legal Literacy

6.4.1. How well did professionals understand the legal processes identified within this review (see list below)?

- The Care Act (2014)
- The Mental Capacity Act
- Domestic Abuse Crime and victims Act
- Homeless Reduction Act?

6.4.2. How were the full parameters of these Acts explored?

6.4.3. What were the limitations to the use of these acts and why?

### 6.5. Complex Cases Support and Supervision

6.5.1. Where do professionals involved in complex and upsetting cases receive support?

6.5.2. Is there clarity within organisations what options are available?

## 7. Independent Reviewer

The named independent reviewer commissioned for this SAR is **Karen Rees.**

## 8. Organisations to be involved with the review:

The following organisations will be asked for Agency Rapid Review Reports:

| | |
|---|---|
| • Registered Charity 1 | Sex work and ASE Outreach and prevention charity |
| • Registered Charity 2 | Charity delivering specialist services for rape or sexual abuse. |
| • Police | |
| • GP Practice | |
| • Specialist Primary Care Practice | |
| • Local Authority Safeguarding Team | |
| • Local Authority Housing | |
| • Local Authority Neighbourhood Safety | |
| • Local Authority Substance Misuse Services | |
| • Ambulance Service NHS Trust | |
| • Vulnerable and Homeless Housing Provider | |
| • Hospitals NHS Foundation Trust | |
| • Mental Health NHS Foundation Trust | |

The following organisations/services will be asked for background information to support the review:

- Children's Social Care
- Registered Charity 3 Charity offering multiple domestic abuse services

**9. Family Involvement**

A key part of undertaking a SAR is to gather the views of the family, involve them in the review and share findings with them prior to publication. TSAB has made contact with Molly's mother, inviting her to be involved. A point of contact within the local council has been given to Molly's mother. The independent reviewer will arrange to make contact with mother through the contact point.

**Project Plan dates:**

| | | |
|---|---|---|
| 1. | Initial planning meeting | 2/11/2021 |
| 2. | Review of Chronology and Documentation by Independent Author | 2/11-19/11/2021 |
| 3. | Scoping Meeting | 23/11/2021 |
| 4. | Terms of Reference agreed | 23/11/2021 |
| 5. | Distribution of case information to all workshop attendees | 08/12/2021 |
| 6. | Learning and Reflection Practitioners' Workshop | 15/12/2021 |
| 7. | First Draft Overview report to all attendees and Panel | 21/01/2022 |
| 8. | Panel meeting | 03/02/2022 |
| 9. | Feedback from Workshop attendees | 04/02/2022 |
| 10. | V2 Overview report to Panel | 11/02/2022 |
| 11. | Panel meeting to finalise report and build Recs | 03/02/2022 |
| 12. | Extraordinary Statutory Partners Meeting | 31/03/2022 |
| 13. | Final report to Board | 26/04/2022 |